**Start for Life funding review – task for Workstreams.**

At the request of the IC Leadership Group, we are to undertake a review of SFL impact and funding with the specific purpose of understanding the risks and requirements should funding cease as planned in March 2025.

We would like you to consider the following questions with your wider workstream colleagues. We will then use the information to inform the wider review.

**Important – this questionnaire should not be considered as a business case or bid for funding.** We know the value of the work that has taken place and that in an ideal world we would continue to provide all delivery and more. However, we need to be realistic. We need to set out the impact and outcomes and set out what must continue. We must concede what may have worked less well or can be managed differently and what risks there are in reducing the funded services. SfL has provided an opportunity to implement new ways of working and we want to define what should be reframed as “business as usual.” this could mean service redesign and consideration of funding, capacity and resources.

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| **Workstream title or subgroup**  | Perinatal and Infant Mental Health |
| **Allocated funding**  |  |
| **Funding breakdown**  |

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| --- | --- | --- |
| **Service** | **Cost** | **Funded by:** |
| CAMHS PAIRS |  |  |
| 0-19 PAIRS |  |  |
| PNMH Midwifery Team subcontract |  |  |
| Talking Therapies subcontract |  |  |
| Perinatal Mental Health Peer Support (Light) |  |  |
| Peer Support Offer for Dads(Zest) |  |  |
| **TOTAL** |  |  |

