Parent-Infant Relationships (PAIR) Services Commissioning Toolkit

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Newcastle University

NIHR | Applied Research Collaboration North East and North Cumbria

Parent-Infant FOUNDATION

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How to get the most out of this toolkit

Commissioners told us they needed this toolkit

This toolkit was created to provide the information and tools commissioners told us they need when commissioning services to strengthen parent-infant relationships. Research conducted in 2021[1] by Newcastle University and the Parent-Infant Foundation, funded by the **NIHR Applied Research Collaboration North East North Cumbria** identified a range of needs and barriers experienced by commissioners seeking to improve support for parent-infant relationships.

Common barriers included:

- lack of clarity about language and concepts in this topic
- not having easy access to evidence about the importance of parent-infant relationships and their potential impact on children's outcomes
- being concerned about poor public understanding and awareness of parent-infant relationship difficulties and services
- not being clear about what their local population might need to strengthen parent-infant relationships
- not knowing where to find evaluations of other parent-infant relationship services
- not having access to examples of good practice
- needing help to know what solutions could work in their local area
- a lack of clarity about levels of care for very young children
- confusion about which commissioners are responsible for commissioning parent-infant relationship services
- funding and workforce development challenges

This toolkit is designed to address each of these points and is **for all commissioners who commission services which promote and strengthen parent-infant relationships**.

This toolkit is not a comprehensive manual, but a curated collection of information, links and signposts to videos, evidence briefings, reports and links to examples of good practice so that you can explore each topic in more depth.

This Commissioning Toolkit expands and updates information in the complementary Development and Implementation Toolkit available on the **Parent-Infant Foundation website**.

How to use this toolkit

Part A equips you with important foundational knowledge before proceeding. Part B walks you through the commissioning cycle (Analyse, Plan, Do, Review). **We encourage you to start with Section A.1 as the basis for all the other sections.**

PART A

Part A, **Section A.1** (What do we mean by parent-infant relationship services? A brief guide to concepts and language) provides important points of clarification to help you avoid confusion further down the line, so we strongly recommend you start there. It will support your conversations with service providers, parents, the local children and families' workforce, senior leaders and the wider system. It will also help orientate you to the topic.

Sections A.2 and **A.3** relate to why this topic matters and who is responsible for commissioning. **A.3** will help you create one of your most important tools – a theory of change. Together, these sections will give you a better understanding of the relevant evidence and which local partners to work with at various points of the commissioning cycle.

PART B

In **Part B**, **Sections B.1** to **B.9** map onto the commissioning cycle (Analyse, Plan, Do, Review) and we suggest completing those activities in that order.

TOOLS

Finally, there are some tools to help you, including an intervention map and systems self-assessment grid.

Invaluable resources

In every section,we signpost you to helpful resources. Additionally, the documents below provide invaluable context, information and help for all parts of the commissioning process.

Rare Jewels[2] – a ground-breaking report about the need for and provision of parent-infant relationship services across the UK. Packed with useful infographics and information.

The Parent-Infant Foundation's Development and Implementation Toolkit – a comprehensive toolkit covering all aspects of commissioning, designing, developing and evaluating a specialised parent-infant relationship team.

Securing Healthy Lives[3] – a recent, real-world example of the Analyse and Plan parts of the commissioning cycle.

Babies in Lockdown[4] (2020) and **Casting Long Shadows**[5] (2022) – two companion reports examining the impact of the COVID pandemic on babies, their families and the services that support them. These reports provide information on the current commissioning context.

PART A

A.1 What do we mean by parent-infant relationship services? A brief guide to concepts and language

You're likely to have heard words like attachment, bonding, infant mental health, emotional wellbeing, infant social and emotional development, parent-infant relationships, ACEs or early childhood development. What might be less familiar is exactly what they all mean and how they relate to one another and to the commissioning process. This lack of clarity was identified as a significant hindrance to the commissioning process by multiple commissioners in the research we undertook to inform this toolkit, so here's a brief guide to language and concepts.

Who

The terms **baby** and **infant** tend to be used interchangeably. In this report both terms refer to children from conception to their second birthday.

What

Bonding is the term used to refer to the process of parents forming an emotional connection to their baby. **Attachment** is the reciprocal process by which a baby forms an emotional connection to its parents or carers. How well parents bond with and care for their baby during **the First 1001 days** of life shapes the quality of attachment the baby forms with that caregiver. Attachment quality is reliably measurable before a child's first birthday and typically remains static during childhood without a significant change of caregiving. There is more detail about attachment patterns in **Section B.1**.

The word attachment can be controversial and is frequently misunderstood. This is partly because it has both a lay meaning (*"I feel really attached to my dog"*) and a much narrower technical meaning (referring to particular patterns of behaviour seen between a baby and its carer during moments of stress). Hence, attachment is technically only one part of the parent-infant relationship. There are other aspects of the parent-infant relationship such as **reciprocity**, **attunement**, **parental sensitivity** or **emotional regulation**.

To avoid this confusion, many professionals prefer instead to use the umbrella term parent-infant relationships (PAIR).

Why

Parents can be experiencing stress and adversity from their current circumstances (e.g. poverty, domestic abuse, housing problems, mental health problems) or from past experiences(such as **Adverse Childhood Experiences and Environments [ACEs]**). Stresses increase the risk that a parent will find it more challenging to provide a safe and secure parent-infant relationship and if that happens the baby can develop indicators of distress. If left unaddressed, this distress can develop into disturbance and later down the line, an attachment **disorder**.

There is a very clear link between these kinds of **parent-infant relationship difficulties** and later mental and physical health difficulties[6,7]. The quality of a parent-infant relationship also has a significant impact on the baby's **brain development, social and emotional development** and other aspects of development. Therefore, commissioning interventions, services and support for parent-infant relationships delivers multiple short- and long-term impacts. **Section A.2** signposts you to the evidence about this and **Section B.1** explains the scale of this problem and supports you to understand the population need in your local context.

Good **infant mental health** is one outcome of a safe and secure parent-infant relationship. This means that where parents have provided safe, responsive and 'good enough' caregiving during their child's earliest years, that child is more likely to learn how to manage their feelings, regulate their behaviour, develop social skills and sustain healthy relationships with others. To some, the term **infant mental health** is unappealing because it is wrongly assumed a baby is going to be labelled, diagnosed or pathologised, that it implies there is something intrinsically wrong with the baby's mind, or that they would be treated with medication or offered talking therapies.

However, the term 'infant mental health' refers to the baby's social and emotional wellbeing which results from the quality of the relationships around them, so **infant mental health difficulties** are always framed as relational. Interventions are also always relational, involving at least one of the baby's carers.

How

There are currently around 42 specialised parent-infant relationship teams in the UK. Some call themselves **Parent-Infant Mental Health Services (PIMHS)**. Sometimes, there is confusion between **'perinatal'** and **'parent-infant'** services. NHS **perinatal mental health** services typically focus on mothers with moderate to severe mental health problems. The work of these services tends to start and end according to the mental health needs of the adult.

The relationship between the parent(s) and baby is not the core focus of the work, although some perinatal mental health teams sometimes offer parent-infant relationship work as part of their care package. Many parents or carers who need support or interventions for their parent-infant relationship do not meet criteria for or indeed need perinatal mental health services. Therefore, both perinatal *and* parent-infant relationship services are needed.

An effective parent-infant relationship service works across sectors and levels of care

In this toolkit we refer to **parent-infant relationship (PAIR)** services as an umbrella term for

a. **support** (a range of activities which encourage the development of healthy parent-infant relationships, sometimes called **primary prevention**)

b. **interventions** (activities which directly address parent-infant relationship difficulties, sometimes called **secondary or tertiary prevention**)

c. **teams** (specialised teams focussing on parent-infant relationships typically at a **specialist level**)

although these are of course on a continuum.

Some practitioners and services deliver support and/or interventions depending on the family's level of need.

Early intervention can mean either:

a. **By age:** intervening **early in a child's life**, irrespective of how complex the parent-infant relationship difficulties already are.

b. **By complexity:** intervening **early in the development of a problem**, irrespective of the age of the child, to prevent difficulties from escalating.

Parent-infant relationship difficulties, by definition, always occur early in the child's life but can already be serious and complex at birth. These are unlikely to improve without specialist intervention so do not confuse "young age" with "easy problem".

Various services and practitioners already support **good quality interaction** and **sound emotional connections** between parents and their baby, including midwives, health visitors, GPs, social workers, family support workers, parenting group facilitators, speech and language workers and voluntary sector workers (See Figure 1). That is why parent-infant relationship service development is always a **system transformation** endeavour, bringing together people and organisations to create effective **care pathways** through **universal, targeted and specialist** levels of care (these are defined in **Section A.3**).

Finally, we strongly advise local discussion to clarify and agree use of terms across the system. Despite widespread agreement that the relationship between a baby and its parents is really important, different professionals, teams and sectors understand and use terms differently. Developing a shared language will help support everyone to work together to support parents and babies.

Figure 1: Strengthening parent-infant relationships is a systems transformation

So what? And what next?

In this section we have described that it is vital to secure a shared understanding of language and concepts in this topic as different people understand common terms and ideas very differently.

Being clear about this will help you digest the evidence and have more productive conversations with stakeholders.

Your first step might be to arrange some conversations and events to develop that shared understanding. Now move on to the next section about why parent-infant relationships matter and the outcomes they contribute towards.

Additional resources

- **What is Infant Mental Health?** (2-minute film)[8]
- **Infographic: What is Infant Mental Health? Why does it matter?**[9]
- Browse the **Parent-Infant Foundation's locations map** on their website to see the variety of team names
- **Webinar from First 1001 Days Movement "How we talk about Infant Mental Health"**[10]

A.2 Why does it matter? Evidence about the impact of parent-infant relationships on children's outcomes

In our research, commissioners told us they needed easier access to evidence about the impact of parent-infant relationships on children's outcomes. This section provides a very brief summary and links to concise, good quality evidence reviews.

> "Throughout my life, professionally and as a parent, I've seen first-hand how drastically the earliest years of life can alter the course of someone's future."
>
> **Jon Sparkes OBE Chief Executive, UK Committee for UNICEF (UNICEF UK)**[11]

The first few years can last a lifetime

What happens to babies can have a large impact on later life outcomes for better or worse. Brain development is at its most rapid and malleable during the first few years of life and optimal brain development is highly dependent on interaction with carers.

See From **Best Practices to Breakthrough Impacts**[12] by the Harvard Center on the Developing Child (2016) for an excellent review of this area.

Parent-infant relationships characterised by sensitive nurturing parenting promotes better lifelong mental and physical health, social skills and adult relationship quality. Although children's futures are not determined by the age of two, the quality of parent-infant relationships are linked to many later outcomes (see Figure 2).

See *Infant Mental Health and Specialised Parent-Infant Relationship Teams: A briefing* (2020) by the Parent-Infant Foundation for a summary of this evidence.

Figure 2: The broad array of outcomes shown to be supported by the quality of parent-infant relationships.

Healthy parent-infant relationships enable babies and toddlers to feel safe and secure, ready to play and explore and learn. Children who have had good early relationships start early education and school best equipped to be able to make friends and learn.

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

Research shows a strong connection between exposure to stress in pregnancy and early life, and later mental health problems.[30,31] By helping babies to cope with early emotions, parents help children to develop behavioural and physiological regulation. These are linked to lifelong health and wellbeing.

Early relationships set templates and expectations for future relationships. Secure, nurturing relationships give babies the skills to form trusting relationships with others. Relational capability is essential for living a healthy and fulfilling life and making a positive contribution to the lives of others.

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

Additional research summaries

- **Best Start for Life**, HM Government (2021) pages 16-18[32]
- **Securing Healthy Lives,** Parent-Infant Foundation (2021), pages 7-12

The impact of parent-infant relationship work

The following section signposts you firstly to information about specific parent-infant relationship interventions and how they have been shown to reduce risks and improve outcomes for parents and children. Interventions can be delivered by a range of different practitioners and services at various levels of care, and might be designed for groups, couples, families or just one parent-infant dyad at a time.

Then we consider the outcomes at the level of a specialised parent-infant relationship team or service. These services blend various evidence-based assessment and intervention approaches into a tailored care package for each family.

Finally, we include links to cost-benefit evidence.

Where to find evidence about parent-infant relationship interventions

There is substantial evidence that parent-infant relationship interventions are effective in the short and long term. Most interventions have their own websites which link to their published evidence or provide contact details. Here, we signpost you to websites which review more than one intervention or provide an overview of intervention approaches. We have also provided an intervention map (in the **Tools section** at the end of this toolkit) which is not exhaustive but does map parent-infant relationship interventions commonly used in the UK to various levels of care.

The Early Intervention Foundation (EIF) is an independent charity and one of the Government's 'what works' centres. Their report **Foundations for Life: What works to support parent-child interaction in the early years (2016)**[33] reviewed 75 programmes.

