 **This document/proposal is an example of early years   
practitioners and managers from across four Local Authorities   
coming together to request a formal governance structure for their group.   
And to request that the ‘infant’ and ‘parent-infant relationship’   
are better represented at a Child and Young People’s Mental Health   
Programme Board (which runs across an Integrated Care   
System footprint). Please feel free to adapt the information   
contained here according to your needs**

**Proposal for   
Children & Young People’s Mental Health Programme Board**

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| **Reference:** | **Agenda item no:** |  | **Action ref (if any):** |  | **Enclosure no:** |  |
| **Title of report:** | Seeking strategic commitment to improve Parent-Infant Emotional Wellbeing (PIEW) and plan specialist provision for Parent and Infant Relationships (PAIRs) in area. | | | | | |
| **Authors:** |  | | | | | |
| **Presenters:** |  | | | | | |

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| **Purpose of the paper:** | This paper is presented to: (tick one)  **Approve:** To formally receive and discuss the report and approve its recommendations or decide on a particular course of action.  **Receive**: To receive and discuss, in depth, noting the implications without formally approving it.  **For information**: To note the report for the intelligence without in-depth discussion. |

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| **Summary of key points:** | **The purpose of this paper is to ask the Board to:**   1. **APPROVE** the following recommendations for the Board:  **(a)** change the title of the Children & Young People’s Mental Health Programme Board to include the word ‘Infant’,  **(b)** revise the Board’s Terms of Reference (TOR) to include an explicit focus on Parent-Infant Emotional Wellbeing in the First 1001 Days (F1001D),  **(c)** expand the Board’s membership to include F1001D and whole-system mental health representation, including public health,  **(d)** drive the development of a business case for specialist PAIRs provision. 2. **APPROVE** the governance and Terms of Reference of a revised Parent-Infant Emotional Wellbeing Sub-Group (see Appendix 2), which will sit under the Children & Young People’s Mental Health Programme Board, as an advisory group to the Board. |
| **Summary of identified issues and risks** | 1. Immature pathways of support for Parent-Infant Emotional Wellbeing (PIEW) in the F1001D, with a clearly identified gap in Parent-Infant Relationship (PAIRs) specialist support, capacity and expertise. 2. A current gap in strategic leadership, planning and governance arrangements for the PIEW agenda. 3. Whole-system strain and staffing pressures on services that work with families in the F1001Ds (e.g., midwifery and health visiting). 4. A need to recognise (and celebrate) differences across all 4 areas of the, whilst ensuring equity of access and support for all families in the who need of PIEW support. 5. There are funding pressures and limitations on resources to help address local demand and gaps for PIEW support, and to develop and sustain evidence-based services overtime. 6. Family Hubs & Start for Life funding ends on 31 March 2025. This risks the sustainability of investments in level-1 and level-2 competencies and interventions, as well as level-3 PAIRs supervision competencies across X. 7. Potential duplication of effort, inconsistencies, and a need to look at economies in developing and sustaining the PIEW workforce across X. |

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| **Equality impact assessment:** | Is this required?  Yes/No | If yes, date completed: | If not, please give reason(s): |
| **Quality impact assessment:** | Is this required?  Yes/No | If yes, date completed: | If not, please give reason(s): |