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| **Data – please include an accessible link to specific related data**  |  |
| **Describe the SfL/FH funded service and activity delivered:**From a starting position of virtually no targeted or specialist infant mental health (IMH) provision and minimal support being available for mild to moderate perinatal mental health (PNMH) needs, Sheffield now has a comprehensive offer for both PNMH and IMH provision across all levels of need. This has been achieved by:* Improving workforce capability, knowledge and skills through an enhanced training offer.
* Delivery of community-based services through Family Hubs
* Development of digital/ remote offer of advice/ support around IMH and PNMH
* Increased capacity (CAMHS practitioners with expertise in IMH and therapeutic work to support parent infant relationships (PIRs) in the Parent and Infant Relationship Service (PAIRS) for specialist therapeutic work with those most at risk and for training and support to the wider pathway.
* IMH practitioner roles within health visiting to facilitate the early identification of emerging difficulties in parent infant relationships and provide appropriate support and timely onward referrals for those requiring more specialist interventions.
* Creation of an innovative and integrated PAIRS service model – delivered jointly by HV and CAMHS. PAIRS practitioners across both services share a point of referral into the pathway and an MDT allocation meeting to ensure smooth movement into the pathway and across the levels of need to ensure families receive the right support at the right time.
* Establishing a comprehensive perinatal MH peer support group offer available across all 7 Family Hubs plus provision of targeted citywide groups, 1-to-1 support and counselling.
* A tailored perinatal MH peer support offer for dads/coparents available citywide.
* Improving culturally appropriate PNMH peer support for parents from diverse cultures and ethnicities
* Reviewing gaps and improvements in PNMH peer support for teenage parents
* Developing a universal antenatal/postnatal education offer to incorporate adjustment to parenthood, bonding and attachment and understanding your baby.
* Creation of a dedicated perinatal MH role in Talking Therapies service which will develop specialist perinatal MH offer for parents referred into the service during the perinatal period
* Development of a range of suicide prevention resources as part of the ‘Talking Saves Lives’ initiative including posters, cards and leaflets for maternity packs which have also been distributed to other citywide partners. PNMH & suicide prevention information developed on both Flourish and Jessops website
* Opportunities for parents to co-design and influence new service developments
* Creation of a stepped care pathway for parents with a history of relational trauma to include early identification of need at universal level (antenatally and postnatally), and enhanced access to timely resources and therapeutic support
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| Please confirm the number of posts funded by SfL. Please include WTE grade and the employing organisation.**Specialist Parent Infant Relationship Service (specialist team plus health visiting)**PAIRS-CAMHS Service Lead, Consultant PsychologistSenior Psychotherapist (Art) Senior Clinical SpecialistClinical SpecialistInfant Mental Health Practitioner (term time)Assistant PsychologistService Delivery ManagerBusiness SupportPAIRS-0-19Specialist IMH Health Visitor Lead Infant Mental Health Practitioner **Emotional Wellbeing Midwifery Team (STH)**Maternity Mental Health MidwifeMaternity Mental Health Support Worker**Talking Therapies (SHSC)**Psychological Wellbeing Practitioner **Perinatal Mental Health Peer Support Support (Light)**SfL/FH Programme ManagerPeer Support Practice CoordinatorPeer Support Workers/Community Engagement Worker (20 hours/week)Integrative Counsellor Data/Analyst **Steel City Dads (Zest)** Peer Support Worker |
| **Evidence base /rationale. This is particularly important where the evidence of impact is minimal. For example, where delivery has been recently established**,Investment in perinatal and infant mental health is supported by an extensive national and international evidence base. The early part of the life course, from birth to young adulthood (0 to 25 years), provides important opportunities for promoting and protecting mental health. Untreated perinatal mental health problems affect maternal morbidity and mortality, with almost a quarter of maternal deaths between 6 weeks and 1 year after pregnancy attributed to mental health related causes. One in 7 maternal deaths during this period were by suicide. Some fathers or partners may also find the transition to parenthood challenging, requiring additional support for their mental health and wellbeing. Additionally, partners of women/birthing people experiencing perinatal mental health problems are at increased risk of developing mental health needs themselves.Perinatal mental health problems cost the NHS and social services around £8.1 billion for each annual cohort of births. A significant proportion of this cost relates to adverse impacts on the child. Children of affected mothers and fathers are at higher risk of poor mental health, physical health, social and educational outcomes. Perinatal mental health problems can impact on a mother’s and partner’s ability to bond with their baby and to be sensitive and attuned to their emotions and needs. This in turn will affect the infant or child’s ability to develop a secure attachment which can have lifelong consequences for their health and wellbeing. By ensuring mothers/birthing people can access the right type of care during the perinatal period the impact of maternal mental health problems on infant mental health and future adolescent and adult mental health can be reduced.Babies have as much