The report found that although the overall evidence base for programmes available in the UK is not yet mature, there is a range of well evidenced and promising interventions that, if carefully commissioned to ensure they fit with local need and context, are likely to be effective in tackling problems identified in the early years. The evidence is strongest for programmes that target based on early signals of risk, such as child behaviour problems, insecure attachment, delayed development of speech and lack of maternal sensitivity, although other types of programmes have also been found effective.

The **Parent-Infant Foundation Development and Implementation Toolkit** (2019) Chapter 4, pages 16-22, describes a range of individual and group parent-infant relationship interventions and links to their research.

The Anna Freud National Centre for Children and Families has published a review of psychotherapeutic approaches with children under 5 entitled **The Evidence Base for Psychoanalytic and Psychodynamic Interventions with Children Under 5 Years of Age and Their Caregivers: A Systematic Review and Meta-Analysis**.[34]

There is additional analysis of parent-infant interventions at the **California Evidence-Based Clearing House for Child Welfare**, although only a handful of the reviewed interventions are currently available in the UK.

Evidence for specialised parent-infant relationship teams (Whole team/service evaluations)

International evidence demonstrating measurable impact of parent-infant relationship *teams* (which use an array of interventions) is growing as countries begin to invest in services for babies and parents. Broadly speaking, parent-infant relationship teams demonstrate improvements in both parental mental health and the quality of the parent-infant relationship.

This 8-minute video[35] summarises the evaluation and impact of a parent-infant relationship team in Essex, Thurrock and Southend. You can also watch the full webinar **here**[36]. Outcome measures for a small group of parents demonstrated improved parental mental health and parent-infant relationships.

An **Evaluation to Assess the Impact of the Newcastle Parent-Infant Partnership**,[37] a qualitative study by Newcastle University funded by the NIHR Applied Research Collaboration North-East North Cumbria (ARC NENC), found improvements in parent-infant and couple relationships and parental confidence and sense of empowerment.

A **published evaluation by Essex University of a parent-infant relationship service for families with safeguarding risks**[38] found significant cost-savings, a reduction in number of children removed into care and a reduction in overall safeguarding concern for about half of the families. You can read more about that service **here**[39].

A published study by Edgehill University (**Briscoe et al., 2022**)[40] found parents reported significantly increased ability to bond with their baby after intervention from a parent-infant relationship team.

An unpublished evaluation of service data from over 450 parents who attended the **Oxford Parent-Infant Partnership** team between 2017-2022 found highly statistically significant improvements in self-report parental anxiety and depression scores and in parent-infant interaction rated by clinical observation (Figure 3). Similar results were published for **Northampton's** NORPIP team[41], **Tameside and Glossop's**[42] Early Attachment Service and Bradford's Little Minds Matter (**Annual Report, page 7**)[43].

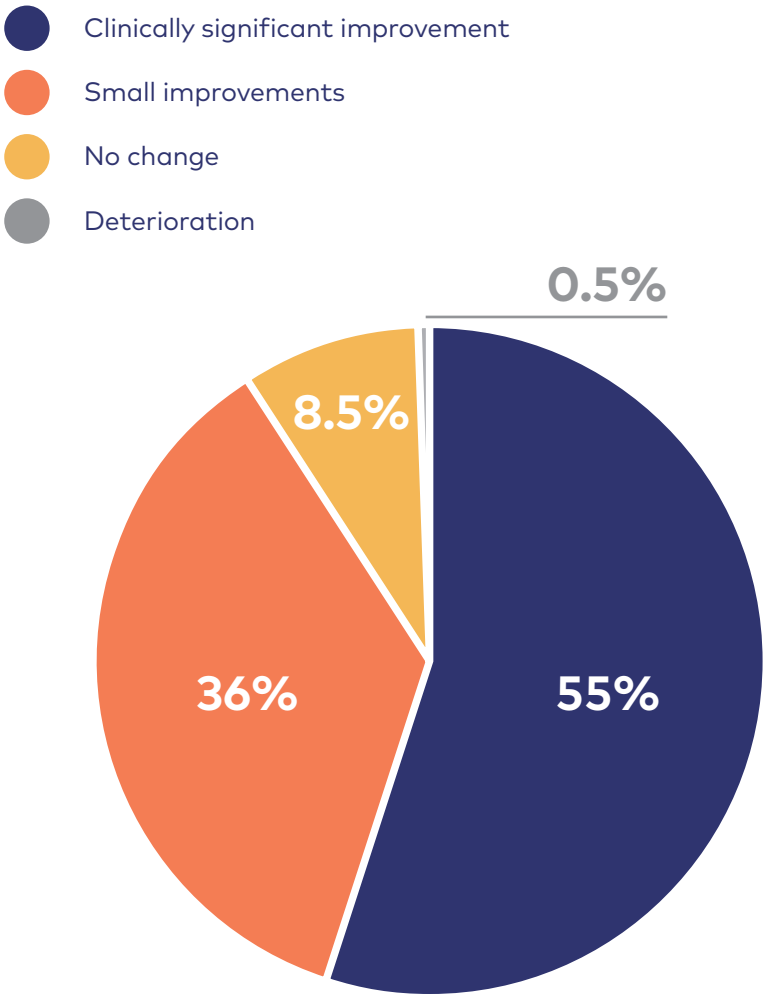

Figure 3: Changes in parent-infant relationship quality following treatment (438 parents, 2017-2022, OXPIP, unpublished data).

Cost-Benefit evidence

As local areas face a combination of budget pressures and increased service demand there is a need to consider the cost-effectiveness of parent-infant relationship interventions and services. For a concise summary of the economic case for investment in early childhood services, see the First 1001 days movement's **Evidence Brief 6**.

In Liverpool, **a social impact study**[44] (2017) found that for every £1 invested in a voluntary sector parent-infant relationship team and postnatal depression service, £13.18 was saved in public costs (health, social care, education and criminal justice) and £59.91 is created in social value (also including social and emotional benefits like quality of life and potential future earnings).

There is a striking difference between the costs to public services for at-risk young people who are securely attached to their parents and those who are not (**Bachmann et al., 2019**[45]). For example, the annual costs for health, education and social services for at-risk young people who were insecurely attached to their fathers were ten times more than those who were securely attached. This difference remained significant, even after adjusting for other confounding factors such as family income, education, intelligence and antisocial behaviour. The authors conclude "attachment insecurity is a significant predictor of public cost in at-risk youth". Recall from **Section A.1**, attachment security is reliably measurable from before the child's first birthday and typically remains static during childhood without a significant intervention or change of lifestyle.

A study from King's College London **A Good Investment: Longer-terms savings of sensitive parenting in childhood**[46], found that young people who were being sensitively parented by the time they were 4-6 years old cost 13 times less than their peers who had not been sensitively parented during early childhood.

This included costs to the family. Excluding costs to the family, the report **Cost-Effectiveness of Infant and Early Mental Health Treatment** (2022)[47] from America estimates a $1.80-$3.30 saving to the public purse for every $1 spent.

For American-developed interventions, the **Washington State Institute of Public Policy** provides a database of cost-benefit analyses. For example, for every $1 spent, Circle of Security saves $3.22, Roots of Empathy saves $4.46 and Child-Parent Psychotherapy saves $13.82. Benefit-Costs Results, Washington Institute for Public Policy **www.wsipp.wa.gov/BenefitCost**.

In 2016, **a comprehensive UK analysis**[48] found that the majority of costs of long term consequences of perinatal mental health difficulties were those associated with the impact on the child.

So what? And what next?

Commissioners asked for a "one-stop shop" of links to research and evidence. In this section, we have provided information about a range of developmental outcomes impacted by safe and secure parent-infant relationships.

We have signposted you to scientific research, and to evidence about the effectiveness and cost-effectiveness of interventions and services. Together, these resources will help you better understand, communicate and mobilise support for the case for investment in parent-infant relationships.

The next section looks at who should be involved in commissioning parent-infant relationship services, and how a theory of change is an essential tool to support the commissioning process.

A.3 Who is responsible? Identifying commissioning opportunities and responsibilities and developing a theory of change

In our research[49], commissioners told us that they are not always clear which strategic workstreams parent-infant relationships (PAIR) sit under, and therefore there can be confusion about who is responsible for commissioning PAIR services.

This section describes different policies and structures across the UK which support the commissioning of PAIR services. We also provide information and links about co-producing a theory of change, which has many benefits, not least in supporting your conversations with colleagues about who commissions what.

Section B.9 references relevant National Institute of Clinical and Health Excellence (NICE) guidance, including for babies in Looked After Care.

This is achieved by:

- local leaders having a good understanding of the first 1001 days and why early relationships matter
- strategic commitment to giving children the best start in life, and a whole system approach to achieving this goal
- partnership working between commissioners and across services
- flexibility, persistence and seizing opportunities to grow and develop the offer

Reference: **Rare Jewels report (Hogg, 2019)**[50]

Identifying commissioning opportunities and challenges

Strengthening parent-infant relationships delivers benefits for health, social care, education and community safety. Parent-infant relationship services run across levels of care and across organisations. This work does not sit neatly within any one institution or policy brief. Therefore, at a national and a local level, responsibility for commissioning universal, targeted and specialist PAIR services is distributed and reliant on excellent communication and partnership working.

Case Studies and Examples of Good Practice in commissioning

You will find more information about how specialised parent-infant relationship teams around the UK are commissioned and funded, including brief cases studies in the **Parent-Infant Foundation Development and Implementation Toolkit Chapter 3: Commissioning and Funding**. **Section B.5** of this toolkit links to examples of parent-infant relationship services around the UK.

National policy and strategy drivers

England

Start for Life Policy

In 2021, the UK Government published **A Best Start for Life: Vision for the 1,001 critical days**[51]. Following this, the Chancellor allocated £300m for 75 Local Authorities to improve their Family Hub provision and Start for Life services. The **Family Hubs and Start for Life programme guide (2022)**[52] sets out guidance for how this money should be spent. This includes £100 million for bespoke parent-infant relationships and perinatal mental health support should be used to *"promote positive early relationships and good mental wellbeing for babies and their families."* Start for Life

This work is supported by the **National Centre for Family Hubs**, a centre of best practice to support the implementation and delivery of family hubs.

If you are one of the 75 areas identified for Start for Life funding, this is a clear driver for strengthening parent-infant relationship support.

Mental Health Policy

CAMHS

The **NHS Long Term Plan** (2019) states that children's mental health services should *"create a comprehensive offer for 0–25-year-olds"*. However, whilst there has been growth and transformation of services across children and young people's mental health services, local services frequently do not see young children in practice. NHS England has recently begun work to better understand this issue by commissioning benchmarking of services and work to understand need.

Perinatal Mental Health

The NHS Long Term Plan also sets out plans for specialist perinatal mental health services to expand access to evidence-based psychological therapies including parent-infant, couple, co-parenting and family interventions. This provides an opportunity to expand parent-infant relationship support for babies whose mothers have moderate or severe perinatal mental illness and are eligible for specialist perinatal mental health service.

The Royal College of Psychiatrists (**2021**)[54] calls for provision of therapeutic interventions for parent-infant relationships in pregnancy and the early years, and *"ideally, a combined perinatal and infant mental health strategy and integrated pathway"*.

Integrated Care Systems (ICSs)

Statutory integrated care systems (ICSs) are partnerships of NHS bodies and local authorities, working with other relevant local organisations, to plan and deliver joined up health and care services. Each ICS has an integrated care board (ICB), which is a statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget, and arranging for the provision of health services in the defined area. ICSs have taken over many of the responsibilities previously held by Clinical Commissioning Groups, including the commissioning of maternity and mental health services.

Guidance on the preparation of integrated care strategies (2022)[55] states that integrated care partnerships should consider how the needs and health and wellbeing outcomes of babies, children, young people, and families can be met and improved. This guidance states that *"The integrated care strategy could take a whole-family approach, recognising that children's and their parents' and siblings' needs are inter-connected..."*.

ICSs represent improved opportunity to commission services which can be delivered across, and deliver benefits for, different parts of the health and social care system.

Maternity

NICE guidelines on antenatal and postnatal care published in 2021 (**NG201**[56] and **NG194**[57]) recommended providing parents with information and support where indicated regarding "bonding and emotional attachment" (see **Section B.9** for further details).

Public Health Services

Responsibility for public health policy in England sits with the Office of Health Improvement and Disparities in the Department of Health and Social Care. Local Authorities commission public health services for their area, including Health Visiting services and other aspects of the Healthy Child Programme. In 2021, national guidance on the **High Impact Area 2 for Health Visiting**[58] was updated, emphasising the importance of infant mental health alongside maternal mental health.

Supporting Families Programme

The Supporting Families Programme helps to ensure that families with multiple disadvantages get the support they need. National responsibility for the programme sits in the Department for Levelling Up, Housing & Communities in Westminster, and it is commissioned by Local Authorities. The **Supporting Families Programme Guidance** (2022-5)[59] contains a revised outcomes framework which recognises the importance of the earliest years, for achieving the best possible start in life. The framework contains outcomes relating to good early years development, including meeting children's social and emotional developmental needs.

