Solutions to Growing the Specialised Parent-Infant Relationship Workforce

CONTENTS

Executive Summary

Introduction

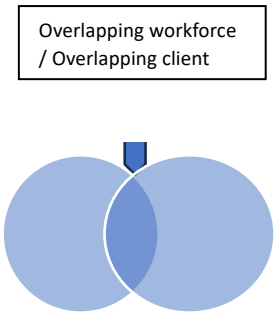
The paper sets out the current context of Perinatal Mental Health (PNMH) teams and specialised Parent-Infant Relationship (PAIR) teams, outlining key differences and overlaps between the two teams, their respective workforces and the client groups whom they serve.

Drawing on consultation with professional stakeholders, it presents a vision for strategic investment in the PAIR workforce which will enable the expansion of this workforce sufficient to enable both specialised PAIR teams and PNMH teams to coexist.

The Current Context

There are 46 specialised parent-infant teams currently in the UK and many more smaller services in development. There is a significant lobby within the sector to roll these teams out more widely with government backing.

Questions arise about how the expansion of parent-infant teams fit with perinatal mental health teams and to what extent their respective workforces and client groups overlap. This paper concludes that whilst there is some overlap between the workforce in PAIR teams and the targeted PAIR offer developing within PNMH teams, there are also significant differences between the cohort of families they serve and the ways in which the teams operate.



Differences and overlaps between Perinatal Mental Health (PNMH) Teams and Parent-Infant Relationship (PAIR) Teams

The core business and starting point of a PAIR team is the baby's wellbeing, and the starting point of PNMH team is the mental health of the mother. However, within the last few years the parent-infant specialist offer within PNMH has grown, meaning there is now a parent-infant arm *within* many perinatal teams which is available for those parents and infants accessing the PNMH service. It is this part of a PNMH team that overlaps with PAIR teams and where the workforce and clinical interventions used are similar. However, the following key differences remain:

- **Referral criteria and cohort of babies reached**.
  The referral criteria for a PAIR team is that the wellbeing and development of a baby is being impacted by difficulties in the parent-infant relationship. The referral criteria for a PNMH team is typically moderate to severe maternal mental health difficulties. The PAIR offer within PNMH is therefore a targeted offer for families in PNMH where a parent-infant relationship difficulty is also identified.

Parent-infant relationship difficulties occur in many more families than just those where there is a maternal mental health difficulty (estimated as 3-4 times more). PAIR teams therefore reach a much wider cohort of babies. See main report for details.

- **The baby is the patient**
  A PAIR team is primarily infant-focused and will typically keep clinical records in the name of the baby whereas, a PNMH team will usually keep records in the name of the parent.

- **Differences in clinical leadership**
  PAIR teams will have a clinical lead who is either a Consultant Practitioner Psychologist or, Consultant Child or Parent-Infant Psychotherapist. Typically, the clinical lead in a PNMH team will be a Consultant Psychiatrist. However clinical leadership of the parent-infant specialist arm *within* a PNMH team is likely to be led by a senior psychological clinician.

- **Unique role of PAIR teams in wider early years' systems through indirect work**
  PAIR teams will typically do about 50% of their work indirectly, via training, consultation and reflective practice with the wider system. In so doing their reach will be far beyond the direct clinical work undertaken with families. PNMH teams are less likely to offer this to the same extent.

Co-existence of PNMH and specialised PAIR teams and the best offer for babies in distress

In areas where there is a specialised parent-infant team operating alongside a PNMH team, there are many examples of partnership working and shared pathways which mean more babies get the support they need, when they need it.

Clearly there is some degree of overlap between the work of a PNMH team and that of a PAIR team, as well as significant differences. To this extent there is also a resultant overlap in the PAIR workforces and a need to consider how to grow the specialist PAIR workforce.

Recommendations for growing the PAIR workforce

The following recommendations build on how clinicians currently become infant mental health specialists. They are therefore practical and achievable and are widely supported by the stakeholders with whom we consulted.

1. **Develop NHS Workforce Competencies based on the Association of Infant Mental Health (AiMH) competencies**
   The AiMH competency framework is a respected and widely used framework within the sector and could form the basis of an NHS Infant Mental Health competency framework which could underpin all workforce developments.

2. **All relevant professions to include infant mental health competencies in their pre-qualification requirements**
   Most relevant professional training, with the notable exception of Child & Adolescent Psychotherapy, does not currently include IMH competencies, meaning that most clinicians obtain these competencies in post-qualification training or experience. Embedding IMH competencies within pre-reg training (such as in clinical psychology for instance) would increase these competencies within the workforce.