right to good mental health - to feel safe and content and connected and cared for - as the rest of us but, alongside this, there is now a wealth of research evidence from a wide range of disciplines that tells us that the earliest years of life provide the foundation for later development. What happens in the first 1001 days does not determine a child’s entire development, but getting things right in pregnancy and the first two years puts children on a positive developmental course, so they can take advantage of other opportunities. We know that the brain can adapt and change throughout life, but its capacity to do so decreases with age. This means it is much easier to influence a child’s development and wellbeing if we intervene earlier and, specifically, during pregnancy and the first two years of life. This is a period of uniquely rapid growth, when babies’ brains, physiological systems such as the stress response, their sense of self and understanding of the world, and capacities such as emotional regulation and language are shaped by the environment and the caregiving environment in particular. The evidence is clear, sensitive, responsive caregiving during the earliest years of life lays the foundation for later health and wellbeing, the benefits of which last a lifetime – and carry into the next generation. When children have sensitive nurturing relationships with caregivers who co-regulate their emotions, they build self-regulation skills which are key to being mentally healthy throughout life. Having a secure attachment and positive understanding of themselves and others and how the world works also has a positive impact on their wider development and a range of other outcomes. These children feel safe to explore and make friends and they're more likely to be able to learn and achieve in early education and school. Supporting babies to be mentally healthy also increases the likelihood of them achieving their full potential and contributing to society and we also know that the ability to regulate emotions and turn to others for support when needed is strongly associated with good physical health and healthy behaviours, decreasing the risk that they'll need to rely on a range of public service support throughout life. It can be more difficult for babies who have not had responsive care to learn to regulate their own emotions, which in turn can affect their physiological responses – with long-term impacts on both their mental and physical health. Chronic unrelenting stress in early childhood – such as, but not limited to, domestic abuse, mental illness, substance misuse, unresolved trauma and poverty – can be extremely damaging to the developing brain, particularly if a child does not have a secure relationship with an adult who can help to ‘buffer’ the impact of this early adversity. This stress, known as ‘toxic stress’, leads to prolonged activation of the stress response systems which can disrupt the development of brain architecture and other organ systems and increase the risk for stress-related disease and cognitive impairment, into the adult years. Babies who receive secure nurturing care do better in terms of their cognitive and social emotional development, development of speech, language and communication skills, readiness for school, and mental health as children and adults. They also have fewer attention problems, are less likely to display antisocial behaviour in adolescence or engage in violent offending. (see Appendix 1). So, providing babies with what they need to be happy and reach their potential makes sense and is the right thing to do to, but there is also a compelling financial argument:At the time when the brain is most easily shaped during infancy and early childhood, we spend the smallest amount of public money on programs which aim to positively influence brain development. Expenditure on programs designed to change the brain dramatically increase in later stages of development when it is more costly and harder to affect change (e.g., specialist looked after children’s placements and services, behaviour support packages in schools, substance abuse or youth justice interventions). Investing in a high-quality, specialist infant mental health service makes good financial sense. The short-term costs are more than offset by the reduction in the need for educational support, better health outcomes, reduced need for social services, lower criminal justice costs and increased self-sufficiency and productivity among families. 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.“*Investing in early childhood development is good for everyone – governments, businesses, communities, parents and caregivers, and most of all, babies and young children... And investing in early childhood development is cost-effective: For every $1 spent on early childhood development interventions, the return on investment can be as high as $13.*” **World Health Organisation, UNICEF and the World Bank (2018).**   Source: Van der Gaag J, Tan JP. The Benefits Source: Centre for the Developing Child, of Early Child Development Programs: Harvard UniversityAn Economic Analysis. Washington, DC: World Bank; 1998One of the challenges in relation to investing in early intervention and prevention when there are so many competing priorities for commissioners is that the some of the returns on the investment don’t accrue for many years to come (and are spread across different services/agencies/ government departments). However, findings from the Scottish Government’s thorough review in 2011 of the benefits of early years intervention by their panel of invited international experts found: * Short term\* savings of £37,400 a year per child from investing in early years services and support from pre-birth to aged five for those who have complex health and social care needs.
* Short term savings for a child with moderate health and social care needs that amounted to £5,100 a year.

