September 2023

Parent-Infant FOUNDATION

Policy briefing: Response to the major conditions strategy

400 specialised parent-infant relationship teams needed for England

Overview

In August 2023, the Department for Health and Social Care published a policy paper on addressing the six major health conditions., including mental health. This 'strategic framework' outlines the government's high-level approach, with a detailed implementation plan still to be developed.

We were delighted to see infant mental health included for the first time at such a high level. Particularly as we had made two prior evidence submissions urging government to include specialised parent-infant relationship teams in their strategy, which support the mental health of parents and babies.

In the new policy framework the government say, "**We recognise that there is more to do in ensuring we consider the whole life course, and tailor services accordingly. For example, we know that half of all mental health problems have been established by the age of 14, rising to 75% by age 24.**[footnote 32] **As a result, there is real opportunity to focus on perinatal and infant mental health, and early intervention for young people."**

In evidence we submitted in June 2023, we urged the government to invest in more specialised parent-infant relationship teams to address this issue. Our submission to the consultation, pointed out that, **"Although the government's Start for Life programme encourages local areas to commission parent-infant relationship teams, they are not mandated to do so, and provision is patchy"**. We estimated that a tenfold increase in the number of specialised parent-infant relationship teams would be needed to deliver the government's vision as set out in the Best Start for Life programme.

In recent years the number of specialised parent-infant relationship teams has been growing, with 45 teams now across the UK, and 14 more in development.[1] The government framework noted this too, saying, **"We are already taking forward some of this work through our Family Hubs and Start for Life Programme, which includes £100 million to enable 75 local authorities to establish and improve perinatal mental health and parent-infant relationship support."**

1. https://parentinfantfoundation.org.uk/network/locations.

400 teams needed in the next 5 years

Recent government investment in the Start for Life programme is very welcome. However, many local areas do not yet have a specialised parent-infant relationship team. We estimate that at least 400 teams are needed in England alone, requiring a tenfold increase over the next five years. The estimate is based on each team supporting on average 150 families directly each year, and providing services to 5% of babies aged 0-2 years in England.

Our estimate is not precise, because assessments of need, staffing and system capacity suffer from a lack of nationally collected and disaggregated data. In the absence of national data, we considered a range of clinical, commissioning and practical factors to arrive at this estimate:

Firstly, we adopted the government's approach to assessing need, which uses 'disorganised attachment' as a proxy measure. While disorganised attachment is not an exact measure of need, it serves as a reasonable proxy. This type of insecure attachment pattern refers to children who, due to unpredictable or hostile care, have been unable to develop a secure attachment to their parent or carer. Babies at risk of developing a pattern of disorganised attachment are overwhelmed, even traumatised, by disturbed relationships with their main caregiver – relationships characterised by unpredictability, hostility or neglect. These babies are living in fear and distress now, and are at the highest risk of later emotional, social and behavioural difficulties.

We know there is a link between disorganised attachment and poor mental and physical health outcomes for children and young people, indicating a need for early intervention with this group.[2] Start for Life puts prevalence of disorganised attachment at 10% of the population, but estimates vary. Academic research suggests the level of disorganised attachment at a population level could be as high as 15%.[3] It should be noted that while this group represents the most vulnerable babies, professionals also recommend supporting babies at risk of developing other types of 'insecure attachment', as they too experience distress that can negatively impact on their development.

Secondly, we considered the gap between need in the population, and appropriate service provision. This gap exists because of the challenge of identifying and referring all babies in need into services. A pragmatic approach to commissioning recognises this gap, and commissions at a lower level than 'total estimated need'. Our approach was informed by ongoing conversations with commissioners and existing parent-infant relationship teams, who shared their experiences and approaches with us. We also factored in learning from areas like Greater Manchester with longstanding experience of supporting their population.

Our recommended approach for population needs modelling, for commissioning purposes, is based on live births using the cohort 0-2 years (so excludes pregnancy).[4] This is an

2. Bowlby J. A secure base: clinical applications of attachment theory. London: Routledge; 1988 2010, Journal of child psychology and psychiatry, *Attachment disorganisation and psychopathology: new findings in attachment research and their potential implications for developmental psychopathology in childhood.* **Jonathan Green, Ruth Goldwyn**.
3. Disorganized attachment in early childhood: Meta-analysis of precursors, concomitants, andsequelae, 1999 MARINUS H. VAN IJZENDOORN **https://www.cambridge.org/core/journals/development-and-psychopathology/article/abs/disorganized-attachment-in-early-childhood-metaanalysis-of-precursors-concomitants-and-sequelae/87A710EAEC0C4167E02811B62CB284CF**.

approach used by local authorities and health bodies across the UK. Although we base the estimate on babies aged 0-2, it should be noted that teams sometimes work with families in the antenatal period, and with babies older than two.