Early Help and Children's Social Care

Many specialised parent-infant relationship teams in the UK work closely with social care services to support babies on the edge of care to ensure that they receive the sensitive, nurturing care they need to thrive. These teams can also support foster carers and adoptive carers to provide children with the nurturing care they need. The Independent Review of Children's Social Care (2022)[60] called for a reform of, and new investment in, family help services in England. The report calls for *"a simplified service that is more responsive, respectful, and effective in helping families."* An action plan for responding to the Review is due in 2023 and should set out new opportunities to improve support for families.

Wales

There is no separate national commitment to parent-infant relationship provision in Wales yet. However, of the seven Health Boards, there are two existing specialised teams and at least two other Health Boards strengthening their provision. A number of policies are conducive to the creation of services and support:

- A Healthier Wales: our plan for Health and Social Care (2019).
- Wellbeing of Future Generations Act (2015)
- Healthy Child Wales Programme (2016)
- Prosperity for All – the National Strategy (2017)
- Talk with me: Speech, Language and Communication Delivery Plan (2020)
- Together for Mental Health (2012) The current Mental Health strategy for Wales ends in 2022, and the new strategy should provide opportunities to strengthen infant mental health provision.
- National CAMHS Strategy – **The Welsh NYTH/NEST Framework**, which aims to "ensure a 'whole system' approach for developing mental health, wellbeing and support services for babies, children, young people, parents, carers and their wider families", is informed by attachment theory and specifically identifies parent-Infant relationship services as part of a comprehensive children's mental health offer.

There is a review of these opportunities in Wales in **Sicrhau bywydau iach/Securing Healthy Lives**[61] "How this work connects to local and national strategy" (2021, pages 45-48) (available in English and Welsh languages).

Scotland

The Scottish Government's 2018/19 Programme for Government set out commitment to improve perinatal and infant mental health services, supported by £50 million investment over four years. The programme is overseen by the Perinatal and Infant Mental Health Programme Board, which is supported by an **Infant Mental Health Implementation and Advisory Group**.

The programme has led to the development of specialist Community Perinatal Mental Health Teams across Scotland and enhanced psychological support for maternity and neonatal settings. Five Boards (Fife, Greater Glasgow and Clyde, Highland, Lanarkshire, and Lothian) are in the process of establishing dedicated multidisciplinary Infant Mental Health teams.

Other Health Boards are embedding Infant Mental Health provision in other ways. The Scottish Government has also established a Perinatal and Infant Mental Health Third Sector Fund. Detail on progress can be found in the programme board delivery plan[62].

UNICEF are calling for the UK governments to include parent-infant relationship support as part of a national Baby and Toddler guarantee.

Their report **Early Moments Matter** (2022) contains a wealth of evidence, including an audit of the disparities in parent infant relationship teams across the nine regions of England.

Northern Ireland

In 2016, the Public Health Agency developed an **Infant Mental Health Strategic Framework**[63] in Northern Ireland which led to the improvement of service provision and workforce development relating to infant mental health. There are currently three specialised parent-infant relationship teams in Northern Ireland, alongside a range of targeted and universal support.

In 2021, the Health Minister launched a new **ten year mental health strategy**[64] which set out an ambition to "ensure that the needs of infants are met in mental health services."

This summary of national policies and opportunities supports one conclusion: strengthening parent-infant relationships can and must be achieved through partnership arrangements. Those partnership arrangement differ from area to area and frequently "break the mould" of who commissions and delivers what.

Co-producing a theory of change

We believe a co-produced theory of change is an essential asset for commissioners and will help you thoughout the commissioning process.

Co-producing a theory of change will help you:

- map a course from where you are now to where you want to be
- crystallise the problem you are trying to solve
- identify the outcomes you want to achieve and effective ways to achieve them
- understand what to evaluate and how

We describe the process of co-production with babies and their families in **Section B.2** and with colleagues in **Section B.3**.

You can use the information and links from **Section A.2** along with the resources below to co-produce a theory of change.

Watch this **6-minute video**[66] by Born in Bradford and this **10-minute video**[67] from the Early Intervention Foundation about how to develop a theory of change.

The National Centre for Family Hubs has a **useful guide to developing a theory of change**[68] as part of its toolkit for family hubs.

The Parent-Infant Foundation have developed two theories of change in their Development and Implementation Toolkit. Scroll to the bottom of their webpages to see their theory of change graphics. The first is about the **changes for individual babies and families** as a result of specialised PAIR services (Chapter 4, pages 5-7), and another about the **system-level impacts** of specialised PAIR services. (Chapter 3, page 5).

You may find you need to revisit and refine your Theory of Change once you have completed a population needs analysis (**Section B.1**), listened to the voices of babies and those who care for them (**Section B.2**) and mapped current service provision exercise (**Section B.3**).

Practice Points: Be very clear about different levels of care

Babies' and parents' needs exist on a continuum, but to make your theory of change more manageable, in this toolkit we refer to three broad levels of care in parent-infant relationship (PAIR) services (See Table 1).

Practice Points: Be very clear about language

It is recommended during all co-production activities, including theory of change co-production, that you be very clear about what terms mean. **Section A.1** will help you navigate language and concepts. For example, "early intervention" can mean either intervening early in a child's life, irrespective of how complex the parent-infant relationship difficulties already are. Or it can mean intervening early in the development of a problem, irrespective of the age of the child, to prevent difficulties from escalating.

The next section of this toolkit will start you on the commissioning cycle by helping you identify your local population need.

So what? And what next?

It's important that all relevant commissioners understand that strengthening parent-infant relationships (PAIR) delivers benefits across health, social care, education, and community safety.

As such, PAIR commissioning does not typically fit neatly into one organisation's brief or policy area. Whilst some services in the UK sit operationally in, or are funded wholly by, CAMHS, public health nursing, social care or the voluntary sector, effective parent-infant relationship commissioning shares one key characteristic: good partnership working.

Additional resources

- What is a specialised parent-infant relationship team? (3 minute film)[69]
- Infant Mental Health Framework for Northern Ireland[70]
- Parent-Infant Foundation Development and Implementation Toolkit Chapter 3: Commissioning and Funding

Table 1: Definitions and examples of different levels of care in parent-infant relationship (PAIR) services.

Level	Description	Examples of activity	Traditionally commissioned as part of
Universal	Services offered to all families, such as GPs, midwives and health visitors.	Bonding and skin-to-skin advice General support and advice about developing a good parent-infant relationship	• Midwifery • Health Visiting • General Practice
Targeted	Services that work with families who need some additional help, such as parenting support from a Family Hub, or an enhanced package of support from a health visitor.	Relationship focussed individual or group-based interventions in family support, midwifery, health visiting skill mix teams etc.	• Early Years • Early Help/Children's Centres • Family Support/Hubs • Health Visiting • Midwifery • Speech, Language and Communication • Educational Support including Educational Psychology • Children's social care • Community safety
Specialist	Services whose work requires a specialist mental health intervention or skill set, usually from a multi-disciplinary team. In mental health services this might be described as 'Tier 2 or 3' rather than 'specialist'.	A specialised parent-infant relationship team including mental health expertise. This can include longer term work to address more complex parent-infant relationship issues.	• CAMHS • Perinatal Mental Health • Paediatric Psychology • Children's Social Care

PART B

ANALYSE

B.1 Establishing your local population needs

This section will help you determine how many babies in your local population might need and benefit from parent-infant relationship support and at what levels (universal, targeted, specialist – see table in **Section A.3** for definitions). Ensuring babies and their families are signposted to the appropriate level of care means resources are used efficiently, and that their needs are met with the right services at the right time to avoid problems escalating.

How to assess your local population need

There is currently no published guidance about how to complete a needs assessment for parent-infant relationship support and intervention. The UK governments do not routinely collect data about clinical indicators of parent-infant relationship difficulties and there is no simple way to audit these across a local population. Previous JSNAs may have focussed on behavioural, health or social care indicators without understanding the role played by parent-infant relationships. However, the Parent-Infant Foundation has recently proposed a model which uses international, national and local research and data.

In an ideal world, services are commissioned to meet the whole population's needs. Our research confirmed that in the real world, commissioners and their partners have to prioritise finite resources. The Parent-Infant Foundation's model demonstrates one possible way to calculate whole population need for your area. **Section B.5** provides examples of how various areas around the UK have made decisions about investment prioritisation. The model proposes three steps:

Step 1: Choose a conceptual framework to help you model the incidence of need

The Parent-Infant Foundation recommends that the most pragmatic and best evidenced conceptual framework for *commissioners*[71] to use is that of attachment. This is because there is over 50 years of research showing that population incidence is more or less predictable depending on a range of adversities and risks factors. Robust research can also link incidence to short-, medium- and long-term outcomes.

To learn more about this recommendation see pages 20-21 of the **Securing Healthy Lives report**[72].

Step 2: Review the evidence about predicted incidence of parent-infant relationship difficulties, and consider local factors which may alter incidence rates

Summaries of evidence about the incidence of attachment patterns can be found in:

Baby Bonds: Parenting, attachment and a secure base (2014)[73], a report by the Sutton Trust. Incidence is discussed on page 9.

A meta-analysis of 80 studies by **Van Ijzendoorn et al. (1999)**[74] is highly regarded and was broadly in line with data from the **US Early Childhood Longitudinal Study**[75] (2007, Table 8.5).

Specifically regarding children in or leaving Looked After care, incidence information has been reviewed by NICE in **NG26 Children's Attachment** (Final Scope 2, page 5, 3.1r).

In brief, babies attach to their parents in 3-4 broad patterns[76] each related to the quality of parental care. Attachment patterns can be reliably measured by the child's first birthday. Attachment patterns can and do change but rarely during the first two years of life unless there has been a major change in the quality of caregiving. Attachment patterns are linked to clear lifelong outcomes across health, mental health, social skills, relationships, education and risk-taking behaviour.

One pattern, disorganised attachment, can particularly undermine children's mental health, social behaviour and educational prospects and is therefore a high-priority target for effective prevention and intervention. Another way of saying this is that **significant parent-infant relationship difficulties have a particularly deleterious impact on children's outcomes.**

Significant parent-infant relationship difficulties have a particularly deleterious impact on children's outcomes.

International research (e.g. **Van Ijzendoorn et al 1999**[77]) shows that in Western countries of relative affluence such as the UK, we can expect the following:

- **Secure attachment pattern**
  around 55-60% of all new births
- **Insecure**
  (including both avoidant and ambivalent subtypes) – around 25-30%
- **Disorganised**
  around 15% incidence in all new births but far higher where trauma and adversity occur. For example, upto 80% of children in Looked After Care have a disorganised attachment[78].

If at a population level your area experiences a higher-than-average level of adversity and trauma, you may need to increase the expected incidence of disorganised and insecure attachments.

Table 2 shows a worked example of this.

For more detailed descriptions of these attachment patterns see:

- Pages 20-21 **Securing Healthy Lives Report**[79]
- Pages 3-5 **NICE National Guidance NG26 Children's Attachment**[80]
- **Infant-parent attachment: Definition, types, antecedents and outcomes**[81]

Data which might indicate how your area compares nationally:

- ACEs prevalence (Adverse Childhood Experiences)
- Multiple Index of Deprivation
- Children living in poverty
- Numbers of looked after children
- Teenage pregnancy
- Low birth weight
- Levels of unemployment

See the full list of risk factors for parent-infant relationship difficulties in Appendix 2C of the Wave Trust's report **Conception to age 2 – the age of opportunity**[82].

Case study

According to local and national data, the communities of Cwm Taf Morgannwg experience more adversity and trauma than the national average for England and Wales. Rates of poverty, children in care and ACEs are around 30% higher.

This local data was used to adjust predicted incidence of parent-infant relationship difficulties. See pages 22–23 of the **Securing Healthy Lives report** to see how [83].

Step 3: Model likely service uptake

Not every baby experiencing a significant parent-infant relationship difficulty will be brought to the attention of services before their second birthday. This is due to a range of system, service and family related factors. These account for the difference between population need and likely service demand.

Examples of why there is a difference between population need and likely service demand

System related factors

There is no parent-infant relationship care pathway, frontline practitioners aren't equipped with the skills to identify parent-infant relationship difficulties, referrers are confused about what, when and where to refer, there is no agreement on who is responsible for working with parent-infant relationships or there is insufficient integration.

Service related factors

Thresholds or geographical limits mean some families have no access to support or services, referral criteria are unclear regarding parent-infant relationships, the parent-infant relationship problem presents as something else (e.g. failure to thrive, behaviour problems), services are visible or accessible to families

Family related factors

The family is worried about stigma or judgement, the family do not know who to ask or do not realise how important parent-infant relationship difficulties are, the family moves area frequently.