3. **A funded programme for clinical placements**
   A funding programme whereby clinical placements (either pre or post registration) from any of the core professional groups, come with funding attached for the host service.

4. **A funded recruit to train programme including the following elements:**

   - **'Recruit to train' to specific posts within a PAIR team/PAIR arm of PNMH**
     A funding package that can be used when recruiting to posts within specialist PAIR teams. The AiMH CPD programme can be used to upskill practitioners to the required level of competencies for the post.

   - **Funded Assistant Child & Adolescent Psychotherapists roles within PAIR contexts.**
     Students on post graduate level pre-clinical courses could take up Assistant Child and Adolescent Psychotherapy posts in a PAIR service (e.g. at Band 5 NHS Agenda for Change). This would enable them to gain clinical experience in preparation for applying to the clinical CAPT doctoral level training.

SCALING UP AND COSTINGS

With the commitment in the NHS Long Term Plan, to grow clinical psychology and child and adolescent psychotherapy by at least 20%-33% and increase training places by 26%, there are many opportunities to increase the parent-infant specialism within the workforce.

Using a model of a PAIR team drawn from Greater Manchester, the estimated cost of scaling up teams over 5 years including post-qualification training to AiMH level 2 is £332,302,759.

1. Introduction

The paper sets out the current context of Perinatal Mental Health (PNMH) teams and specialised Parent-Infant Relationship (PAIR) teams, outlining key differences and overlaps between the two, their respective workforces and the client groups whom they serve.

Drawing on consultation with the main professional stakeholders, it presents a vision for strategic investment in the PAIR workforce which will enable the expansion of this workforce sufficient to enable both specialised PAIR teams and PNMH teams to coexist and work together in a way that best serves vulnerable babies. The paper sets out recommendations to expand the specialist parent-infant workforce in a sustainable way.

This expansion is key to achieving the Start for Life programme's aim of supporting the 10% of babies at risk of 'disorganised attachment', as well as the NHS Long Term Plan to providing access to mental health services for 0-25 years olds.

A key focus of this paper is how to expand the parent-infant workforce alongside the Perinatal Mental Health (PNMH) programme. The two programmes do not in the main draw on the same workforce, but there is some overlap, so it is important when growing the two services, that the workforce needs of one do not jeopardise the success of the other.

The paper will:

1. Set out the current workforce context for PAIR (Parent and Infant Relationship) specialists
2. Compare the respective workforces of PNMH and PAIR teams
3. Give an overview of the current routes to becoming a parent-infant specialist
4. Make recommendations that could increase the workforce of parent-infant mental health specialists in both the short, and the longer term.

In writing this, the following stakeholders have been consulted:

- The Association of Infant Mental Health (AiMH-UK)
- The Association of Child Psychotherapists (ACP)
- The Institute of Health Visiting (Mental Health Lead)
- The Network Lead for parent-infant specialists within PNMH
- A number of clinical leads of existing specialised parent-infant teams
- The CYP IAPT 0-5 Module Lead at the Anna Freud Centre
- Members of the working group on the draft for the British Psychological Society (BPS) Position Statement on 0-5's Well-Being and Mental Health

2. The Current Context

2.1 Specialised Parent-Infant Relationship team composition

The composition of a specialised parent-infant relationship team varies across the UK. However, there are common elements as well as necessary pre-requisites, to meet the Parent-Infant Foundation definition of what constitutes a specialised parent-infant relationship team.[1] These are:

[1] https://parentinfantfoundation.org.uk/our-work/what-is-a-parent-infant-team/

2.1.2 Clinical leadership

To reflect the primary focus on the baby and parent-infant relationship, teams are led by a Consultant Practitioner Psychologist or, Consultant Child or Parent-Infant Psychotherapist, who meets Association of Infant Mental Health (AiMH) competency level 3. The team will be multi-disciplinary, and all team members will have achieved AiMH competency level 2. [2]

A Clinical Psychologist, Child/Parent-Infant Psychotherapist or equivalent will typically oversee assessments and formulation of all babies and parents entering the service. This specialist assessment will ensure that a family gets a tailored response to their needs and a multi-disciplinary team will keep the baby and their relationships as the focus of all care planning.