**Programme updates:**

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| **Progress update (reporting period):** |
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| **Background and key areas of focus:** |
| 1. **What is Parent-Infant Emotional Wellbeing?**   The term ‘Parent-Infant Emotional Wellbeing’ encompasses infant emotional wellbeing, parental mental health, and parent-infant relationships (PAIRs). See Figure-1 below:     1. **Why prioritise Parent-Infant Relationships?**   Following a surge in neuropsychological research over the last three decades, **there is a substantial increase in national policy focus and investment in the First 1001 Days of life** (from conception to 2 years of age).  This research has identified parent-infant relationships (PAIRs) as:   * A key mechanism of enhanced/diminished lifetime outcomes * A prime but often overlooked opportunity for effective early intervention.   Significant PAIRs difficulties disproportionately increase the risks of poorer mental and physical health, social, emotional and behavioural outcomes, safeguarding outcomes, and educational and employment outcomes (see Figure-2 below and references in Appendix 3). This drives later demand in children’s and adult mental health and child protection services.  [Add relevant local stats here]  **Figure 2:**  We could reliably identify the highest-risk parent-infant relationships before babies are 12-18 months old, offering the chance to identify and support earlier. PAIRs have typically been overlooked as a window of opportunity for preventative and very early interventions.  **Certain PAIRs interventions have been shown to have a Return on Investment of up to 13** **times**, depending on the intervention and target group2. Switching focus to the PAIRs during pre-birth assessments demonstrably reduces the number of babies removed at birth17.  The longitudinal evidence about PAIRs demonstrates a positive impact not just throughout the lifespan but intergenerationally. Despite this, **most staff nationally have no training in PAIRs assessment or intervention**, have no access to specialist supervision/consultation and much of the service offer does not typically address parent-infant relationship difficulties directly.  Start for Life programme investments have helped to start growing a cohort of workers with competencies to deliver level-1 and level-2 support and interventions (see Appendix 4 for FH&SfL funding). This funding is also helping to build local level-3 supervision. Note: national FH&SfL Programme funding is for 3-years from 2022-23 to 2024-25.  Significant PAIRs difficulties are unlikely to be resolved through *universal or targeted* interventions.   1. **What could PAIRs specialist interventions look like in [insert location]?**   *(Note: the narrative below is only intended to provide a flavour of what [ ] might want to strategically explore over time - from a shorter to longer-term commissioning perspective).*  As per the Parent-Infant Foundations’ Commissioning Toolkit2, this is highly specialised work, so service development is most effectively started by recruiting a consultant psychotherapist/practitioner psychologist to:   * Build capacity through delivery of workforce training and skills development, consultation and some joint working with key agencies * Ensure integrated clinical pathways are developed to connect existing PAIRs work at a universal and targeted level * Stimulate future commissioning and service development * Advocate for the needs of babies with parent-infant relationship difficulties in children’ strategies, partnership programmes and workforce development plans.   This can be expanded into direct work with families when additional clinicians at varying grades can be recruited.  **An example of short-term development:**  One option would be to recruit either a full-time consultant clinician (8B/C) in each of the four areas, or one part-time senior strategic clinician (8C/D) to manage one dedicated, full-time clinician (varying grades) in each of the four LA areas.  Service example: Leeds Infant Mental Health Service started over 20 years ago with one Consultant Psychologist co-located with Sure Start and the Pre-Birth Assessment team. She worked jointly with colleagues to provide specialist consultation, joint visits and a small amount of clinical work. After she was able to recruit a second practitioner, together they started delivering workforce training, more consultation to the children and families workforce, plus more clinical interventions with families. (Leeds is now an award-winning PAIRs team which trains all parts of the workforce, as well as delivering direct work with families).  **An example of medium-term development**:  Starting to build a small team of multi-disciplinary staff to accept referrals for direct work with families, and to increase capacity for workforce training, consultation and joint working.  Service example: Flintshire (North Wales), Keighley (West Yorkshire) and Torquay (South West) NHS CAMHS ring-fence part of their clinical resource to enable PAIRS work with under 2’s. They deliver workforce training, specialist consultation and direct work with families.  **An example of long-term development:**  A multi-disciplinary PAIRs team in each locality to meet the needs of up to 5% of the birth population. See the Parent-Infant Foundation (2023) summary of evidence of the impact of specialised parent-infant relationship teams18.  Service example: In Manchester, there is an NHS, multi-disciplinary PAIRs team for each of the 10 local authorities, and these are overseen by one part-time PAIRs Strategic Lead (8D).   1. **Why now?**   Over 30% of the recent Family Hubs and Start for Life investment from the DHSC/DHE Family Hubs & Start for Life Programme (2022-2025) is specifically allocated to strengthen *universal and targeted* support for parent-infant relationships and mild-moderate perinatal mental health (PMH), and to build local PAIRs competencies (see table below and Appendix 4).  Through local mapping exercises[[1]](#footnote-1), this work is beginning to help identify pathway gaps in our assessment of and response to parent-infant relationship difficulties, especially at a specialist level. Generally, local CAMHS services do not have the capacity to work with parent-infant dyads in the F1001D, with specialist PAIRs provision mainly being limited to care proceedings work.  As all four areas grow the PAIR competencies of their level-1 and level-2 workforces, we anticipate seeing increased demand for specialist parent-infant relationship interventions, access to specialist consultation and the need for further workforce training. This is a national trend - the number of *specialist* parent-infant teams has grown from 27 to 45 in the UK in the four-year period from 2019 to 2023.  **Why strengthen governance for PIEW across [Insert location]** |