The difference between "need" and "demand" is the number of babies we miss

Systems leaders including commissioners should be mindful that those babies who are not identified by services may nevertheless be in significant need and may likely include the most marginalised, vulnerable and at-risk babies.

Systems transformation work should include how to improve outreach to these families, particularly those most at risk of later referral to children's social care. Attrition between need and demand represents at least in part a systems failure to identify all babies in need.

In 2021, there were 42 specialised parent-infant relationship teams across the UK. Depending on locality they are resourced to see 1-5% of their local live birth rate.

The Parent-Infant Foundation model of population needs analysis suggests that in areas experiencing the national average levels of adversity and deprivation:

55-60%
of babies and their parents will not need parent-infant relationship (PAIR) support beyond a universal offer.

1.5-2%
will have moderate parent-infant relationship difficulties that will require access to a specialist PAIR team for short-term direct work.

6.5-8%
will have mild-moderate parent-infant relationship difficulties and will seek help through targeted services.

5%
will have severe parent-infant relationship difficulties and would access a specialist PAIR team for direct work which is likely to be longer term.

However, the remaining children will also be vulnerable:

16-20%
will have mild-moderate PAIR difficulties which may increase their risk of later mental health problems, but they are unlikely to access services before the age of 2.

10%
will have severe PAIR difficulties but limited/no engagement with services and therefore remain highly vulnerable. Ideally, they would be referred to a specialist PAIR team following improved outreach.

Worked example of local prevalence calculations

Incidence of various attachment patterns can be toggled up or down depending on how prevalent the risk factors described earlier in **Section B.1** are in your local area.

Table 2: Worked example of how to adjust attachment pattern incidence according to local indicators of trauma and adversity.

Estimated incidence of attachment patterns per 1000 live births	Example 1: Population level data shows approximately UK average levels of disadvantage, adversity and trauma	Example 2: Population level data shows average levels of disadvantage, adversity and trauma are around 5% lower than UK average	Example 3: Population level data shows average levels of disadvantage, adversity and trauma are around 5% higher than UK average
Disorganised	**Disorganised** (15%) = 150 babies per year	**Disorganised** (assuming a 5% reduction = 14%) 140 babies	**Disorganised** (assuming a 5% increase = 16%) 160 babies
Insecure	**Insecure** (25-30%) = 250-300 babies	**Insecure** (assuming a 5% reduction = 24-28.5%) 240-285 babies	**Insecure** (assuming a 5% increase = 26-31.5%) 260-315 babies
Secure	**Secure** (55%-60%) = 550-600 babies	**Secure** (58-63%) = 580-630 babies	**Secure** (58-63%) = 580-630 babies

Worked example of likely service uptake

Not every baby experiencing a significant parent-infant relationship difficulty will be brought to the attention of services before their second birthday. This is due to a range of factors explained earlier in **Section B.1**. Figure 4 shows a worked example of likely service uptake.

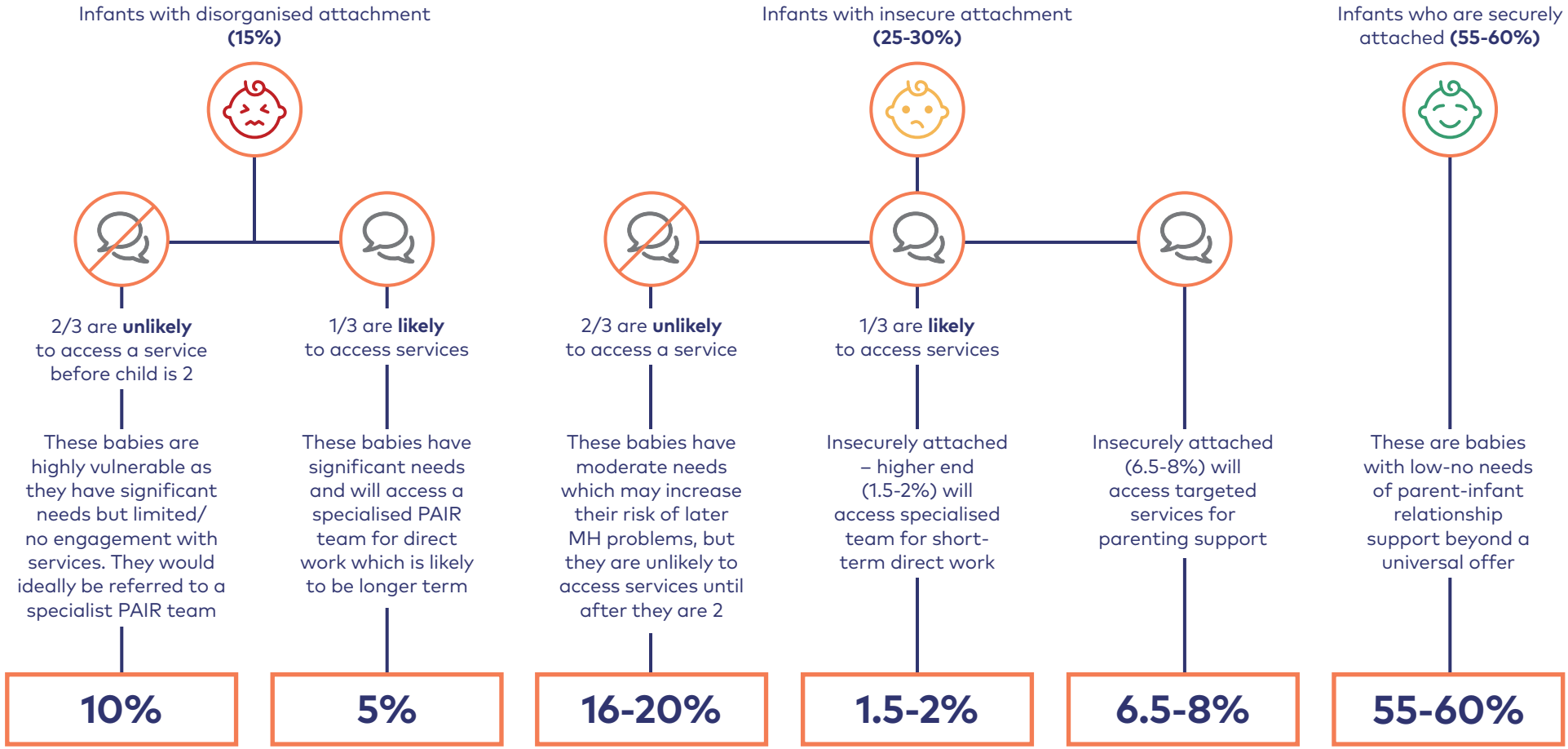

Figure 4: Modelling likely service uptake by combining incidence with predicted attrition

Model assumptions

This model makes some assumptions which are based on an understanding of the international research and clinical experience but which have not yet been independently tested:

1. An increase in family and community level risk factors (poverty, domestic abuse, ACEs) increases the prevalence of attachment insecurity and disorganisation in similar proportion. e.g. 30% increased disadvantage increases rates of disorganised and insecure attachment by 30%. This may be either an over- or under-estimate.

   Relevant evidence shows that around 15% of children in the general population have a disorganised attachment with their primary caregiver, but it is much higher in vulnerable groups: children of mothers experiencing domestic violence at 57%[84], of mothers using drugs and alcohol estimated at 43%[83], of mothers with depression estimated at 21%[83], children experiencing abuse or neglect 80%[85].

2. Between 66-75% of families experiencing moderate-severe parent-infant relationship difficulties are unlikely to access appropriate services before the child is two, due to the range of factors outlined in **Section B.1**.

So what? And what next?

An essential part of commissioning is understanding population need. This section has explained how to determine local population need but with emphasis that many vulnerable babies are and will continue to be missed by services. This has implications for commissioning: as care pathways and services improve, more vulnerable babies will be able to access the parent-infant relationship services they need, and this increase needs to be built into expectations about service demand.

You may need to review your theory of change from Section A.3 considering the information you have discovered in your population needs assessment.

The next section of this toolkit moves on to think about how to listen to the voices of babies and those who care for them.

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B.2 Listening to babies and those who care for them

The right of all children to be heard and have their views taken seriously in accordance with their age and maturity is laid down in Article 12 of the **UN Convention on the rights of the child** (UNCRC). The European Commission provides **a range of helpful resources to support participation**[86] with children and their carers, including a link to the **Lundy Model of Participation**[87].

Meaningful co-production

Co-production is more than just consultation. The **National Centre for Family Hubs** Co-production Toolkit[88] defines co-production as "a way of working together in which support providers and those in need of support are recognised as stakeholders and are part of the same decision-making process". We recommend the **National Centre for Family Hubs Toolkit module on co-production** which highlights that there are different levels and types of co-production and references Treseder's degrees of participation model.

Meaningful co-production in parent-infant work puts the voice of the child at its centre. It also includes the voices and participation of babies and families whose needs have not been met, so that services can be commissioned and delivered in ways that are more likely to meet those needs.

Infant, from the Latin *infans*, means unable to speak. But babies do speak with *their behaviour*. Parents and specialists in infant communication can articulate the experiences and needs of babies.

By listening to local babies and their carers you will gain:

- more knowledge of what people and communities need and expect
- a better focus on the outcomes that matter to babies and families and the bigger picture, rather than a narrow focus on delivery
- improved outcomes through having better met needs and more effective targeting, leading to better value for money
- more chance of getting things right first time – minimising costs
- increased likelihood that people will be more satisfied with services
- improved tailoring of services to your local community needs
- increased public trust in local organisations
- a more participatory approach to service design

Reference: **Involving people in commissioning services – a guide** (Norfolk County Council).

Who to include

Involving the voices of babies and families is best done by those with the skills, knowledge and experience to engage parents with careful attention paid to include the voices of more marginalised groups, and to represent the experiences of babies. This may mean commissioning individuals/organisations to undertake the work.

Your consultation should include diverse voices, including fathers and partners, LGBTQI+ parents, sole parents, families from a range of ethnicities and cultures, younger parents, parents with babies on the edge of or in care, and those facing additional adversities such as domestic abuse and poverty.

Resources for co-production and involving families in commissioning services

We highly recommend the National Centre for Family Hubs Toolkit (2022) which includes a **module on co-production** with children and families.

The New Economic Foundation has produced **Commissioning outcomes and co-production: a practical guide for local authorities** (2014).

NHS England provide statutory guidance to Clinical Commissioning Groups on Patient and Public Participation[89] in commissioning health and care **here** including in Appendix B a template assessment and planning form.

A co-production team of community representatives and Norfolk County Council staff have produced this guide to **Involving people in commissioning services**.

Resources for involving babies and very young children

There are several Voice of the Child toolkits available (e.g. **Warrington**, **Derby**) but none address consultation with pre-verbal very young children.

This article suggests a framework for doing so: **Look who's talking: factors for considering the facilitation of very young children's voices**.[90]

Typically, the voice of the baby can be articulated by specialists in the field. Here is an example: **The importance of the Health Visitor's role in recognising the voice of the infant**.[91]

Resources for consulting parents

The largest consultation about future parent-infant relationship services was conducted in 2021 by the Parent-Infant Foundation. Over 475 parents contributed. You can read about the methodology and results in the **Securing Healthy Lives report**.[92]

Blackpool Better Start consulted with 75 parents about parent-infant relationships in 2022 and their report is **here**[93].

So what? And what next?

This section has emphasised that parent-infant relationship services should be co-produced with babies and those who care for them. Whilst listening to the voices of pre-verbal babies and very young children is inevitably harder than those of older verbal children, it is both possible and important. Co-production will improve the chances that the services you commission meet the population need, are used and are effective.

Your theory of change from Section A.3 might need revision considering what you learn from babies and those who care for them, and you may wish to co-produce future version with babies and families.

The next section of this toolkit moves on to mapping and reviewing existing service provision.

ANALYSE

B.3 Mapping and reviewing existing service provision

Understanding existing provision (of both commissioned and non-commissioned services) is an integral part of the commissioning cycle. Mapping contributes towards:

- ascertaining current practice, care pathways and referral thresholds to provide insights into capacity across the system of support, interventions and services
- identifying strengths and examples of good practice
- identifying groups who are unable to access services or whose needs are not being met effectively
- identifying duplications, gaps and risks in the system
- informing future service planning and quality standards
- considering current spending and value for money
- understanding strengths and gaps in workforce competencies
- identifying potential for innovation and development
- benchmarking against latest evidence or standards

Engaging relevant partners across the system in co-production

To map existing parent-infant relationship support and interventions, you will need good engagement across the region from all relevant partner agencies including the third sector.

Watch this **short video**[94] to see how Newcastle's First 1001 days think tank brought people together. Towards the end of the video, there are 3 questions which can help you structure your partnership engagement. Note the striking visual representations of babies to keep people focussed on the 0-2 period and avoid the **Baby Blindspot**.