2.1.3 An infant-focused multi-disciplinary team

In 2019, the Parent-Infant Foundation commissioned an analysis of the cost of a specialised parent-infant relationship teams across England, based on the workforce employed in PAIR teams across Greater Manchester. [3]

This analysis used three alternative models of team composition, but all included the following as a baseline:

- Clinical Psychologist, Child/Parent-Infant Psychotherapist Clinical Lead
- Clinical Psychologist/Child/Parent-Infant Psychotherapist clinicians
- Parent-Infant specialists/Early Attachment Specialists/Health visitor/Midwife/Social worker
- Admin Staff
- Service Manager

Other teams may also include posts such as Family Coordinator, Parent Support Workers and some include a Parent Therapist as well[4].

Without a nationally recognised workforce framework, the parent-infant workforce has developed idiosyncratically according to local thinking. However, despite different job titles, multi-disciplinary PAIR teams would typically (and ideally) include a Specialist Midwife, Specialist Health Visitor and a Social Worker. All of whom have done additional post-qualifying PAIR training. We know that parent-infant specialist posts have often been filled by many other allied mental health professionals with post-qualifying experience and/or training. This includes Family Therapists, Counsellors, Music Therapists, Occupational Therapists, CYP IAPT and others.

Recent research by the Parent-Infant Foundation provides insight into the current composition of parent-infant teams.[5]

The multi-disciplinary nature of PAIR teams is pivotal to its success. An MDT brings:

- A multi-disciplinary lens to meet the needs of babies and families, enabling in-depth formulation, care planning and risk management focused around the needs of the baby.

---

[2] https://aimh.uk/the-uk-imh-competency-framework/

[3] *Costing Parent Infant (PI) Relationship Teams in England* By Professor Gabriella Conti & Dr. Elena Bassoli, (2019) (Being updated in Jan 2024)

[4] *The State of Specialised Parent-Infant Teams in the UK*, (2023-4) Not yet published.

[5] Ibid.

- A route for teams to engage with the respective professional groups locally and the families with whom they work. Having a Specialist Health Visitor in the team for instance, can facilitate engagement with the local HV team where typically many referrals to a PAIR team will come from. Similarly, a Specialist Midwife, will facilitate antenatal referrals, where we know some of the most effective work can be done with families; and a Social Worker is often the critical link to ensuring that families who are engaged with social care get access to support, which in some cases can prevent babies going into care[6].

2.1.4 Training in clinical interventions ranging from targeted to highly specialist support

In addition to all clinicians in parent-infant teams attaining AiMH competency level 2, via a variety of post-qualification training, they are likely to have been trained in a range of parent-infant interventions. The following are the most widely used across the UK according to our recent research[7]:

- Watch Me Play!
- Video Interaction Guidance (VIG)
- Neonatal Behavioural Assessment
- Watch, Wait and Wonder
- Circle of Security
- Parent-Infant Psychotherapy
- Other specialist formulation led interventions.

PAIR teams across the UK also use a further 19 types of parent-infant relationship interventions. The range of interventions enable families to be offered therapeutic support that is tailored to their relational needs and their level of complexity.

2.1.5 PAIR teams place in the system

PAIR teams have developed according to local, rather than national, drivers and so have different funding streams and commissioning arrangements. Currently two thirds of specialist PAIR teams receive funding from the NHS, with social care, public health, local authorities and charitable funders also providing joint or sole funding in other areas.

In terms of location, some teams may be hosted by CAMHS but work across the early years sector; whilst some are funded by social care and have a focus on working with infants on the edge of care; whilst others, more recently, have been initiated through Start for Life funding and sit within Family Hubs, but include NHS clinicians in the team.

These differences also reflect the characteristics of teams themselves where, by necessity they work in close connection with the many different services who support parents and babies, who are their main referrers.

A core part of the work of a PAIR team is the indirect work they do with the wider early years sector to upskill and support them through training, consultation, supervision and reflective practice offers.

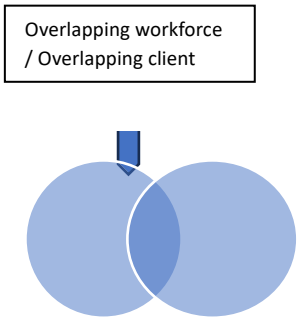
---

[6] Lesley Briscoe,Lisa Marsland,Carmel Doyle,Gemma Docherty, Anita Flynn & Phillip Gichuru (2022) *A mixed method study to explore the maternal impact and outcomes of a specialist Building Attachment and Bonds Service (The BABS Study)*

[7] Ibid. Used by 20 or more P-I teams.

3. PERINATAL MENTAL HEALTH TEAM COMPOSITION

3.1 Differences and similarities between the PNMH and specialised PAIR teams' workforce



3.1.2 The parent-infant specialist workforce within the wider perinatal team

By contrast to PAIR teams, the primary focus of a PNMH team is the mother's mental health and therefore, the majority of its workforce is drawn from practitioners with expertise and experience in adult mental health.