| **Actions requested from the Board:** |
| Insert name would like to recommend that the Children & Young People’s Mental Health Programme Board take the following actions:   1. Revise its TOR to explicitly include the word ‘infant’ within the Board’s title, and formally acknowledge the need to meet the mental health and wellbeing needs of the infant in the F1001D, as well as older children and young people. 2. Expand its membership to include key strategic, whole-system stakeholders in the F1001D. This needs to include Public Health representation, and a recognition by the Board of the role this discipline plays in the promotion of mental health and wellbeing across the life-course. 3. Establish accountability links and/or representation by the XXXX Local Maternity & Neonatal System, for the purposes of effectively embedding PAIRs level-1 competencies and support, and level-2 interventions within local maternity services. 4. Acknowledge the work of the Parent-Infant Foundation Group over the last year and support the transition of this Group into the newly named XXXX Parent-Infant-Emotional Wellbeing Group. (See Appendix 2 the draft TOR of the sub-group). This sub-group will have an advisory role in influencing commissioning and service planning discussions regarding future specialist PAIRs provision - to help build a more robust whole-systems pathway of support for families in the F1001D.   **Additional actions for the Board:**  This paper also asks the Insert name Programme Board to take a strategic lead on the following:  **Additional actions for the Board:**  This paper also asks the XXXXX CYP Programme Board to take a strategic lead on the following (actions listed against NHS Forward Plan commitments in bold italics):   * ***Increase understanding of the emotional wellbeing need of Babies, Children and Young People (BCYP) across the system, embedding this in all age commissioning****.*   The Board will take a whole-systems approach to bringing key leaders, decision makers, commissioners, services and communities together to ensure the XXXXX has a robust PAIRs pathway and is meeting the PAIRs needs of the local population in the first 1001 days.  The Board will ensure evidence is collated about current and future anticipated need in the XXXX for specialist PAIRs support in this overlooked age group (in the First 1001 Days from conception to 2), working closely with the sub-group.   * ***Improve health outcomes for our most vulnerable including Children in Care, Special Educational Needs and Disabilities, most deprived etc.***   Parent-infant relationship difficulties are more likely in marginalised and at-risk groups such as those experiencing poverty, infants in care, infants with SEND needs, infants who have been in NICU. The Board will propose system-responses, supported by the sub-group.   * ***Develop an integrated specification for ICYP, evidencing good partnership working and shared outcomes.***   The Board will ensure suitable governance arrangements and membership for ongoing response planning. It will work with the sub-group to identify existing PIEW and PAIRs service strengths, gaps and development opportunities across the XXXX footprint.  The Board will work with the sub-group in the development of a XXXX workforce development plan for PAIRs - ensuring consistency and economies of scale across the four areas.   * ***Co-production and ability to inform, challenge and embed service improvements.***   The Board will work with the sub-group to ensure the service user voice can be included in commissioning, service design, delivery and monitoring. The Parent-Infant Foundation’s Commissioning Toolkit provides guidance about including the infant’s voice.  The Board’s membership will collectively identify a small, pooled resource/funding to support PAIRs coproduction work.  The Board will work with the sub-group and service users to develop a communication strategy to help clarify the lexicon relating to parent-infant emotional wellbeing, parent-infant relationships and promote emerging PAIRs pathway developments.   * ***Developed joint commissioning, improved service efficiency and effectiveness.***   The Board will consider and propose system-responses to PAIRs needs, including funding and commissioning. Over time, the Board will work closely with the sub-group to oversee implementation and monitor of the impact of systems-wide initiatives for PAIRs.  The Board will explore existing funding, services and commissioning interdependencies and harness investments, using joint or integrated commissioning approaches to strengthen Parent-Infant Emotional Wellbeing support across the XXXX.   * The Board will ensure that any XXXX plans, service investments and/or interventions for strengthening PAIRs are robustly evidence-based and costed for sustainability. * The Board will build (and adequately resource) evaluation into all strategic plans, new service or intervention investments for PAIRs from the beginning. The Board will make tough decisions to stop doing things, or to do things differently if we are not improving outcomes, whilst working to achieve value for money. * ***Clear service pathways for patients.***   There is already some ongoing local work to develop PIEW pathways at the levels of ‘Getting Advice’ and ‘Getting Help’ of the THRIVE model. However, we need a recognised governance route to pull together the work and ensure integration, co-ordination and avoid duplication. The Board will drive the development of the ‘Getting More Help’ and ‘Risk Support pathways’ for the F1001D, which can then be localised to the four council footprints. |