How to map and review existing services

One aim of mapping is to create a regional level "map" of the offer to babies and parents, so keeping the baby's perspective in mind is essential. Can all babies who need it access this service? Do all babies have access to all levels of care as required?

Another aim is to identify local strengths and gaps. Understanding who can and can't access services (referral criteria, geographical boundaries etc), and who does and doesn't use services (service data) can be helpful here. Mapping is necessarily a collaborative activity as

you rely on others for information about their services. Using a variety of methods will help improve reach and the level of detail in responses. It will also help you understand whether there is any slippage between service level agreements and what the service can currently deliver.

Mapping methods include:

- collaborative mapping workshops
- talking individually to frontline practitioners and service managers
- surveys and structured response forms
- reviewing service level agreements and service data

Mapping tools

Mapping tools provide a framework for enquiry and a way to collate large amounts of information into a manageable summary that identifies local strengths and gaps. Mapping parent-infant relationship support and interventions might be a stand-alone activity, or part of a wider evaluation of a directorate, service area or system. For the latter, we recommend you use one of the Early Intervention Foundation's Maturity Matrices *plus* the Parent-Infant Relationships (PAIR) Services Mapping Tool in the **Tools section** of this toolkit.

The Early Intervention Foundation (EIF) have comprehensive maturity matrices for **Maternity and Early Years** and **Early Years and Speech, Language and Communication** in England and Wales. These help assess the level of development in relevant systems and services. Remember from **Section A.2** that healthy parent-infant relationships contribute to cognitive development including speech, language and communication. This is partly through improved quality and quantity of appropriate interaction, so strengthening parent-infant relationships contributes to improved speech, language and communication outcomes.

Mapping parent-infant relationship support

In order to keep your mapping exercise manageable, we recommend you differentiate between:

- services or activities which generally promote protective factors and reduce risk factors for parent-infant relationship difficulties, or generally promote family and child health
- services or activities which specifically focus on parent-infant relationships.

To map parent-infant relationship at universal, targeted and specialist levels, the Parent-Infant Foundation has provided a mapping tool in the **Tools section** of this toolkit.

The Scottish national **Mapping of parent-infant intervention and support services** (2020)[95] was conducted jointly by the NSPCC and the Perinatal Mental Health Network of Scotland, and is useful to anyone across the UK as an example of good practice.

The report **Mapping parent-infant services in Wessex**[96] describes a regional mapping exercise, which includes RAG rating of key services such as CAMHS, health visiting and children's centres.

Pages 13-18 of the **Securing Healthy Lives**[97] report contains a summary of a local mapping exercise in south Wales conducted in 2021, which used interviews, a survey and multi-agency workshops. Again, this can be used across the UK as an example of good practice.

Tips for mapping parent-infant relationship provision

Include the voluntary sector, which might be doing significant work to remove barriers, support parents and broker relationships into services as well as providing direct parent-infant relationship interventions.

Support, intervention and services are different from one another (see Section A.1) and you will probably want to map all three.

Avoid terms like early intervention because some people think that means early age while others think it means early in the development of a problem irrespective of age (see Section A.1).

Invite anyone who delivers services to families to participate, including volunteers.

Even unborn babies can require specialist parent-infant relationship intervention so map universal, targeted and specialist levels across the conception to two period.

Using a variety of methods will improve the reach and accuracy of your mapping exercise.

Mapping spending

It can be helpful (although potentially challenging) to additionally map current spend on responding to parent-infant relationships difficulties. This analysis could help identify opportunities for joint commissioning and pooling budgets, which is facilitated by the integrated working approach behind family hubs.

Mapping spend can also support stability and opportunities for development in the specialist sector by providing longer-term funding. This was identified as a barrier to commissioning in our research with commissioners.

Parent-infant relationship work is delivered and therefore funded through different workstreams and commissioners so collaborating with commissioner colleagues will be essential.

The information in **Section A.2** on cost-benefit analyses might be useful, as might the general advice in the **VAWG Services Commissioning Toolkit**[98] (2022, pages 20-21).

So what? And what next?

Mapping and reviewing current service provision helps you to compare what your theory of change (Section A.3) says you need with what you currently have, to identify priorities for development. You cannot know what to commission without knowing what and how the system already delivers by way of parent-infant relationship support, interventions and services across the levels of care.

This section has linked you to various examples of mapping reports and tools. Together with your population needs analysis (Section B.1) and priorities identified by babies' and families' voices (Section B.2), you are ready for the next phase of the commissioning cycle, "Plan".

PLAN

B.4 Developing a strategy

Why develop a strategy?

A *co-produced* Parent-Infant Relationships (PAIR) strategy will help you:

- engage and mobilise stakeholders.
- facilitate discussion about a feasible and proportionate response to needs, one that feels joined-up for babies, families and the workforce.
- raise awareness about the nature and scale of parent-infant relationship difficulties and the evidence of long-term impacts and potential cost-savings.
- articulate a "relational frame of mind" to underpin services for babies and those who care for them.
- communicate the vision, aims and priorities for parent-infant relationship support.
- raise the profile of parent-infant relationships across all levels of organisations and systems.
- mitigate the risks of low stakeholder engagement.
- maximise the possibility of partnership funding.
- focus people's minds on priorities and delivery over the next few years.

Co-producing a strategy

Co-production with babies and families is discussed in **Section B.2** and with colleagues across the system in **Section B.3**. If you do not already have one, we strongly recommend a parent-infant relationships (sub)group with formal terms of reference to develop the strategy and steer the work.

What to include in an effective strategy

There are good, general advice and practice points about writing an effective strategy and conducting an Equality Impact Assessment in the **Violence Against Women and Girls Services Commissioning Toolkit**[99] (2022, pages 32-36).

In brief, an effective strategy describes:

1. The nature of parent-infant relationships, the benefits of safe and secure parent-infant relationships, the impact of their difficulties on children, parents and communities over the short and long terms.
2. The local vision. This is typically along the lines of 'the provision of safe and secure parent-infant relationships with at least one carer for all children in our region'.

3. The scale of the need (supported by your population needs analysis).
4. The views of local families and stakeholders (supported by your co-production work).
5. A description of any gaps to be addressed (supported by your mapping work).
6. The aims and objectives of the strategy, which typically evolve around strengthening parent-infant relationships, and preventing and rectifying difficulties. See **Section B.5** to connect with examples of good practice.
7. A theory of change (see **Section A.3**)
8. An overview of the actions to be taken which will meet the needs of the local community in both the short and longer term. Include deadlines and accountabilities.
9. The resources required and how these will be provided.
10. A clear governance framework specifying the roles and responsibilities of key stakeholders, including at a senior leadership level. For example, your PAIR strategy could be included in your local Health and Wellbeing Plan with the associated governance framework.
11. A consultation and communications strategy. A **stakeholder analysis**[100] might help.
12. The workforce development plan.
13. How your strategy will be constantly used to guide the work, and when and how it will be monitored for effectiveness, reviewed and updated.
14. Risks and mitigations. These might include a lack of awareness or understanding of the topic and/or strategy, insufficient engagement, pressures on time and funding, insecure funding arrangements, key stakeholder turnover, local organisations developing initiatives unilaterally

Practice points: Developing a strategy

- **Listen to a diverse range of stakeholders, including meaningful engagement with marginalised groups.**
- **Be clear about how decisions will be made and by whom**
- **Circulate widely a final draft for consultation before publication**
- **Use varied media and channels to make sure everyone understands what they are responsible for, including deliverables, communication, cascading, representation of colleagues and feedback.**

Examples of relevant strategies

NHSCT **Infant Mental Health Strategy (2017)**[101]

Greater Manchester Perinatal, Parent-Infant Mental Health Model (2020)[102]

So what? And what next?

Co-producing a PAIR strategy with families and stakeholders will facilitate a focus on the effective delivery of outcomes and enhance strategic accountability.

Alongside strategy development, it can be helpful to see what is working well elsewhere. Section B.5 provides information about how to connect with examples of good practice.

PLAN

B.5 Examples of good practice and different service models

There is no one model of parent-infant relationship services; the UK has a wide variety of models. In our research[103] commissioners told us they didn't know where to get information about examples of good practice so this section provides information about how to make connections with services around the UK.

Contacting established teams, services and their commissioners

The Parent-Infant Foundation website **locations tab** provides contact details for all existing specialised parent-infant relationship teams across the UK. Specialised teams are psychology or psychotherapy led multi-disciplinary teams who typically work at a specialist level. Most services take referrals from conception to two, some go up to children aged 4 years or even 7 years.

The Parent-Infant Foundation also facilitates the UK's only network for parent-infant relationship teams – the Parent-Infant Teams Network – which brings teams and areas interested in developing teams together both virtually and in person. This network is open to commissioners and anyone involved in the service development process.

Watch this very short video on Youtube from the Parent-Infant Foundation to find out more about **What is a specialised parent-infant relationship team?**

Characteristics of specialised parent-infant relationship teams

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

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

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

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

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

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

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

Service models

Manchester has a specialist PAIR team in each of its ten boroughs and has developed a vision of integrated parent-infant and perinatal services. There is a 4 minute video **here**[104] or read their strategy **here**[105]. The UK's only fully integrated perinatal and parent-infant mental health service is **PPIMHS** in north east London, although others are moving towards integration (one example is **G-PIMHS** in Gwent) or work very closely (one example is **Together with Baby** in Essex, Thurrock and Southend).

Most specialised parent-infant relationship teams are located in the NHS, usually in public health nursing or CAMHS. One team is located in social care (Liverpool Parent and Baby Relationship Service) and another in the communities' directorate of a local authority (Cardiff). Others are run by charities, some of which provide commissioned services to the public sector. Four teams are located in Better Start areas, so their funding and delivery arrangements are strongly partnership-based.

NHS PAIR services:

- Building Attachment and Bonds Services (BABS) (**Knowsley**, **Wigan**)
- **Leeds Infant Mental Health Service**
- **Tameside and Glossop Early Attachment Service**
- **Parent-Infant Mental Health Service** (Surrey)
- **Enfield Parent-Infant Partnership**
- **Bury Early Attachment Service**
- **CAMHS Infant Mental Health Team** (Fife)
- **CAMHS Under 5s team** (Plymouth)
- **Children and Parents Service** (Manchester CAPS)
- **Gwent Parent-Infant Mental Health Service (G-PIMHS)**
- **Halton & Warrington Baby Infant Bonding Support (BIBS**
- **Heywood, Middleton & Rochdale Early Attachment Service**
- **Lanarkshire Infant Mental Health Service**
- **Together with Baby** (Essex, Thurrock and Southend)
- **Kensington & Chelsea and Westminster Under 5s Service**
- **Lothian Parent and Infant Relationship Service (PAIRS)**
- **Oldham Early Attachment Service**
- **Haringey Parent Infant Psychology Service (PIPs)**

NHS PAIR services *(continued)*:

- **Perinatal Parent Infant Mental Health Service** (PPIMHS, North East London Foundation Trust)
- **Sheffield PAIRS**
- **Stockport Infant Parent Service**
- **CAMHS Under 5s** (Tavistock & Portman, Camden)
- **Thriving Together** (Cornwall)
- **Wee Minds Matter** (Greater Glasgow and Clyde Infant Mental Health Service)

Local Authority PAIR services:

- **Cardiff Parents Plus**

Voluntary sector PAIR services:

- **Oxford Parent-Infant Project**
- **Little Minds in Mind** (Newcastle)
- **BrightPIP** (Brighton)
- **DorPiP** (Dorset)

PAIR services funded through partnership arrangements:

- **PAIRS** (Lambeth)
- **Little Minds Matter** (Bradford)
- **Blackpool Better Start** (in development)
- **Healthy Little Minds** (Nottingham)
- **ABCPiP** (Northern Ireland)
- **Croydon Best Start PIP**
- **The Parent-Baby Relationships Service** (Liverpool)

Strengthening existing services

Some areas commission new teams (e.g. Together with Baby in Essex, Thurrock and Southend), while others seek alternatively or additionally to expand their existing services. For example, by ensuring ring-fenced resource for very young children in CAMHS, developing specialist perinatal infant mental health Health Visitor posts, creating psychology-led services in children's centres and family hubs, and recruiting parent-infant therapists in perinatal mental health services.

Your mosaic of support should ensure appropriate provision at universal, targeted and specialist levels. Note that providing *specialist* parent-infant relationship work requires highly-qualified psychotherapists and/or psychologists as part of a multi-disciplinary team because that is where the appropriate therapeutic skill set sits.

See the recommendations section of **Securing Healthy Lives**[106] for a range of recommendations to strengthen existing support and services.

The beginning of Chapter 6: Setting Up a Service of the **Parent-Infant Foundation's Development and Implementation Toolkit** talks through four useful development steps.

Capacity Building

Most specialised parent-infant training teams offer consultation, joint working, practice embedding/reflective practice groups and/or some form of training, tailored to their local context. For example, **Leeds Infant Mental Health Service** has trained over 2500 local practitioners in their Babies' Brains and Bonding course. This training integrates neuroscientific research about how babies develop with attachment theory and evidence-based practice on how to support emotional and social development in the early years of life. Importantly, this training is also offered free to the third sector.