**Rationale**The project plan for this workstream was ambitious and transformational. The vision was not just about delivering more of something or delivering something new where there was a gap, but to develop an integrated pathway with new and existing offers/ services working together more effectively and efficiently, particularly around infant mental health, but also perinatal mental health provision across Sheffield. It has also been about improving the way we work together and building the positive relationships we need to be able to deliver effective, accessible services to families. The impact of the integrated pathway that has been created is greater than the sum of its parts.**IMH**We know what babies need for a good start in life: Alongside protection from significant and chronic stress and adversity and a safe & stimulating environment to explore, they need sensitive, responsive care from at least one adult. We also have growing evidence about which interventions are effective in promoting sensitive and responsive care and an understanding of those parents/carers that are at greater risk of struggling to provide the sort of care their infants need. Based on this knowledge, the programme plan set out to build on the embryonic specialist IMH offer within CAMHS to develop a specialist multidisciplinary parent infant relationship service. This service would support the development of an integrated pathway, upskilling and enabling professionals coming into contact with families with young babies to identify emerging need in the PIR and either provide support or make appropriate onward referrals. In addition to developing close relationships with the Family Hub and Early Help offers, the vision included the development of specific PIR/IMH pathways with midwifery and health visiting to support provision for mild to moderate PIR need. Where it is identified that families experiencing complex and/or enduring difficulties in their early relationships, where babies’ emotional wellbeing and development is particularly at risk, the PAIRS provide targeted and specialist therapeutic work (see PAIRS template).**PNMH**About half of all cases of perinatal depression and anxiety go undetected and many of those which are detected fail to receive evidence-based forms of treatment. This is partly due to a lack of recognition and awareness of mental ill health and its signs and symptoms, particularly amongst some black and ethnic minority groups. Across all cultures, some women are reluctant to disclose how they are feeling due to the stigma associated with mental health problems and fears that they may be judged. In Sheffield, the specialist PNMH service provides mental health support to women experiencing moderate to severe mental health difficulties in the perinatal period (up to the baby’s first birthday). However, we know that many parents who experience mental health problems in the perinatal period do not meet the threshold for the specialist service. The Start for Life PNMH/IMH workstream has, therefore, invested in an expansion of the PNMH peer support offer to increase to increase the provision and reach of support for low to moderate mental health difficulties in the perinatal period. This includes both their community based and targeted offer and support for parents from a diverse range of backgrounds and cultures (see Light template). A separate contract was awarded to Zest to address the recognised gap in MH provision for fathers by establishing a Sheffield-based peer-support service dedicated to supporting dads' mental health during the perinatal period (pregnancy to baby's second year). (see Zest template).We also know that some women are at a higher risk of experiencing perinatal mental health problems than others. Associated risk factors include a history of abuse in childhood, teenage mothers, a history of baby loss or traumatic birth or relationship difficulties. The risk to the mother and baby is increased when combined with other risk factors, such as domestic violence and abuse or substance misuse. The development of an early and relational trauma pathway has been undertaken as part of Sheffield’s Start for Life programme to address an identified gap in services for women whose needs do not meet existing service thresholds for mental health support (see ERT template). |
| **Outcomes: What difference has the funded activity made? (evidence of impact on families/other services) What has changed** **as a result of the work? feedback/evaluation etc.**The funding has had a transformative impact on Sheffield’s capability to identify and assess perinatal mental health needs and attachment difficulties at an early stage and capacity for partnership working to address need. Sheffield’s programme has received national recognition for its innovative approach and for being a bold commissioning model borne out of collaboration (between health and the local authority including public health), shared resources, and a shared model of working between CAMHS, health visiting, midwifery and Early Help which has disrupted the regular pattern of provision and enabled positive changes in working practice towards a more integrated system. The programme team has been invited to present its work at several national webinars and national meetings.Metrics demonstrating evidence of impact and outcomes are being continually developed and individual templates for each of the funded programme activities have been submitted separately providing qualitative and quantitative details of the difference which the funding is making. A key programme objective is to ensure that more families get appropriate support in a timely manner, with better understanding and identification of needs across the workforce and there is increased awareness of where families can get suitable help. We can already see a change in practice across the system with rapidly increasing numbers of (earlier) referrals for all funded activities being made by a wider range of services. There is also emerging evidence that we are doing better at improving equity of provision for parents from more deprived areas of the city and across Sheffield’s BAME communities. 41% of Light’s new service user registrations in Q4 of 2023/24 came from individuals living in IMD 1 or 2 areas, indicating the 20% most deprived communities in Sheffield. There has also been an increase in the proportion of individuals from BAME backgrounds from 17% in Q3 to 29%. Work with dads/coparents is also expanding rapidly since the new Steel City Dad’s worker took up post in February 2024 with 28 dads accessing support consisting of a mix of online, telephone and in person activities and numbers growing all the time. Current figures suggest that 33% of families accessing the PAIRS service identify as an ethnicity other than White British or White Irish (this compares to a figure of 20.9% of the Sheffield population who identify in this way).The case studies provided in Appendix 2 gives an illustration of how the integrated care pathway is working in practice to meet needs more effectively and helping to achieve a positive impact on outcomes. |
| **What benefits have been realised because of the funded activity. Consider wider impacts on other services or families**. * Increased availability of PNMH/IMH services at community level with improved reach and connections with the wider Family Hub service offer
* Consistent, collaborative multi-agency working increasing joined-up practice & joint assessments with a focus on the whole family situation.
* More opportunities for families’ mental health needs to be identified and help made available at multiple access points through the perinatal period
* Improved knowledge of perinatal and infant mental health across the early years’ workforce helping practitioners understand how to ask sensitive and timely questions about needs and make appropriate referrals for ongoing support.
* Greater understanding of the barriers to accessing perinatal mental health support with more tailored and culturally competent services being provided to increase access for disadvantaged/marginalised families.
* Sheffield has made rapid progress in just 2 years from a position at the beginning of 2022 of having no dedicated IMH service (and being well behind other areas in this respect), to having an established specialist parent infant relationship pathway and service offer.
* Increased availability of accessible IMH/PNMH digital and paper resources for families and professionals codesigned with a range of partner organisations and service users.
* Earlier identification of perinatal mental health concerns and emerging difficulties in the parent infant relationship.
* Increased awareness across the pathway of the wider offer, with each part of the system understanding the role that others play so that no matter where a family presents, they are supported to access the support they need.