However, following publication of new guidance from NHSE in 2023[8], there has been an expansion of the parent-infant offer to those parent-infant dyads within perinatal, and consequently of the PAIR specialist workforce within PNMH. To achieve this aim, PNMH teams have either developed existing staff in post or recruited new staff with additional parent-infant competencies, to create this new arm within PNMH, and this has led to some overlap in the two workforces.

According to a recent census of the PNMH workforce[9], the majority of the workforce still remains primarily adult-focused, but with an increasing number of parent-infant specialists, although there appears to be a lot of variation across the country.

The census also states the following relational interventions are the most widely used in PNMH teams, and whilst there is some overlap with PAIR teams, the interventions are for a different cohort of families

- Video Interaction Guidance (VIG)
- Circle of Security Parenting
- Watch, Wait and Wonder
- Parent-Infant Psychotherapy

3.1.3 Differences in clinical leadership

In PNMH teams, the clinical lead is most typically a Consultant Psychiatrist. However, in PAIR teams, clinical leads are mainly Consultant Practitioner Psychologists or Consultant Child/Parent-infant Psychotherapists. However, as the targeted parent-infant specialism has developed within PNMH, then this arm of the service is likely to be led by a senior psychological clinician.

3.1.4 Difference in patient records between PNMH and PAIR teams

[8] NHSE, 2023, *Psychological Therapies for Perinatal Mental Health: Implementation Guidance*

[9] NHS Benchmarking Network, 2023 *Perinatal Mental Health Workforce Census 1st April 2022 – 31st March 2023*

The primary focus of PNMH teams is the parent's mental health. The primary focus of a PAIR team is the infant's mental health. PNMH teams will of course also address some of the infant's needs and PAIR teams, the needs of the parent. However, the way in which teams record their work is often reflective of this difference. The 'patient records' in a PNMH team will typically be that of the parent. Whereas in a PAIR team, the 'patient record' will most commonly and ideally, be that of the infant – or in a few cases, there are also linked records with the parent.[10]

3.1.5 PAIR teams reach many more babies and parent-infant relationships in need of support

3.1.6 Through direct work

The threshold for PNMH teams vary, but typically referral criteria will focus on parents with moderate to severe mental health problems.

Whereas for PAIR teams, the referral criteria includes difficulties in parent-infant relationships and babies showing signs of distress and where their development is put at risk - *regardless of the mental health status of the parent.*

We estimate that between 70-90% of families in need of parent-infant relationship support are not eligible for support from a perinatal mental health team [11]. Many vulnerable babies have parents who will not be eligible for support through PNMH teams.

The cohort of families whose needs are met by specialised parent-infant relationship teams but not by a PNMH team include:

- There is 'vulnerability in the infant' e.g. prematurity, low birth weight, developmental delays
- They are engaged with Child Protection, but no mental health diagnosis
- Have experienced domestic violence
- Where substance misuse is an issue
- Are carrying intergenerational trauma which may not manifest as a mental health issue
- There are other risk factors that put the P-I relationship at risk, physical and learning disabilities in the parent or infant.
- Are adoptive or foster parents facing the challenges of infant trauma and/or early attachment deficit
- Have 'low to moderate' mental health issues below the threshold for PNMH support.

PAIR teams will aim to work across the spectrum of need; using a formulation led approach, a team will offer specialist assessments and range of clinical interventions from targeted support through to long term highly specialist therapeutic interventions.

3.1.7 Through indirect work with the wider early years system

An important part of the work of a PAIR team is offering training, supervision, reflective practice and consultation to early years practitioners in their locality, including Midwives, Health Visitors and Family Workers. All teams offer this in a variety of ways that fits with the needs of their areas and we recommend this is around 50% of their work. In this way, the numbers of families whose lives can be changed by a PAIR team is far in excess of those offered direct clinical interventions.

[10] The question of how records are stored varies a lot and will often be determined by what database is used in a service.

[11] Birmingham Women's Hospital (2022) *Nurturing our Future* estimates 10% of babies in need of P-I support are eligible through PNMH; Unpublished data from I-CAMHS in Northern Ireland estimates 20-30% of families in need of support are eligible through PNMH.