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

OXPIP offers a wide range of courses including extended courses on infant observation, assessment, a parent-infant therapist diploma, short courses such as ghosts in the nursery, emotional regulation and group work, and public lectures.

Bradford's **Little Minds Matter** team have offered training for interpreters and those working with interpreters to ensure they are well-supported and that the relational ethos of parent-infant work is fully embedded. You can also read more about the service evaluation of their consultation activities **here**.

Read the **Rare Jewels** report[107] (2019) for more case studies about the work of parent-infant relationship teams in Leeds (p16), Croydon (p19), Liverpool (p26) and Norfolk (p32).

So what? And what next?

Learning about the ways other areas have commissioned and designed services will help you co-produce your own local plans. This section responds to commissioners' needs to hear about and connect with examples of PAIR commissioning and service delivery around the UK.

You will find the Parent-Infant Foundation's Parent-Infant Teams Network and the links in this section are a good starting point for this.

You may want to revise your theory of change (Section A.3) after learning about the different examples of good practice.

The next section of this toolkit moves us into the 'Do' phase of the commissioning cycle.

DO

B.6 What to commission and how to write the procurement specification

In our research with commissioners, it was clear that not knowing what to commission was a barrier. Previous sections of this toolkit have helped you understand what is needed in your local area and how to plan a response.

This section links you to information about different kinds of services to include in system design and transformation.

Checklist

Before you embark on the Doing stage of the commissioning cycle, check that your Analysis and Planning stages have enabled you to answer the following questions:

- ☐ **What has the evidence told you about what is needed? (Section A.2)**
- ☐ **What is the scope of the need locally? (Section B.1)**
- ☐ **What do local babies and parents identify as their needs? (Section B.2)**
- ☐ **What have staff and managers from the local workforce told you is needed? (Section B.3)**
- ☐ **What does your theory of change tell you has to happen for those needs to be met? (Section A.3)**

Where to find examples of Parent-Infant Relationship (PAIR) services commissioning arrangements

The Parent-Infant Foundation's online Development and Implementation toolkit, **Chapter 3: Funding and Commissioning a Specialised Parent-Infant Relationship Team** includes information about how specialised parent-infant relationship teams across the UK are funded, examples of commissioning arrangements, a description of a team in whole time equivalents, a theory of change, and information about other networks and organisations to be aware of.

How to choose what to commission

Below you will find suggestions for what types of activities you could include in procurement specifications at universal, targeted and specialist levels. **We strongly advise you to seek expert clinical advice about which interventions will be best for your area.**

In addition to the evaluation summaries we signposted you to in **Section A.2**, there is an intervention map in the **Tools section** at the end of this toolkit to help you map interventions at different levels of care. The Parent-Infant Foundation's **Development and Implementation Toolkit**, especially chapters 3 and 4, can also help. Also, see the recommendations section of **Securing Healthy Lives**[108] for a range of recommendations to illustrate strengthened support and services across all levels.

Below are some examples to consider:

UNIVERSAL

Advice, support, signposting, self-management, single contacts.

Including content specifically on promoting PAIRs in all individual and group activities (e.g. antenatal classes, feeding support) and printed materials.

Raising public awareness of the help on offer and signposting to reputable websites and apps (e.g. **Look See Sing Play**).

Routine enquiry: Asking every parent how their relationship with their baby is coming along.

Workforce training to strengthen identification and assessment practice, including when to seek consultation from PAIR specialists. The selective use of appropriate screening tools when indicated.

Delivering universal interventions (e.g. **Neonatal Behavioural Observation** (NBO), **GroBrain**, **Solihull Approach Foundation**).

Making sure parents know who can offer advice and support regarding their relationship with their baby.

TARGETED

"Getting help", outcomes focussed interventions for mild-moderate difficulties.

Individual and group interventions which strengthen parent-infant relationships where there are some risk factors or mild-moderate difficulties (e.g. **Video Interaction Guidance** under appropriate supervision, **Watch Me Play**).

Parenting programmes which include more content focussed on PAIRs (**Mellow Bumps/ Babies**, **Circle of Security**).

Peer-led consultation (e.g. Specialist health visitor led consultation).

Assessment processes: PAIRs are specifically addressed in all assessment processes, including child protection, mental health and family support assessments. Assessing only risk factors is not sufficient.

SPECIALIST

"Getting more help", extensive treatment involving mental health professionals.

A multi-disciplinary parent-infant relationship team which splits its time:

50% direct interventions to families:

- Specialist assessment and formulation (including contribution to pre-birth and child protection assessments)
- Individually tailored specialist therapeutic individual and group interventions e.g. parent-infant psychotherapy, psychologically-led combined interventions, video feedback interventions to promote positive parenting and sensitive discipline (**VIPP-SD**). Some will be long-term interventions.

50% capacity building activities across the system to include

- Ongoing consultation/supervision across the system including to the third sector
- Support with assessment and management of relational risk
- Joint visits or joint working with cases at a targeted level
- Specialist nursery and home observations
- Consultation to the team around the family and advice about formulation
- Input to strategies and policies
- Improving access to latest research and evidence about what works for PAIRs
- Workforce training to develop **infant mental health competencies**[109]

Good practice across the system

- Ensuring parent-infant relationships are specifically included in all assessment processes, including child protection, mental health and family support assessments.
- Workforce development to raise confidence and capability.
- Very high levels of co-ordination and integrated working.
- Additionally, and especially for the most marginalised babies and families, community and voluntary sector activities which reduce barriers and broker relationships with services for parents.

Practice points for a good procurement specification

1. In the introduction include:

a. A brief description of the context, the problem you are trying to solve, the nature and scope of the service required.

For example, "Parent-infant relationships are a key mechanism by which lifelong wellbeing can be enhanced or diminished. As stated in our XXX strategy, we want to ensure every baby has access to secure, nurturing relationships with their parents/carers. As part of our multi-level approach to support, intervention and services, we are looking to commission a [multi-disciplinary parent-infant relationship team] to:

Provide specialist assessment, formulation and group and individual therapeutic interventions to parents/carers and their babies from conception to child's [second/fourth etc] birthday.

Provide specialist parent-infant relationship case consultation and/or supervision to colleagues across the system.

Design and deliver relevant workforce development and training to build capacity across the system aligned to the AIMH UK Infant Mental Health Competencies Framework.

Act as a source of expertise regarding parent-infant relationships for the purposes of strategy development, commissioning and multi-agency working".

b. A description of the user group for whom the service will be provided and the overall purpose and aims of the service.

This should anticipate service demand and any additional needs of service users (e.g. mental health problems, drug or alcohol dependencies, disability, language barriers).

For example:

"The purpose of the service is to:

- rectify and strengthen parent-infant relationships for families experiencing moderate-severe difficulties
- support colleagues in a range of universal and targeted services to promote and strengthen parent-infant relationships for families experiencing mild-moderate difficulties
- work with a range of multi-agency colleagues to promote healthy development of parent-infant relationship difficulties
- provide parent-infant relationship expertise across the system

We are keen to hear how providers will engage typically marginalised babies and families, including fathers, black and brown parents, those finding services hard to access and/or facing additional adversities, babies on the edge of care. Also, in how providers will work in conjunction with colleagues from perinatal mental health services, CAMHS, health visiting, midwifery, family support agencies, the third sector and other relevant services. Proposals should describe their

intended care pathway and any variations depending on particular presenting issues."

c. Locally agreed principles or values underpinning the service

For example: "Services should be underpinned by a "relational frame of mind" which applies to both service delivery and work with colleagues, partners and stakeholders across the system. Good applications will describe a trauma-informed approach which can provide timely and effective interventions, based on latest research and evidence. Providers are required to work in a highly collaborative fashion with colleagues, services and organisations across the region."

d. Definition of any technical terms or abbreviations used in the document

e. Description of the recent background of the service or client group

For example, is it a new service or existing one? What is already in place to support this client group?

2. Detailed Service Description

Give a comprehensive description of the size and nature of the service based on your analysis work (including needs assessment, mapping activity and the voices of local parents and babies).

Include information about how the service will be managed.
For example: "This new team will form part of our [directorate] and be managed by the [Head of X Service]. The team will be led by a psychologist or psychotherapist with Level 3 IMH competencies and be made up of a range of appropriately qualified and trained multi-disciplinary parent-infant practitioners. Providers may wish to propose joint posts with local agencies. The team will provide these services to babies and those who care for them who live in Region X and who are experiencing moderate to severe parent-infant relationship (PAIR) difficulties or a high number of risk factors for PAIR difficulties. We anticipate this to be approximately X% of the annual live birth rate.

Referrals will be accepted from a range of multi-agency sources as well as from families themselves. Local parents have told us they want to be able to self-refer to services which are timely, non-judgemental, accessible in places they find comfortable and which are baby-friendly."

3. Specific standards and targets

Be clear what you expect the service to deliver by way of inputs, outputs and outcomes, and which of these are requirements and which are more flexible. As there is no national outcomes framework for parent-infant relationships yet, so how to measure clinical outcomes is likely to need some dialogue and negotiation (see **Section B.8** for further information).

For example: "Services will be benchmarked against the Royal College of Psychiatry's recommended service characteristics and the Parent-Infant Foundation's characteristics of a specialised parent-infant relationship team. Providers should explain broadly which interventions they might deliver, and why, referencing sources of evidence, and describe by what processes final decisions on intervention selection will be made. Please highlight any opportunities for innovation, joint-working or growth. There should be a clear description of anticipated clinical outcomes and how these will be measured and benchmarked."

4. Monitoring arrangements

Describe the ways in which you intend to monitor the service to demonstrate to and satisfy stakeholders that the purpose of the service and its intended impact are being delivered. For example:

"Providers will be required to:

- work collaboratively with commissioners to create a mutually beneficial monitoring approach
- measure clinical outcomes using evidence-based and validated tools, and to collect service user feedback.
- provide quarterly performance reports which include summarised output and outcome data, complaints and compliments. These will be reviewed at quarterly review meetings in the first operational year, frequency to be reviewed beyond that.
- disseminate an annual impact statement which summarises the outputs and outcomes of direct work with families, and indirect activities such as consultation and training."

So what? And what next?

Commissioners told us they needed help to access information about what to commission for parent-infant relationship (PAIR) services. This section has provided practical guidance and links to resources to help you write a well-informed, effective procurement specification to support a whole system approach.

In the next section, we move on to think about workforce and provider development.

DO

B.7 Workforce and provider development

In our research, commissioners identified workforce development as both a barrier and an enabler of parent-infant relationship (PAIR) service commissioning. The challenge of an under-developed 'market' and parent-infant relationships workforce is well-recognised nationally. This section signposts you to sources of information that may be able to help your workforce development and provider development plans locally.

Workforce development

Despite the evidence on the importance of parent-infant relationships, there has been little or no national work to develop the requisite workforce (although this is slowly changing).

Many universal and targeted level staff and volunteers already deliver highly effective parenting support, interventions and services to children and families. However, babies' needs are different to those of older children (this is well described in the **Rare Jewels report**[110]) and working with parent-infant relationships requires the competencies described in the Association of Infant Mental Health's Infant Mental Health Competencies Framework.

There is no guarantee that relevant staff, including midwifery, health visiting, social work, CAMHS and perinatal mental health staff have the necessary PAIR competencies because these are rarely developed during pre-qualification. Virtually all health, social care, education and voluntary sector staff will need post-qualification training to develop PAIR competencies. Fortunately, there is a wealth of post-qualification trainings available, in all formats including face to face, online and self-directed learning.

In particular, working therapeutically with significant PAIR difficulties requires detailed and comprehensive assessment, formulation and intervention knowledge. This is why at the specialist level, services are expected to be psychology or psychotherapy led.

Commissioners can play a role in workforce development by:

- **supporting an audit of workforce strengths and gaps**
- **supporting a strategic workforce development plan**
- **ringfencing resource for training**

Provider development

To maximise providers' potential to deliver PAIR services, we recommend a multi-agency PAIR (sub)group to deliver:

- a co-produced strategic PAIR development plan which includes local agreement on what good looks like for parent-infant relationship support (**Section B.4**)
- a workforce audit of strengths and gaps with a strategic workforce development plan

It is crucial to involve health, social care, education and the voluntary sector in these activities because PAIR providers can develop in any of these sectors. Co-production with families is covered in **Section B.2** and with colleagues in **Section B.3**.

If you are contacting other services around the UK (**Section B.5**) you might ask them about how their local PAIR steering group is set up and governed.

Procurement Practice Points

In view of the workforce and provider pressure described above, you should ensure procurement opportunities are widely advertised with plenty of lead in time. This is so that potential providers across the public and third sectors have enough time to form collaborative bids. Ensure that you have provided a glossary of terms so that there is no confusion about the relational nature and scope of the work.