**Appendix 1**

**Current Parent-Infant Foundation Group (PIF) Membership**

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| **– MH Lead Provider** | | |
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| **Parent-Infant Foundation (PIF)** | | |
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| **Occasional Representative / Specialist Resource** | | |
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**Terms of Reference Parent-Infant Emotional Wellbeing Sub-Group** **Appendix 2**

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| **Purpose** | The **purpose** of the group is to **(a)** strengthen local Parent-Infant Emotional Wellbeing workforce developments and evidence-based interventions, **(b)** recognise local contexts, cultures and differences through system-mapping, and **(c)** share lessons learned across the locality - as a whole-system.  This forum will help influence and support the Board to grow robust pathways for Parent-Infant Relationship (PAIRs) support, from ‘Getting Advice’, ‘Getting Help’, ‘Getting More Help’ through to ‘Getting Risk Support’ (Thrive model).  The term ‘Parent-Infant Emotional Wellbeing’ encompasses parental mental health, infant emotional wellbeing, and parent-infant relationships (PAIRs). This sub-group will have local oversight of all PIEW elements. |

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| **Context** | Parent-infant relationships have a significant impact on the infant's brain development, social, emotional development and wellbeing. 15% of new babies experience complex or persistent relationship difficulties with their care giver. Young children experiencing significant distorted relationships with their main caregiver can go on to produce a poor range of social, emotional, and educational outcomes.  Good parental mental health and wellbeing, and confidence as a new parent, results in better outcomes for infants. However, 1 in 5mothers and 1 in 10 fathers experience mental health problem during the antenatal period or in the weeks and months after their infant is born. Not all parents with these problems will lack reflective capacity. However, it is also the case that relatively mild mental health issues can inhibit the ability for a parent/s to provide their infant with the sensitive and responsive care they need. |
| **Sub-Group Objectives** |  |
| **Accountability** |  |
| **Authority** |  |
| **Membership** |  |
| **Quorum** |  |
| **Timing and place of meetings** |  |
| **Administration** |  |
| **Review** |  |

**Governance Structure Figure 1**

**Appendix 3**

**References**

1 NHS Location (2023) Joint Forward Plan

2 Parent-Infant Foundation (2023) [PAIR Services Commissioning Toolkit](https://parentinfantfoundation.org.uk/tools/commissioning-toolkit/). Page 25: Prevalence of PAIRs difficulties. Page 15: Cost-Benefit Evidence

3 National Institute for Health and Care Excellence (NICE) [Children’s attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care](https://www.nice.org.uk/guidance/ng26/documents/childrens-attachment-final-scope2)

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UNICEF Breast Feeding Initiative – BFI Parent infant relationship building referenced as a minimum best practice for all babies and families, regardless of feeding method.