3.2 Co-existence of PNMH and PAIR teams

In areas where there is a specialised parent-infant relationship team in operation alongside a PNMH team, there are many examples of positive co-existence and partnership working.[12]

In half of these areas, there is a formal shared pathway in place, and Greater Manchester is an example of best practice in this area. [13]. Many areas have also developed shared reflective spaces, where referrals can be discussed, as well as consultation arrangements when either service needs advice from the other. The majority of PAIR teams report that they get referrals for parents with moderate to severe mental health problems and many of these referrals will come from the PNMH team or maternal mental health hub.

When PNMH and PAIR teams work collaboratively together, clinicians report that more babies and their families are more likely to receive the support they need. The relationship between these two teams is a critical factor in successful implementation of specialised PAIR teams.

[12] The State of Parent-Infant Teams op cit.

[13] Tameside and Glossop **Integrated Parent-infant Mental Health Pathway**. (2016)

4. Workforce Frameworks

4.1 Current frameworks

There is currently no NHS framework for workforce competencies in the mental health needs of under 5s. Although Infant Mental Health is mentioned in the following documents:

- Scotland's Perinatal Mental Health Curricular framework[14]
- Health Education England's Competency Framework for Perinatal Mental Health[15]
- Health Education and Improvement in Wales's (HEIW) Perinatal and Infant Mental Health Curriculum[16] Perinatal and Infant Mental Health Curriculum

4.2 AiMH-UK competency framework

The Association of Infant Mental Health UK (AiMH-UK) have a competency framework which is widely used in the early years sector.[17] This framework describes competencies at levels 1, 2 and 3 which distinguish between:

(1) general knowledge and skills (for those working at a universal level in the early years),

(2) advanced knowledge and skills, (for those working clinically with parents and infants) and

(3) the knowledge and skills required to supervise and manage. For further information about the AiMH competencies.

The AiMH Infant Mental Health Comptency Framework (IMHCF) was developed in collaboration with international expert organisations and revised in 2022. The framework represents core skills and knowledge for safe and effective work to support parent-infant relationships.

The levels of expertise are represented as a portfolio which reflects specific work roles/ responsibilities (levels 2 and 3 are typically tied to graduate and regulated professionals such as Health Visitors, Psychologists, Psychotherapists, Social Workers). Clinical capabilities of levels 2 and 3 practitioners are the same, with additional competencies around management/ supervisory/ service development responsibilities at level 3.

4.3 IMH Continuing Professional Development Portfolio[18].

AiMH-UK also have a CPD programme, designed to help individual practitioners map their skills, knowledge and practice experience against the UK Infant Mental Health Competency Framework (IMHCF), and to build their own Infant Mental Health portfolio. This includes:

i A reflective tool for self-assessing practice.

ii Identifying areas of practice (skills and knowledge) to be developed.

---

[14] Infant mental health competencies are included in Dimension 3 of NHS Education for Scotland's (2019) Perinatal Mental Health Curricular Framework: A framework for maternal and infant mental health,

[15] Health Education England (2018) Competency Framework for Perinatal Mental Health

[16] HEIW (2021) Perinatal and Infant Mental Health Curriculum

[17] AiMH UK, Infant Mental Health Competency Framework

[18] https://imhcpd.aimh.uk

iii Guiding selection of training and self-directed learning.

iv Supporting post-training consolidation of learning (assimilation and synthesis).

Importantly, the IMHCF / IMHCPD Programme is a valuable tool for planning and developing specialist parent-infant relationships support services. Similarly, for a quality service provision, it unifies the PAIR workforce in a high baseline skillset for safe and effective practice.

5. Routes to Becoming a Parent-Infant Relationship Specialist

5.1 This section outlines how clinicians become parent-infant relationship specialists within the current context. This will inform the subsequent recommendations which outline proposals to expand and develop the PAIR workforce, should PAIR teams become part of public policy and commissioned across England.

There is no single pathway to becoming a PAIR specialist. The most commonly taken routes can either be within pre-registration training or post-qualifying. The key professional groups listed below have each been addressing this issue within their respective professional training courses:

- Child and adolescent psychotherapy
- Clinical Psychology
- Health Visiting

Below are the main routes to becoming a specialist parent-infant relationship clinician:

5.2 Clinical placement during professional training

- Clinical Psychologists do not currently include specialist parent-infant relationship as a mandatory part of their pre-registration training, however, some (not many) *clinical psychologists* undertake a placement in a parent-infant context, typically for 6 months in the final year of their training.