So what? And what next?

Meeting the need for parent-infant relationship (PAIR) services requires an appropriately qualified workforce. Most practitioners do not acquire sufficient PAIR competencies pre-qualification. Post-qualification training and competencies vary widely on an individual basis. This means that there may not be any or many local providers to respond to procurement applications. This is a challenge recognised across the UK with little sign of any national developments to ease the situation.

We therefore recommend you co-produce a workforce development strategy, undertake a workforce audit of skills and competencies (see Resources box) and ringfence some resource for training across the children and families' workforce.

We now move on to look at the final step in the commissioning, "Review".

Additional resources

- AiMH-UK Infant Mental Health Competencies Framework
- Online Infant Mental Health Training Resources for Professionals[111]
- NHS Education for Scotland: Infant Mental Health (from www.nes.scot.uk)
- Securing Health Lives: workforce audit (pages 30-33)[112]
- Rare Jewels report[113]

REVIEW

B.8 Monitoring and evaluation

Commissioners told us they recognise both the value and the challenge of monitoring performance and evaluating impact. They also told us that they value qualitative feedback and service user feedback at least as highly as quantitative feedback.

This section includes information, links and resources to help you:

- create a monitoring and evaluation plan
- discuss the measurement of clinical outcomes

Section B.9 describes national clinical guidance and service standards which can help with benchmarking.

The value of a theory of change

Evaluation, monitoring and reporting requirements are resource intensive activities for providers so they need clarity about what data you want them to provide and how and why you will use it. Your theory of change (**Section A.3**) is invaluable in this regard because it will have specified the short-term outcomes you intend to measure. These in turn lead to your medium-term and long-term impact, which you may or may not be able to directly measure.

You may need to refine your theory of change to ensure the outcomes are clear, logical, feasible and measurable.

We recommend you seek expert advice about the best evaluation tools to accurately measure your specified outcomes.

Co-producing a monitoring and evaluation plan

Ideally, commissioners and providers work collaboratively to agree a mutually beneficial approach to understanding the impact for babies and families. This is an approach which acknowledges the complexity of families' lives, the specialised nature of work with babies, and the challenges of collecting meaningful data. Tightly focussed data sets might be smaller but tell you more relevant information than an unfocussed but larger dataset.

You might also agree an approach to gathering "third-party" data such as such as routine health visitor data or insights, child protection plan data and other longer-term indicators which your theory of change has predicted will change following parent-infant relationship work.

Performance monitoring

By performance monitoring, we mean capturing a range of qualitative and quantitative data which can tell you how well the provider is delivering against the service level agreement or contract. Your performance monitoring might include asking providers for a selection of the following:

1. Measuring clinical outcomes using evidence-based and validated tools (see below) to demonstrate impact for babies and families.
2. Providing regular quantitative and/or qualitative summary data and reports to demonstrate adequate throughput and reach. Examples include:
    - Number and ages of babies, parents and siblings referred, accepted, seen for assessment, engaged in PAIR treatment (individual/group), completing individual treatment or groups, to demonstrate adequate throughput.
    - Number of individual appointments offered and attended, and number of group places offered and taken up, to speak to service capacity.
    - Spotlights on particular groups of parents; fathers/partners, LGBTQI+, younger parents, black/brown parents. For example, this might be a themed report about a particular population of parents which describes: the work of the service; adaptations the service makes to maximise accessibility and remove barriers; how the service improves practice and outcomes; any clinical outcomes; service user feedback.
    - Number of PAIR training places /consultation slots/joint visits offered and taken up by colleagues in other services.
3. Attending meetings to provide updates about the performance of the service.
4. Demonstrating how feedback and learning loops are active and reflective.
5. Collecting and summarising service user feedback, especially qualitative data and including complaints and compliments.
6. Case studies and vignettes (which can be written by staff or service users, printed or by video).
7. Writing and disseminating a periodic impact report which summarises outputs and indirect activities such as consultation, training, marketing, awareness raising, strategy development and joint initiatives.
8. Gathering feedback from other stakeholders (e.g. referrers, other practitioners who have attended training or participated in consultation, reflective practice groups or supervision delivered by a parent-infant relationship service.

If your service level agreement has specified wider systems work such as strategic support or workforce development, you might want to ask for specific reporting on these aspects.

Evaluating clinical outcomes

We recommend Chapter 8 of the **Parent-Infant Foundation's Development and Implementation toolkit**, entitled 'Managing Data and Measuring Outcomes' for an overview of this topic.

In brief, the holy grail of a short, validated pre and post parent-infant relationship measurement tool which is cheap, easy to administer and score, does not yet exist[114]. There is no NHS guidance on this yet, but the Royal College of Psychiatry have made some **recommendations**[115] as part of their perinatal psychiatry report (CR216), and some **recently published systematic reviews**[116, 117] recommend particular scales.

Typically, existing services use parent self-report questionnaires and/or clinician observation which measure change in various aspects of the parent-infant relationship. You can find a summary table of these **here** in the Parent-Infant Foundation's Development and Implementation Toolkit. There are also some tools which measure the degree to which the parent(s)' specified goals have been achieved. (e.g. Goals Based Outcomes, Parent and Baby Outcomes Star).

You may have a local rationale to additionally measure parental mental health, a common positive outcome of parent-infant relationship work. We advise areas to consider aligning these tools with those used by local health visitors.

Parent-infant relationship interventions may not be lengthy enough to measure appreciable change in child development, such as social-emotional development, but tools for this are reviewed in the **Parent-Infant Foundation's Development and Implementation toolkit** at the end of Chapter 8.

Be mindful that some clinical measurement tools are not validated for pre and post intervention use, only for clinical assessment purposes.

Our advice is to specify in contracts that clinical outcomes should be routinely measured using evidence-based, validated tools before, during and after interventions, but that the exact tools to be used will be decided through dialogue between providers, commissioners, service users and any additional experts as required.

So what? And what next?

Commissioners need to know whether the services they have commissioned are having the desired impact for babies, families, the workforce and the wider system.

This section provides links and information to help you co-produce a monitoring and evaluation plan. Another next step might be to review your theory of change to ensure outcomes are clear, logical, feasible and measurable.

The final section of this toolkit summarises relevant national standards and clinical guidance.

Additional resources

- Existing services may be happy to describe their evaluation approach, and often do so in their annual reports or impact statements. You can connect with other areas through the Parent-Infant Teams Network facilitated by the Parent-Infant Foundation. Some of their published evaluation reports are linked in **Section A.2** on outcomes.
- The **Child Outcomes Research Consortium** provides good, general advice about outcomes and experience measurement, including using Goal Based Outcomes.
- The **VAWG Services Commissioning Toolkit** (2022)[118] includes good, general advice about performance monitoring and outcome measurement (pages 45-48).

REVIEW

B.9 National guidance and service standards

This section contains information and links to relevant service and clinical guidance from the Royal College of Psychiatrists (RCPsych), the National Institute for Health and Care Excellence (NICE) and the Royal College of Midwives (RCM). Head back to **Section A.3** for information about which national policies and strategies relate to parent-infant relationships (PAIR).

Royal College of Psychiatrists

There are currently no national quality standards for specialised parent-infant relationship teams, however in **'Perinatal Mental Health Services: Recommendations for the provision of services for childbearing women' (2021)** the Royal College of Psychiatrists describe:

- what a good quality parent-infant mental health service should look like (page 23)
- what a good quality CAMHS service should offer for parent-infant relationships (page 24)

The Parent-Infant Foundation has also described **"Characteristics of a Specialised Parent-Infant Team"** in Chapter 1 of the Development and Implementation toolkit.

National Institute for Health and Care Excellence (NICE)

Children's Attachment (QS133) and Children's Attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care (NG26)

The National Institute for Health and Clinical Excellence states that securely attached children have better outcomes than non-securely attached children in social and emotional development, educational achievement, and mental health (**QS133**, page 6).

Quality Statement 1. Children and young people who may have attachment difficulties, and their parents or carers, have a comprehensive assessment before any intervention programme.

Quality Statement 3. Parents and carers of preschool-age children with or at risk of attachment difficulties are offered a video feedback programme.

NG26 recommends an initial 10 session video feedback programme delivered in the parental home by a trained health or social care worker to improve the relationship between the young child and their caregiver.

It also recommends families with children who are at risk of going into care also undertake parent–infant psychotherapy on a weekly basis, for at least a year, to improve attachment difficulties.

Child Abuse and Neglect (NG76)

Up to 80% of children who have been neglected or abused exhibit disorganised attachment, the pattern associated with highest risk of poorest outcomes. NICE guideline **NG76** makes it clear that attachment-based interventions should be offered to foster carers, adoptive parents, special guardians, foster carers or kinship carers looking after young children who have been abused or neglected.

Antenatal Care [NG201]

NG201 states that antenatal classes should include information about how the parents can bond with their baby and the importance of emotional attachment.

Postnatal Care [NG194]

In **NG194**, Section 1.3.15-18 make recommendations about promoting emotional attachment through discussion and providing information to parents antenatally and continuing postnatally. This includes the importance of face-to-face interaction, skin-to-skin contact and responding appropriately to the baby's cues. Additionally, for health staff to "Recognise that additional support in bonding and emotional attachment may be needed by some parents who, for example:

- have been through the care system
- have experienced adverse childhood events
- have experienced a traumatic birth
- have complex psychosocial needs.

Antenatal and Postnatal Mental Health care (CG192)

Mothers with an existing mental health problem are a higher-risk group in experiencing difficulties with their mother-baby relationship (this is also true of all parents). This has been recognised in NICE's clinical guidance on Antenatal and postnatal mental health [**CG192**, 1.9.12-13] which recommends practitioners assess the parent-infant relationship in any case where a mother is diagnosed with a mental health issue either during pregnancy or the post-natal period and that practitioners consider further interventions to improve the parent-infant relationship.

Early years: promoting health and wellbeing in under 5s (QS128)

Quality Standard 128 states that parents and carers of children under 5 should be offered a discussion during each of the five key health visitor contacts about factors that may pose a risk to their child's social and emotional wellbeing. It recommends an interagency assessment and plan to determine what further support a family needs to address these problems.

For commissioners this means that they commission services with local protocols to discuss the factors that pose a risk to a child's social and emotional wellbeing with parents and carers.

This quality standard is endorsed by the Department of Health and Social Care as required by the Health and Social Care Act (2012).

Social and Emotional Wellbeing: Early Years (PH40)

NICE's public health guidance on social and emotional wellbeing in the early years [**PH40**] makes it clear that assessing vulnerable children and identifying their needs requires an interdisciplinary approach from a range of professionals. Additionally, that midwives and health visitors should work in partnership with other early years practitioners, such as psychologists, therapists, family support workers and other professionals, to ensure families receive co-ordinated support.

Royal College of Midwives

Key practice messages for midwives and maternity support workers are presented in the RCM's report **'Parental Emotional Wellbeing and Infant Development'** (2019)[119].

TOOLS

Service Mapping tool

The service mapping tool will support you to:

- Map what Parent-Infant relationship support is available in your area.
- Identify any gaps in provision.

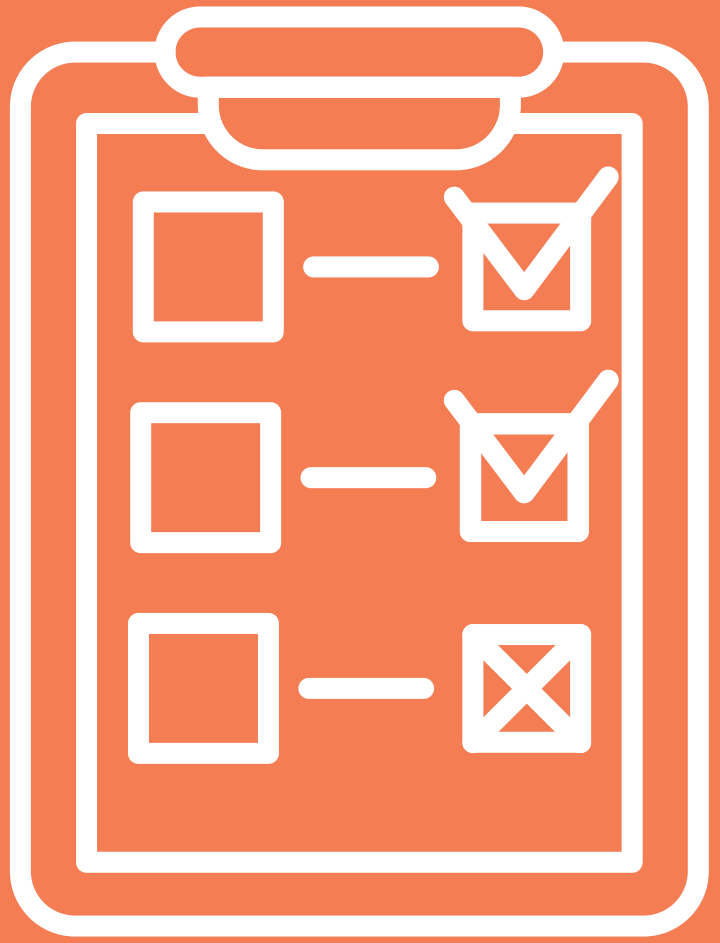
Click here to access the tool online on the Parent-Infant Foundation website.