The pathway currently includes partners across three NHS Trusts, the LA and the voluntary sector. We have focused on skilling up the workforce across the pathway to recognise the importance of sensitive, responsive care and to provide multiple opportunities to identify those parents in need of support over and above the universal offer. The aim is that families are supported to access appropriate, good quality, holistic support in a timely manner, and that they can easily move within the pathway dependent on their needs at any given time. Within the pathway we are encouraging the use of complementary approaches and consistent messaging, with each part of the system understanding the role that others play. Effective working partnerships have been forged across different services and at different levels. Examples of innovative integrated working include:* The specialist parent infant relationship pathway which is a collaboration between CAMHS and the 0-19s health visiting service with a single point of access and cases allocated to appropriate clinician according to level of need/ complexity and type of intervention required. Infant Mental Health Practitioners are embedded in the HV teams but receive supervision, training, and operational management from the specialist team. The pathway is proving effective in supporting identification of need earlier in the child’s life.
* The Emotional Well-being Clinic within antenatal care is jointly delivered by the Early Years Family Intervention Service and the perinatal mental health midwifery team. Families needing additional support receive a holistic assessment of need. A mental health passport is created, and they can be connected into the early help/ family hub offers. Where appropriate, families are tracked postnatally and are offered a proactive visit from an IMH practitioner within PAIRS when the baby is 2-3 months old to assess the need for parent infant relationship support.
* Light have initiated outreach activities in mosques and various community settings across the city, encompassing both faith-based and secular organisations including GP surgeries, midwifery clinics, coffee shops, libraries and playgroups. There has also been close co-ordination with the Link Worker Team at Jessop Maternity Wing enabled several non-English speaking parents to access PNMH peer support.
* Much of the PNMH/IMH Start for Life programme activity would not have been possible without close partnership working between the LA and SCFT including the formal agreement that SCFT would act as lead provider and, on behalf of the Council, put in place Start for Life financial, contracting and service monitoring arrangements with other NHS and VCSE organisations.
* Collaboration between PAIRS, PNMH, and PNMH Midwifery team to pool resources and link with Sheffield’s Parenting team offer to coordinate and co-deliver targeted groups such as Mellow Bumps and Circle of Security which aim to promote healthy parent infant relationships.
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| **Can provision be mainstreamed within other budgets? If so, provide detail on conversations /agreements/** **current status of negotiations etc, for example any discussions with ICB (Integrated Care Board) or NHS colleagues**The perinatal mental health peer support delivered by Light and Steel City Dads provided by Zest are funded by Start for Life until 31 March 2025. No further funding has currently been identified through the Council or from other commissioning organisations to continue these activities after this point. A small separate Public Health contract exists for delivering perinatal mental health peer support in Family Hubs.In relation to the SfL funded posts within PAIRS, SCFT have at risk recruited into permanent roles, and are committed to continuing to provide specialised IMH provision as long as a suitable and sufficient funding stream is in place. Despite the LTP stating that children and young people aged **0**-25 should have access to NHS funded mental health services, infant mental health has not been seen as a priority by commissioners or managers of CAMH services who are under pressure to address long waiting lists and improve crisis care. Similarly, 0-19s HV service managers are required to deliver on the mandated visits and activities within the core HCP and as a result are likely to prioritise this over continued IMH provision. If there is no identified funding stream for the specific provision of IMH work, practitioners in SfL funded posts would be absorbed back into mainstream 0-19 or CAMHS provision to fulfil demand in other areas of the service and provide job security for the post holders. If this was to happen, the PAIRS service offer in its current form would cease to exist. This would revert to the embryonic pathway with minimal staffing, which would be insufficient to provide an impactful volume of direct clinical intervention for families, and drastically reduce capacity for indirect work to upskill the wider workforce. In relation to the SfL funded posts within midwifery, postholders who are currently seconded would return to their substantive posts if funding were to cease at the end of the SfL programme. Alongside losing the funded posts, which has enabled the service to more than double the volume of individuals receiving directly targeted support, the service would also lose the additional seconded resource which has been assigned due to the prioritisation of this provision.  |
| **If funding is not found what is the impact? What will be left? Where is the risk? (where in the system would the risk be greatest?) what interdependencies exist?**Delivery of effective perinatal and infant mental health support is complex as it cuts across a wide spectrum of children’s and adults’ services. Sheffield has been striving to develop a truly integrated perinatal and infant mental health pathway harnessing the skills, capability and experience of services delivered by health, the local authority and the community and voluntary sector. A truly integrated pathway enables pooling of both resources and expertise to create a seamless approach to service delivery from universal through to targeted/specialist support. All parts feed into a whole system of support and removing any element would destabilise the entire pathway leading to service fragmentation, with fewer parents and infants being able to access help and poorer outcomes for those families who are receiving support. There would be heightened risks for populations and communities where barriers to accessing services already exist such as socio-economic disadvantage or reluctance to disclose mental health difficulties due to stigma.Other consequences would include:* There would be a deterioration in overall outcomes for infants currently being referred for support via 0-19 service, CAMHS, FIS/Parenting, EWB team. These children will likely show up in other services later down the line e.g., needing emotional, behavioural or learning support in school; being referred for neurodevelopmental assessment; child health services; FIS; CAMHS; and ultimately adult mental health services.
* Whilst upskilling of the core and wider workforce to identify need has been a key feature of the programme, the withdrawal of the service offer will mean support available is likely to be too little and/or too late, with families in crisis likely to receive no service or be offered other (potentially inappropriate) forms of support. Newly acquired learning and skills will be lost over time if they are not used and maintained through on-going supervision/ support.
* More families will fall through the gaps causing a growth in inequalities and widening of disadvantage through the lack of targeted support.
* Whilst difficult to evidence in the short term, the evidence clearly demonstrates that longer term impacts will exist for school readiness, social care, economic burden of NEETS amongst other outcomes.
* The PAIRS team sits at the heart of the IMH pathway, providing specialist training, support and supervision to other services within it. Without a specialist service acting to underpin and steer provision across the pathway, provision would be negatively impacted across the continuum of need.
* Little/no ongoing capacity for workforce development/ support available
* Work on a trauma informed antenatal care pathway will end with consequence that full implementation of the Early and Relational Trauma Pathway will become almost impossible.
* Families are likely to see a return to a more fragmented offer of support with services likely to restrict access in order to manage what limited resources they have. This will impact on capacity for collaborative work between services which has been creating efficiencies and improving service user experience of accessing support.
* Loss of SfL funded resource in midwifery and HV is likely to lead to later identification of need (both PNMH and IMH). In addition to the human cost, presentation at a later point with greater acuity/ higher complexity of need will result in the need for more lengthy and costly interventions with increased demand on specialist provision.
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| **If reduced funding were available, what compromises is acceptable? what are your priorities within this work. What are your recommendations?**Reducing or removing elements of the current pathway model or reducing funding across all elements of the pathway. It is difficult to see where compromises can be made given the interdependencies that are built into the pathway and the domino effect of removing any element on other services and the functioning of the pathway. A more targeted service offer i.e., based on socio-economic deprivation or population need would run the risk of causing other unintended inequalities in access and potentially creating a postcode lottery.It is important to note that even if funding is maintained at existing levels, current provision is insufficient to meet the spectrum of core need for PNMH and PIR support. Based on national prevalence estimates and a Sheffield birth rate of 5737 (Sheffield’s yearly birth rate averaged over the period 2017-2022), it is estimated that up to 855 women/birthing people potentially experience mild-moderate depressive illness and anxiety in the perinatal period each year. In 2023/24 with the benefit of SfL funding, 465 parents accessed support from Light. Based on the estimate of need described in more detail in the PAIRS template, it is estimated that 428-450 families in any given (yearly) cohort would benefit from PAIRS support and would be likely to access it (there are a further 856-899 families who would benefit from PAIRS support but are unlikely to come to the attention of services). Due to the service having only been at full establishment for 6 months, at this stage of implementation we are not able to give an accurate figure for the capacity of the PAIRS service (in terms of how many families it is able to support per year as currently funded). However, current estimates suggest that current capacity will not meet the figure above of 428-450, let alone the much larger number of families who would benefit from PIR support but are not coming to the attention of services and who are likely to include the most vulnerable, marginalised and at-risk babies. Again, proportionate reduction of budgets across all services within the pathway would create a ripple effect impacting effective interface between services. The diagram at Appendix 3 provides an illustration of how interconnectivity has advanced through the investment of Start for Life funding. |
| Breakdown of estimated costs of recommended continued delivery