- Association of Child Psychotherapists (ACP) registered C*hild and Adolescent Psychotherapists* (CAPTs) usually have a 4-year clinical training placement in a CAMHS setting. During this time, they are expected to gain clinical experience of assessing and working with patients aged 0-25 years, as well as experience of working with parents and families. Many specialise in being able to offer psychoanalytically informed perinatal and parent-infant work. CAPTs will already have done two years infant observation as part of their pre-training requirement, so will already have a good knowledge of the needs of babies. The ACP Competence Framework for CAPTs includes psychoanalytic psychotherapy (assessment and treatment) with infants.[19]

- *Health Visitors* will do a clinical placement as part of their year-long training which is usually provided by their sponsoring/seconding health provider. This is most likely in a universal context but can be in a PAIR context.

5.3 Specialist post-qualifying training

[19] ACP Competence Framework (https://childpsychotherapy.org.uk/acp-register-standards/standards-training-0/competence-framework)

There are a number of different training courses available across the UK, which range from short courses to a year or two long post-qualifying training courses. All PAIR specialists will have taken some of these courses in order to gain AiMH competencies. See Appendix 1 for further details. Some examples include:

- Short courses in an aspect of PAIR work.
- Specialist one-year PAIR training courses - often attended by Clinical Psychologists, as well as other allied mental health professionals and Health Visitors.
- Parent-infant psychotherapy courses – highly specialised courses which are two years long and usually only open to qualified clinicians.
- A *Perinatal Infant Mental Health champions* training is available for Health Visitors who want to become a Specialist Health Visitor[20].

All of the above routes will typically also include additional training in some PAIR interventions.[21]

5.4 Recruit to train

There are a number of formal and informal 'recruit to train' models in existence:

5.4.1 Recruit to train within local teams. Some PAIR teams in areas where it has proved hard to recruit specialists, (e.g. Thriving Together PAIR team in Cornwall), have used a recruit to train approach when advertising posts. Post have been advertised with funded post-qualifying training included.

5.4.2 Assistant Child & Adolescent Psychotherapists (ACAPTs).

This is a 'grow your own' model currently being trialled in Luton and a few other areas in the UK. Assistant CAPTs are recruited during their post-graduate pre-clinical training to work in a PAIR service. See recommendations section below for further details.

5.4.3 Children and Young People's Improving Access to Psychological Therapies (CYP IAPT).

A government funded recruit to train programme where trainees are trained in two core PAIR interventions and take up a post in a parent-infant context. Graduates from this programme often have an existing professional training and are well placed to become parent-infant practitioners in PAIR teams.

[20] Health Education England (2016) *The role of Specialist Health Visitors in Perinatal and Infant Mental Health*
[21] Institute of Health Visiting (2023), *Specialist Health Visitors in Perinatal and Infant Mental Health: where they are and what they're doing* Hilda Beauchamp Perinatal & Infant Mental Health Lead.

6. The NHS Long-Term Workforce Plan and Professional Groups

6.1 The NHS LTP includes plans to increase the psychological workforce and the health visiting workforce

The NHS recently published a Long-Term Workforce Plan[22] (LTWP), which sets out an ambition for a growing and sustainable NHS workforce through to 2037. This includes a plan to shape a more psychological NHS and a commitment to grow clinical psychology and child and adolescent psychotherapy by at least 20%-33%. This is to be achieved by increasing training places by 26%.

The LTWP also includes plans to expand training routes into the health visiting workforce by between 32% and 74% by 2030/31, with an ambition to expand training places by 74% to over 1,300 by 2031/32.

The plan will need to be supplemented by pathway-specific and profession-specific plans at local, system, regional and national levels but it represents an important opportunity to increase and shape the specialist PAIR workforce. In order to build a sustainable PAIR workforce in the long-term, profession specific plans will need to be developed within the key PAIR professions. i.e. Clinical Psychology, Child and Adolescent Psychotherapy and Health Visiting.

There are already plans in place within the relevant professional bodies including The British Psychological Society (BPS), Association of Child & Adolescent Psychotherapists (ACP) and the Institute of Health Visiting (IHV). The Parent-Infant Foundation has consulted with both the ACP and the IHV in writing this paper and had sight of the early draft from the BPS.

- The BPS is about to publish a 0-5 position paper which will consider the need for a competency framework for working with the under 5s and the need for this to be included in pre-qualification clinical training.

- The Association of British Psychologists are also playing an active role in bringing work with babies and families into clinical practice. [23]

- Child and Adolescent Psychotherapists are already expected to have 0-5 clinical experience during their training and an ability to work with infants is included in their competency framework.[24] The ACP is keen to expand and facilitate these existing routes to enable CAPTs to become further embedded in the PAIR workforce.