Self-audit tool

The purpose of the self-audit tool is to:

- Assess your own development and maturity as a parent-infant team against a set of commonly agreed descriptors.
- Work towards creating a service development action plan.
- Use it as a leverage for funding, or in whole system wide discussions.

Click here to access the tool online on the Parent-Infant Foundation website.



Service mapping tool for parent-infant relationship services

	SERVICES, ACTIVITIES AND INTERVENTIONS	FOCUS OF THE SUPPORT	LEVEL OF SERVICE
Think about a parent whose relationship with their baby (conception to 2 years) is raising concern. **What any kind of support or intervention is available (if any) in each of these areas to improve the parent-infant relationship?**	**What services, activities and interventions are there that promote and improve the parent-infant relationship?** (e.g. Baby Bonding leaflet, parent-child interaction parenting group, specialist health visitor, specialist parent-infant team)	**Does this aim to primarily:** 1. **Support the parent's own mental health specifically or,** 2. **Support the parent-infant relationship?**	**Is this service predominantly:** 1. **Universal** (offered to everyone) 2. **Targeted** (for those identified as needing more help) 3. **Specialist** (offering specialist interventions by highly qualified staff), or 4. **A mix of these levels?**
Midwifery. This might include direct parent-infant relationship support in community and acute midwifery, antenatal groups, specialist midwives incl. midwives for more vulnerable groups, leaflets and other written information, advice (e.g. skin to skin, feeding methods), baby apps (e.g. Baby Buddy).			
Health Visiting. This might include individual or group based support, specialist PIMH HV posts, nursery nurse activities, leaflets and written information, apps which are routinely recommended, public health advice which includes information specific to bonding or PIR relationships. It may also include post-baby loss, bereavement or birth trauma support/intervention.			
Children's social care (safeguarding). This might include specialist assessment of the parent-infant relationship including pre-birth, individual and group interventions, specialist therapuetic teams who can offer parent-infant work, specialist foster placements for attachment problems, attachment services for babies who are Looked After.			
Perinatal Mental Health Services. This might include individual or group interventions, videos or apps, written information, or parent-infant trained staff, where there is specific focus on the relationship between parent and baby. Include MBU services if you have an inpatient unit.			

ASSESSMENT	FURTHER DETAILS	REFERRAL CRITERIA: IS ANYONE EXCLUDED?					IDENTIFYING GAPS	
Will they receive an individual assessment of the parent-infant relationship before receiving an intervention?	**Please add any more detail about the available service here.**	**Is this service available to fathers and co-parents?**	**What is the accepted age range for referrals (e.g. conception to age 2, 0-5)?**	**Can parents self-refer to this service?**	**Is this service provided ante-natally?**	**Does this service have restrictions on who can be referred** e.g. by age, complexity of need, co-morbidity, geographical boundaries, high threshold of need?	**To what extent does this service has capacity to see all the families who need it?**	**What else could be provided to enable more parents and infants to get the level of support they need.**

Service mapping tool for parent-infant relationship services (continued)

	SERVICES, ACTIVITIES AND INTERVENTIONS	FOCUS OF THE SUPPORT	LEVEL OF SERVICE
Think about a parent whose relationship with their baby (conception to 2 years) is raising concern. **What any kind of support or intervention is available (if any) in each of these areas to improve the parent-infant relationship?**	**What services, activities and interventions are there that promote and improve the parent-infant relationship?** (e.g. Baby Bonding leaflet, parent-child interaction parenting group, specialist health visitor, specialist parent-infant team)	**Does this aim to primarily:** 1. **Support the parent's own mental health specifically or,** 2. **Support the parent-infant relationship?**	**Is this service predominantly:** 1. **Universal** (offered to everyone) 2. **Targeted** (for those identified as needing more help) 3. **Specialist** (offering specialist interventions by highly qualified staff), or 4. **A mix of these levels?**
Neonates and paediatric ICU. This might include particular care packages or techniques used to address concerns about the parent-infant relationship.			
Child Development Centre/paediatrics. This might include group or individual interventions, written information, or specialist staff who can offer direct parent-infant relationship support, including for children on specific care pathways (eg for ADHD, ASD, FASD).			
Voluntary and third sector. This might include group or individual support and/or interventions which are focussed on improving parent-infant relationship difficulties.			
Other. This might include services which provide parent-infant relationship focussed support and interventions for special groups of children such as those with visual or hearing impairments, palliative care, refugee and asylum families, families of particular ethnicities, or through other services such as a GP clinic.			

ASSESSMENT	FURTHER DETAILS	REFERRAL CRITERIA: IS ANYONE EXCLUDED?					IDENTIFYING GAPS	
Will they receive an individual assessment of the parent-infant relationship before receiving an intervention?	**Please add any more detail about the available service here.**	**Is this service available to fathers and co-parents?**	**What is the accepted age range for referrals (e.g. conception to age 2, 0-5)?**	**Can parents self-refer to this service?**	**Is this service provided ante-natally?**	**Does this service have restrictions on who can be referred** e.g. by age, complexity of need, co-morbidity, geographical boundaries, high threshold of need?	**To what extent does this service has capacity to see all the families who need it?**	**What else could be provided to enable more parents and infants to get the level of support they need.**

Intervention Map

COLOUR KEY: Blue indicates the level for which the intervention is primarily designed. Yellow indicates that the intervention is not sufficient on its own to address difficulties at this level but it may contribute to positive outcomes here when integrated with other approaches.

	Format	Public Campaigns/ Thriving Families	Universal	Targeted	Specialist
Look Say Sing Play	Public Campaign				
Getting It Right From the Start	Booklet and film clips				
Getting to Know Your Baby	Film clips				
Hungry Little Minds	Videos and activities for parents and their babies				
Baby Buddy by Best Beginnings	Mobile app and website				
Watch Me Play	Individual				
Five to Thrive	Content to incorporate in individual or group work				
Therapeutic Baby Massage and Baby Yoga	Individual or Group				
GroBrain	Individual or Group				
PEEP	Individual				
Early Yes	Individual				
Solihull Approach Understanding Your Baby	Group				
Solihull Approach Antenatal	Group				
Family Links Welcome to the World	Group, from 24 weeks pregnancy				
Family Links Parenting Group	Group				
Family Links Playful Parenting	Group				

	Format	Public Campaigns/ Thriving Families	Universal	Targeted	Specialist
Family Links Working 1 to 1 with Parents	Individual				
Family Links Working 1 to 1 with Parents	Individual				
Solihull Approach	Individual				
VIG	Individual				
Neonatal Behavioural Observation (NBO)	Individual, babies 0-3 months				
Baby Steps	Group, antenatal to few months postnatal				
Incredible Years Baby and Toddler	Group				
Baby Triple P	Group				
VIPP-SD	Individual, babies from 6+ months up				
SUSI	Service model based around individual work				
Mellow Babies	Group				
Watch Wait and Wonder	Individual or Group				
Circle Of Security	Group				
ABC: Attachment Bio-behavioural Catch Up	Group				
Infant-Parent Psychotherapy (IPP)	Individual				
For Baby's Sake	Group for babies experiencing domestic abuse				
Parent-infant psychotherapy and other formulation-led psychological interventions	Individual				

Self-assessment grid: What does a good parent-infant relationship system looks like?

	Foundations	Early Growth	Good Progress	Well-established
Strategic leadership	There are key champions of parent-infant relationships who are raising the profile of the importance of PAIRs.	There is some strategic infrastructure focussing on PAIRs but more generally awareness of its importance is patchy.	There is a dedicated strategic workstream for PAIRs with clear governance and decision-making responsibilities.	There is well-established, senior leadership commitment to drive PAIR developments forward. This is based on a good understanding of how PAIRs can help deliver local strategic priorities.
Use of research and evidence	Understanding of the latest research about the research and evidence about PAIRs is not widespread. Ensuring all health services are delivering information and support in line with NICE recommendations on promoting emotional attachments.	There is evidence that local services are developing PAIR interventions, services and staff competencies using the latest research and evidence.	There is evidence that local strategies and plans are being based on a good understanding of the latest PAIR research and evidence.	There are mechanisms in place to ensure latest research and evidence are accessed and used in strategic planning, commissioning, service delivery and workforce planning.
Financial investment	There are existing services which promote protective factors and reduce risk factors for PAIR difficulties (e.g. Early Help, Health Visiting)	There is funding for PAIR development work and/or services (e.g. mapping of existing services and gaps, workforce audits, PAIR-focussed interventions)	Commissioners commission PAIR specific services or interventions in response to locally audited strengths and gaps, and population need.	There is funding for a sufficient clinical offer at specialist, targeted and universal levels, both antenatally and postnatally.
Community involvement	There is evidence of formal consultation with parents regarding PAIRs.	There is evidence that the voices of the baby and of typically marginalised parents are clearly heard through consultation.	Parents and the wider community are engaged in some aspects of co-developing PAIR services and support.	There is inclusive baby and parent involvement in commissioning, governance, design and evaluation of PAIR support and interventions.
Strategies and policies	All relevant local strategies include specific reference to children under 2 and their families, including those relating to Early Years, Early Help, Children and Young People, Edge of Care and Looked After Children, Maternity, Children's Mental Health and Perinatal Mental Health.	All relevant strategies acknowledge the unique needs of babies and reference Babies, Children and Young People (rather than CYP), and the importance of supporting PAIRs as a key mechanism of impact.	Work to support PAIRs is included in all key partnership strategies.	There is a locally developed and agreed PAIR strategy, with commitment from senior leaders across the system and clear accountability. The impact of the PAIR strategy is monitored and the strategy reviewed.
Workforce development	Key champions have been delivering local training relevant to PAIRs. There is an understanding of how various professions contribute in different ways to strengthening PAIRs.	Some organisations are using the Infant Mental Health Competencies Framework such that gaps in PAIR training are known and acknowledged. They are building it into workforce planning e.g. commissioning relevant training, including PAIRs in individual CPD plans and job descriptions.	There is a co-ordinated approach across organisations. Data is being used to assess current workforce strengths and needs and to plan workforce development activities.	There is a jointly agreed and implemented workforce development strategy for parent-infant relationship workforce competencies development, with clear monitoring and accountability.

Self-assessment grid: What does a good parent-infant relationship system looks like? (continued)

	Foundations	Early Growth	Good Progress	Well-established
Services and Interventions	There are some interventions available locally which are shown to improve PAIRs.	There are interventions available locally which specifically address PAIRs.	There is a growing clinical offer antenatally and postnatally to specifically address PAIR difficulties. There has been some strengthening of identification and assessment through the review of screening and assessment protocols.	There is a sufficient and effective clinical offer in place at universal, targeted and specialist levels, which includes identification, assessment, support and intervention. There are antenatal and postnatal interventions at all levels which specifically address PAIRs.
Capacity building activities	There are some local or online PAIR training opportunities made available to staff.	There are some opportunities for specialist case consultation or practice-embedding activities but these are limited (e.g. to certain professional groups).	Training, case consultation and practice-embedding activities are more widely available but remain limited in some ways. There is the possibility of joint visits with specialists in certain cases.	Staff from NHS, local authorities and the third sector can access: (a) specialist case consultation regarding their parent-infant relationship work (b) post-training practice embedding support (c) local practice development opportunities such as webinars, reflective practice groups (d) joint visits with specialists to families by mutual agreement.
Service user experience	Service users have access to a means of feedback about their experience of PAIR support and intervention. Service user feedback is monitored to ensure representation from typically marginalised groups and action taken where indicated. Feedback is reviewed and acted upon.	Service users have a choice of different channels to provide feedback.	Service user feedback is enhanced with case audits or other means of representing service user experience.	There is a formally facilitated service user forum.
Co-ordination across the system	Staff from different agencies work together on a case-by-case basis	There is evidence of joint working across agencies specifically relating to PAIRs	A PAIR care pathway is developed and agreed through multi-agency collaboration. There may be a shared referrals allocation meeting.	There is evidence of an integrated PAIR care pathway being effective and routinely monitored at a partnership level, with changes made as necessary. There may be an advanced level of co-ordination across agencies such as multi-agency PAIR teams or shared spilt posts.
Outcomes and impact	Some outcome data is collected.	Outcome data is routinely collected and reviewed to inform service development. Outcome measurement tools are evidence-based.	Data systems are adapted to support routine outcome data collection. Outcome measurement tools are regularly reviewed against latest evidence.	Data is routinely collected through data systems and monitored at a partnership level to demonstrate the impact of PAIR support and interventions, and to inform strategic development.

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