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| **Service** | **Cost** | **Funded by:** |
| CAMHS PAIRS |  |  |
| 0-19 PAIRS |  |  |
| PNMH Midwifery Team subcontract |  |  |
| Talking Therapies subcontract |  |  |
| **TOTAL (SCFT lead provder)** |  |  |

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| --- | --- | --- |
| Perinatal Mental Health Peer Support |  |  |
| Peer Support Offer for Dads |  |  |
| **TOTAL (LA peer support contracts)** |  |  |

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| --- | --- | --- |
| **COMBINED PATHWAY TOTAL** |  |  |

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| **If funding were to continue, what would you retain? What would you Change? What would be your next steps?**This type of transformational system change takes time to deliver and embed. Delivery of the Start for Life programme started very late due to external delays in funding being allocated which has meant that start-up and delivery has been compressed into a 2-year timeframe, providing little opportunity to test the model in full or demonstrate meaningful outcomes. Many aspects of the SfL PNMH/IMH workstream offer are in phase 1 – implementation and testing - therefore it is hard at this stage to evidence what is working well/ less well and what we might need to change. This is partly due to there being insufficient outcome data at this time and partly as, by its very nature, some of the impact will take several years to emerge (e.g., improved school readiness, ). Ongoing service evaluation and impact analysis will enable future refinement of the model based on local evidence of impact to gauge longer term benefits. There is a really strong argument, therefore, for the continued funding of the pathway to enable us to gather the information needed to make well-informed commissioning decisions about the development of the pathway. Our preference would be for a 5-year commissioning plan to be agreed by partners which ensures investment at incremental levels with a long term commitment to consider a plan for expansion to close the gap between capacity and demand. This would require ongoing conversations at a senior commissioning level across the LA and health to develop a sustainable funding strategy and action plan with commitment from all partners to address all components of the current pathway including investment in the voluntary sector peer support offer. Further work would be necessary to accurately ascertain what we’d need in each part of the system which would take time to complete.  |
| Breakdown of estimated costs of recommended retained/additional/changed deliveryCostings provided within individual service templates which have been submitted separately. |
|  |

**Appendix 1**

**Importance of Parent Infant Relationship for Later Outcomes**

Better speech, language and communication

4Topping, K., Dekhinet, R., & Zeedyk, S. (2013). Parent–infant interaction and children’s language development. Educational Psychology, 33(4), 391-426.