- The Institute of Health Visiting (HV) already has a recognised specialist role, often known as 'Specialist Health Visitors in Perinatal and Infant Mental Health' and is working to further develop this. In a recent publication[25] they recommend the development of:

    - A national set of Perinatal and Infant Mental Health quality standards for Sp HV PIMH, health visiting and health visiting services.
    - The development of credentials for Advanced Clinical Practice (ACP-health visiting) to strengthen and recognise the contribution of the Sp HV PIMH role.

[22] NHSE (2023) NHS Long Term Workforce Plan

[23] Working psychologically with babies and their families - ACP UK

[24] ACP Competence Framework (https://childpsychotherapy.org.uk/acp-register-standards/standards-training-0/competence-framework)

[25] IHV (2023) *Specialist Health Visitors in Perinatal and Infant Mental Health: where they are and what they're doing* Hilda Beauchamp, Perinatal & Infant Mental Health Lead

6.2 Potential untapped workforce in the private sector and other psychological professions

In addition to these professional groups there is a potential untapped workforce in the private sector and in other practitioner psychologists:

- A British Association for Counselling and Psychotherapy (BACP) workforce survey reports that approximately 19,000 counsellors have undertaken specific training for working therapeutically with children and young people (BACP, 2021). Over half (55.5%) of this workforce say they could take on more work.[26] Post-qualifying training could redirect some of this workforce into the PAIR sector.

- Other HCPC registered practitioner psychologists can similarly engage in post-qualifying training to become parent-infant specialists e.g. educational psychologists/counselling psychologists.

[26] 'Thousands of counsellors are ready to work with children and young people' (bacp.co.uk)

7. Recommendations

The Parent-Infant Foundation recommends the following solutions to expand the specialist PAIR workforce.

7.1 Develop NHS Workforce Competencies based on the Association of Infant Mental Health (AiMH) competencies

The expansion of this workforce needs to be underpinned by a commonly agreed set of standards.

Anyone in a PAIR service to be working towards the AiMH competencies. This can be formally under the guidance of their line manager or supervisor using AIMH's CD programme or embedded into job descriptions and development plans. Specialist PAIR practitioners can aspire to be on the Infant Mental Health Recognition Register which recognises that they have acquired all the competencies at their level or practice.

7.2 All relevant professions to include IMH competencies in their pre-qualification requirements

Apart from ACP registered Child and Adolescent Psychotherapists, most relevant professional trainings (e.g. Clinical Psychology) do not currently include IMH competencies, meaning that most clinicians obtain these competencies in post-qualification training or experience. Embedding IMH competencies within pre-registration training would increase these competencies within the workforce.

7.3 Funded clinical placements

A funding programme whereby clinical placements from any of the core professional groups come with funding attached to the host organisation.

Clinical placements for trainees in any of the core PAIR professions is one of the main ways of becoming a PAIR specialist. However, currently only half of all PAIR teams have trainees and most clinical placements do not come with funding. One of the main obstacles to PAIR teams taking trainees is the resource needed to support the placement. For example, there is usually an expectation for the host organisation to provide weekly clinical supervision alongside other support.

An incentivised scheme whereby placements came with funding attached (to provide backfill for this time commitment) would mean that this could be taken up more widely. Consultation with clinical leads suggest they would be open to taking more placements if back fill funding was provided.

For Child and Adolescent Psychotherapists, clinical training posts are usually in CAMHS services, but they are sometimes split posts, enabling trainees to gain experience of working with the 0-25 age range within both generic and specialist services, including perinatal and parent-infant teams. An expansion of this best practice model whereby a training post includes time working in a PAIR service would likely work well.

Clinical placements can also take place within well-developed PAIR arms within PNMH teams, as well as 0-2 or 0-5 specialist services within a CAMHS setting (which offer specialist PAIR interventions but not yet a full MDT PAIR team).

This idea of funded clinical placements was widely supported when consulting key stakeholders in writing this paper.

7.4 Funded post-qualifying 'recruit to train' packages in a PAIR context

Establish funded post-qualifying packages that can be used when recruiting to posts within specialist PAIR teams and PAIR arm of PNMH. Several recognised courses can be funded that fill the skills gaps in PAIR teams and builds the workforce. The AiMH CPD programme can be used to support and guide this training and ensure development of clinicians to the appropriate competency level.