**Appendix 4**

**Family Hubs and Start for Life Programme Funding**

30.8% of total FH&SfL funding is allocated to strengthen perinatal mental health and parent–infant relationship support,

**Extract from: Annex I: perinatal mental health and parent–infant relationship support**

How this funding should be used:

There are three main ways that this funding should be used:

1. Improving workforce capability through training
2. Supporting workforce capacity through funding additional resource at family hubs
3. Enhancing your services to ‘go further’

Improving workforce capability through training

Good perinatal mental health and parent–infant relationship support is underpinned by a knowledgeable, skilled, and confident workforce. We have developed a training framework to guide local decision makers on the competencies staff need to support families.

This framework is designed to enable training to be developed in tiers according to types of practitioners being trained and what local need is. It is linked to the Infant Mental Health Competency Framework (AIMH-UK)62.

We encourage you to consider how training is delivered to promote join-up across different types of support – for example, multiagency professionals and volunteers.

**Level 1: increasing awareness and identification of difficulties**

Funding can be used to offer training on perinatal mental health and parent–infant relationships as a minimum.

We recognise that you may have been offering this training for some time. If that is the case, you may wish to use your funding to go further and offer training on:

* trauma informed care in the perinatal period
* father and co-parent inclusive practice in the perinatal period

*Target audience: this training should be available to everyone who provides support to families expecting a baby or who have a baby under the age of two. This may 62 https://www.hee.nhs.uk/our-work/mental-health/perinatal-mental-health/competency-frameworkperinatal-mental-health 83 include; health visitors, midwives, nursery nurses, nursing associates or early years practitioners, early help workers, family support workers, mental health nurses, neonatal practitioners, social workers, volunteers (for example, peer support workers).*

For elements of the workforce who may not have received any prior training in these areas, such as volunteers, you may like to encourage them to complete the elearning available via Health Education England63.

**Level 2: Accessing and supporting families through evidence-based interventions**

We will establish national contracts with two training providers so that several practitioners from your local authority area will be able to access training to deliver evidence-based interventions that promote parent–infant relationships.

The interventions are likely to include video-feedback and a targeted intervention to promote parent–infant relationships, which could be delivered in a group or one-toone.

*Target audience: this should be available to those who will be able to use it to support identified parent–infant relationship difficulties. This could include; health visitors, midwives, psychological professions, social workers, early years workers.*

**Level 3: Increasing supervision capabilities**

A national contract will be established so that a small number of practitioners will be able to supervise those supporting parent–infant relationships. We hope that this will help to build your local capacity to provide good clinical supervision to those supporting parent–infant relationships.

*Target audience: experienced supervisors, such as psychologists, psychotherapists, or family therapists*

Family hubs require adequate workforce to support families with mental health and parent–infant relationship difficulties. Building a diverse workforce model, incorporating skill mix, will help to mitigate workforce capacity challenges.

Through the development grant, you will be expected to employ staff dedicated to support families with perinatal mental health and parent–infant relationships. Staff are expected to:

be trained in, and able to identify, parent–infant relationship and perinatal mental health difficulties https://www.e-lfh.org.uk/programmes/perinatal-mental-health/

provide support to families through evidence-based interventions (for those who have attended ‘level two’ training as per the text above)

* act as champions for promoting the importance of perinatal mental wellbeing and good parent–infant relationships, whilst being appropriately supervised and supported
* provide outreach support in person and virtually for families and babies
* connect and refer families to the most appropriate support to meet their needs

You will have the best understanding of the types of practitioners who may suit these roles. You may wish to consider:

* nursery nurses
* nursing associates
* early years practitioners
* family support workers

Deciding who you employ in these roles should be based on whether they will be able to support parent–infant relationships after they have attended ‘level two’ training, as per the text above. In considering which roles may be able to safely and effectively support parent–infant relationships, you may wish to consider the AIMHUK competency framework mentioned above. To complement skill mix, this may mean employing staff at a Band 5 level (NHS Agenda for Change64)

1. [↑](#footnote-ref-1)