Taking all this into account, our estimate assumes only one third of babies at risk of disorganised attachment (taken to be 15%) will access specialist services. This equates to around 59,600 babies in England, meaning approximately 400 teams. This represents an ambitious scale-up of services, but it is important to be ambitious for babies as we are considering a suitable target to achieve over the next five years.

By way of comparison, The NHS Long Term Plan set the ambition that at least 66,000 women with moderate to severe perinatal mental health difficulties would have access to specialist community care from pre-conception to 24 months after birth (over 5 years).[5]

How to grow parent-infant relationship services

The Start for Life programme explicitly prioritises developing services and professionals to focus on parent-infant relationships and provides funding for 75 local authorities to do this. However, it does not explicitly require local authorities to establish specialist services to support the most vulnerable babies. Neither does it identify where local expert champions will be found when there is no specialised service available. In areas where specialised parent-infant teams exist, local experts typically act as the catalyst to establishing local services. Areas that don't have a local champion can struggle to find the expertise to establish a new service.

A further challenge is that specialised services rely on the wider health and care ecosystem for referrals. If babies are not identified because social workers, midwives or health visitors are short-staffed and overwhelmed with their caseloads, then they can't be referred for specialist support. For new teams to work, they need to sit alongside a sufficiently resourced early years workforce. Also, the wider workforce needs adequate time, understanding and training to be able to identify babies in need and refer them.

In practice, we know that families need to be supported both by teams and also by other services, depending on their varying needs. A good approach adopted by several areas is the Thrive model', which provides varying levels of care, depending on need.[6] We also recommend a more nuanced approach to estimating the level of need in local areas, which acknowledges that some teams will work across the spectrum of need (i.e. not just supporting those at risk of disorganised attachment but also babies at risk of other types of insecure attachment) and that not all families in need will access support.

At a local level the estimate of need should also take account of other risk factors in the population. We have developed a toolkit for commissioners wishing to understand why teams are needed in their area, and what this looks like. This is free to access on our website.[7]

4. **Commissioning Toolkit** - Parent-Infant Foundation (parentinfantfoundation.org.uk)
5. **NHS Mental Health Implementation Plan 2019/20** – 2023/24 (longtermplan.nhs.uk)
6. **CAMHS Infant mental health Pathway I-Thrive Activities** – Parent-Infant Foundation (parentinfantfoundation.org.uk)
7. **https://parentinfantfoundation.org.uk/tools/commissioning-toolkit**

Following publication of the government's major conditions framework, we expect a more detailed strategy and implementation plan to follow. Within our evidence submissions to government we recommended that their strategy needed to:

- Help parents to reduce stressors that make it harder for them to respond to their babies' needs (for example, supporting parents with their own mental health challenges).
- Create mental health services that support families struggling with their early relationships and concerns about babies' mental health and development.
- Design a workforce plan to enable specialist services to be created and delivered.
- Ensure the wider workforce supporting babies and families are sufficiently resourced and trained in the importance of early relationships, so they are able to identify when these are under strain and require specialist support.
- Improve mental health service data to show how many babies are supported by services and what care they are receiving.
- Integrate national and local working by creating a joined-up national vision and strategy for babies, children, and young people, which sets out clear shared outcomes across services.

Public support for parent-infant relationship services

It is encouraging to see growing public support for services that support the parent-infant relationship. This is indicative of increased public awareness of the importance of relationships to mental health. Respondents to the government's Mental Health Strategy consultation (in 2022) said 'social and family relationships' had the biggest influence on their mental health (77%). They also prioritised 'early intervention', which is both clinically and cost effective. A focus on relationships and effective early intervention is the approach embodied by parent-infant relationship teams. Their work is critical to the mental health of thousands of babies, parents and carers, and sometimes even to their survival.

As one mother supported by a team told us,

"I probably would have asked to be admitted. I think that's how bad it was because I was so bad I didn't want to pick up my daughter, you know, I would let her cry. [...] I do think without the care I probably would have called the health visitor and said, 'You need to take me away because I'm either going to continue to harm myself and it's going to progressively get worse and then I'm going to harm my baby.'"