Safer parenting

5 Baer, J. C., & Martinez, C. D. (2006). Child maltreatment and insecure attachment: A meta‐analysis. Journal of reproductive and infant psychology, 24(3), 187-197.

Better adult mental health

6 Mickelson, K. D., Kessler, R. C., & Shaver, P. R. (1997). Adult attachment in a nationally representative sample. Journal of Personality and Social Psychology, 73(5), 1092–1106. [https://doi.org/10.1037/0022-3514.73.5.1092](https://psycnet.apa.org/doi/10.1037/0022-3514.73.5.1092).

6Dozier, M and Rutter (2016) Attachment states of mind and psychopathology in attachment. In J. Cassidy & P. R. Shaver (Eds.), Handbook of attachment: Theory, research, and clinical applications Third edition (pp. 715-738). The Guilford Press.

Better school readiness

7 Williford A, Carter LM, Pianta R (2016). Attachment and school readiness. In J. Cassidy & P. R. Shaver (Eds.), Handbook of attachment: Theory, research, and clinical applications Third edition (pp. 966-982). The Guilford Press.

Reduced lifetime costs to public purse

8Bachmann, C. J., Beecham, J., O'connor, T. G., Scott, A., Briskman, J., & Scott, S. (2019). The cost of love: financial consequences of insecure attachment in antisocial youth. Journal of Child Psychology and Psychiatry, 60(12), 1343-1350.

Better cognitive and social-emotional development

9 Alhusen, J. L., Hayat, M. J., & Gross, D. (2013). A longitudinal study of maternal attachment and infant developmental outcomes. Archives of women's mental health, 16(6), 521–529.

<https://doi.org/10.1007/s00737-013-0357-8>.

9 Belsky, J., & Fearon, R. (2002). Infant–mother attachment security, contextual risk, and early development: A moderational analysis. Development and Psychopathology, 14(2), 293-310. doi:10.1017/S0954579402002067.

9Groh, A. M., Fearon, R. P., van IJzendoorn, M. H., Bakermans‐Kranenburg, M. J., & Roisman, G. I. (2017). Attachment in the early life course: Meta‐analytic evidence for its role in socioemotional development. Child Development Perspectives, 11(1), 70-76.

Reduced child attention problems

10 Pallini, S., Morelli, M., Chirumbolo, A., Baiocco, R., Laghi, F., & Eisenberg, N. (2019). Attachment and attention problems: A meta-analysis. Clinical psychology review, 74, 101772.

Reduced intergenerational transmission of parenting difficulties

11 Van Ijzendoorn, M. H., & Bakermans-Kranenburg, M. J. (2019). Bridges across the intergenerational transmission of attachment gap. Current opinion in psychology, 25, 31-36.

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Reduced adolescent antisocial behaviour

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**Appendix 2**

**Case Study 1**

Mother initially attended well-being clinic. She was pregnant with her second child. She is an Asylum seeker and experienced poor mental health due to the traumas she witnessed and experienced in her home country. She had another child aged 1. She was also experiencing physical pain sustained due the trauma- the pregnancy was increasing this pain. Mother presented in clinic (and subsequent home visits) as flat.

*Outcome of clinic:*

-Referral to Early Years Intervention

-Baby basics referral made

-Perinatal passport completed

-Doula referral made

*On-going support:*

Perinatal Midwifery Team: offered further supportive phone calls and ensured the perinatal passport was shared with the health visitors.

Early Years FIS: Offered practical support which included getting a new mattress to reduce pain, supporting to groups, supporting with parenting for both parents, TAF meetings to look at multi-agency plan, supported when moved by the home office. Offered several rounds of VIG and made onward referral to PAIRS to offer circle of security programme.

0-19 Service: Joint visits were completed between the 0-19 service and FIS. This included for the one-year development check. This enabled one professional to have a discussion with mum whilst the other role modelled the information with the older child. This supported mum as she also needed to move less during the visits. The health visitor also attended TAF meetings.

PAIRS: Period of engagement joint with FIS worker; family have significant competing demands such as immigration status uncertainty and poor maternal mental health. Mum ambivalent about accepting further support initially but is now receptive to engaging with some additional parent-infant relationship work. Circle of security attachment based programme about to commence.

Concerns raised at clinic and during initial support:

* + Poor maternal mental health that was impacting infant/child relationship
	+ Parent whose mental health was declining in part due to physical health experienced during pregnancy.
	+ Isolated family
	+ Mother with previous traumatic experiences impacting her mental health. The uncertain immigration status was contributing to the poor mental health.

*Outcome:*

* Both parents feel confident in their parenting abilities and with looking after their children
* Positive infant/parent relationship observed between parents and both children.
* Both children going to groups regularly and so family less isolated
* Mother presenting as more animated on visits and reporting an improved mental health.
* No escalation to crisis or statutory services required.
* Baby born safely and there was a positive birthing experience.
* No concerns around development of baby

Feedback from parent:

On the well-being clinic:

“It was easy because it was where my midwife was, and I knew where to go. It was good to get help with my baby and me all at one place. The midwife and the lady were kind to me when I visited”

On support from all agencies:

Dad felt that “We had support from lots of people but it was good that S (FIS worker) told me what was happening and who was doing what job as no one had told me who everyone was before”. He felt that support “has been very good and we feel like we have been listened to”.

Mum felt that “everyone wanted to help me and my baby”. She reflected on the difference in support compared with when the family’s oldest child was born and commented that “maybe life would have been different if we had this with him too, things have been so much better, and not as lonely or difficult,”

Around multi agency work mum reflected that “Having help which we understood was very good, when not everyone talks to us this isn’t good, but in this team people do talk to you each time they see you”

**Case Study 2**

Mother initially attended well-being clinic. Mother was relatively new to the country and pregnancy was unexpected. Lack of preparation for baby- despite mother working she had been financially unable to buy baby equipment. Mother is Black and in clinic raised concerns about Black women being more likely to die during childbirth. Mother presented as very low and isolated. Concerns that her relationship with the baby’s father was unhealthy and unsupportive.

*Outcome of clinic:*

* Perinatal passport completed
* Baby basics referral made
* FIS Intervention referral made
* Discussion around accessing Light support

*On-going support:*

Perinatal Midwifery Team: follow on calls to discuss well-being and perinatal passport shared with health visiting service

Early Years FIS: supported to get to groups, supported to walk to local parks, supported around understanding of baby development, referral to Light, positive praise around parenting, discussions around healthy relationships and support to access GP to discuss mental health. At the start of the intervention FIS visited weekly due to concerns around presentation of mother and that some weeks she had not left the flat. Referral was made to PAIRS.

0-19 Service: Joint visit was completed with the health visitor, and they were kept up-to-date on the support being offered and referrals being made.

PAIRs: Liaised weekly with named Health Visitor within the team. Initial home visit completed together with FIS. 7 visits in total with 5 baby massage sessions completed in the home. 2 sessions completed with Dad as well as Mum. We focused on the nurture, touch and attunement during these sessions and relaxation time together for Mum and baby. At the beginning of interventions Mum felt overwhelmed by baby’s crying. At the end of the sessions, it was evident how relaxed both Mum and baby were. Over the 5 weeks Mum was responding week by week to baby’s cues and began to join in with singing by week 3. I also spent some of the sessions focusing on tummy time and play, Mum became very responsive to these sessions.

Concerns raised at clinic and during initial support:

* + Poor maternal mental health – mother presented as very flat and low and didn’t want further support in this area
	+ Parent who lacked confidence and reporting feeling unsure if she had a good relationship with her son
	+ That the relationship between parents was not supportive
	+ Isolated family - mum didn’t know anyone in the local area
	+ Lack of money

*Outcome:*

* Mother now talks positively about her relationship with her child.
* Mother goes to groups and regularly goes out of the house.
* Mother sought support for her mental health which she is reporting has improved.
* No escalation to statutory or crisis services needed despite weekly visits being required for a period of time.
* Baby born safely and positive experience of birth
* No concerns around development of baby

Feedback from parent:

When discussing the well-being clinic- “I was afraid to come at first because I didn’t know if I would be judged but they were very accommodating, and I was able to describe how I felt”.

When discussing subsequent support- “There has been so much support- it was what I needed and has been really helpful”

When discussing support from multiple agencies (clinic, FIS and PAIRS)- “It works well” (reference to having support from PAIRS and FIS). “It has been helpful with my mental well-being and transitioning to being a mum and to look at me as person in myself as well- 5/5 for support”. “Really enjoyed the baby massage sessions together and now enjoying the time together in the evening when I do massage at bath time.” “I have valued the support from PAIRS and FIS and feeling now is the time to become independent.”

ROMS completed at the beginning and end of interventions:

GAD-7/PHQ-9 (Moderate anxiety/depression) at the start of intervention.

GAD-7/PHQ-9 (Low mild anxiety/depression) at the end of intervention.

My baby (warmth scale from 20 to 31) by the end of intervention.

On routine outcome measure of emotional health and well being package of care Mum felt she was around 4 on confidence at the beginning with a score of 8 at the end of the interventions.

Mum reports that she feels more ‘positive scores were due to the increase in her confidence within parenting following support from PAIRS and FIS.’