This approach offers an opportunity to grow the PAIR workforce by offering funded post-qualifying training attached to a role within in PAIR team. The type of training can be pitched at different levels depending on the needs within the team. See appendix 1 and 2 for examples of training available. (i.e. highly specialist, or targeted level). During this year, additional CPD training could be undertaken ensuring that each trainee achieves AiMH competencies at level 2 or 3 (see Appendix 3), alongside training in specific evidence-based interventions. (e.g. VIPP, VIG, ABC, Watch, Wait Wonder, etc)

7.5 Funded Assistant Child & Adolescent Psychotherapists roles

This builds on an existing model developed initially by Luton CAMHS 0-5 service and supported by the ACP.

To be eligible for the child and adolescent psychotherapy clinical training accredited by the ACP, students will have completed a 2-year post graduate level pre-clinical course (or equivalent) including a 2-year weekly infant observation.[27] Students on these courses could take up Assistant Child and Adolescent Psychotherapy posts in a PAIR team or PAIR service within PNMH (e.g. at Band 5 NHS Agenda for Change). This would enable them to gain clinical experience in preparation for applying to the clinical CAPT doctorate.

Employing Assistant Child and Adolescent Psychotherapists would also support PAIR teams to imbed a 'grow your own' model, in which they could offer CAPT clinical training post opportunities to trainees who already have experience of working in PAIRs.

The above is only an initial sketch and clearly any implementation would need further consultation with key professional bodies. However, all the stakeholders consulted in writing this are in agreement with these recommendations.

[27] https://childpsychotherapy.org.uk/training-events-0/pre-clinical-courses

8. WHAT DOES THIS MEAN FOR SCALING UP SPECIALISED PAIR TEAMS?

The exact mechanism and process for scaling up the PAIR workforce would need further analysis, but the following is a helpful guide.

In our latest policy briefing in response to the Major Conditions strategy 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.' [28]

An average team would comprise 7.33 whole time equivalent (WTE) posts which would include:

- 1x Clinical Psychologist
- 1 x Child and Adolescent Psychotherapist (CAPT)
- 1 x Clin Psych/CAPS/ or equivalent allied mental health professional
- 3 x Parent-Infant Specialist (e.g. Health Visitor, Mid Wife, Social Worker)
- 1 x Service Manager/Admin

All of the above (except the service manager/administrator) will need a combination of either a clinical placement and/or post-qualifying training to attain level 2 in AiMH competencies. Two of the senior clinicians will need further training to attain level 3 AiMH in order to supervise and clinically manage the team.[29]

Clinical psychologists and child and adolescent psychotherapists

With the commitment to grow clinical psychology and child and adolescent psychotherapy by at least 20%-33% and increase training places by 26%, this will bring the annual number of training places up to 1,258–1,397 by 2033/34. If 50 of these places had clinical placements in a PAIR context per year, this would bring the number of newly qualified clinical psychologists and CAPTS with a PAIR specialism up to 250 in 5 years.

In addition to this if 50 recruit to train placements were funded per year, the number of additional parent-infant specialists would reach 500 within 5 years.

If 50 Assistant CAPT posts were created, then this would create a pool of potential leaders for future PAIR teams as well as ongoing clinical roles within teams.

Parent-infant specialists

There is huge potential to draw from other professional groups and upskill to become parent-infant specialists. This includes Social Workers, Health Visitors, Occupational Therapists, and other Psychological Therapists.

Private sector

[28] Parent Infant Foundation 2023, *Policy Briefing: Our response to the major conditions strategy*

[29] PAIR leadership training is an area that also needs development

The pool of untapped workforce in the private sector is estimated by the Fund the Hubs campaign[30] to have the capacity to be able to work with over 51,000 children & young people a week. If some of this capacity could also be upskilled to work with parents and infants, this would further add to the workforce pool.

The estimated cost of scaling up teams over 5 years including post-qualification training to AiMH level 2 is £332.3million. This represents new investment of £265m over and above £67m which is already costed into the system.[31]

Appendices

1. Specialist Parent-Infant Relationship training courses
2. Cost of scaling up teams over 5 years

[30] https://www.mind.org.uk/news-campaigns/campaigns/children-and-young-people-s-mental-health/fund-the-hubs/

[31] These figures have been updated to reflect the same inflationary assumptions applied to the other labour costs set out in Appendix 2 on page 24. Previously the level of new investment was overestimated at £269m and the existing costs in the system underestimated at £63m.

Appendix 1

Specialist Parent-Infant Relationship training courses

1. Parent-Infant psychotherapy training

British Psychotherapy Foundation

Eligibility: already UKCP qualified i.e. open to psychotherapists

Duration: 2 years

Further details: https://www.britishpsychotherapyfoundation.org.uk/education/training/psychoanalytic-parent-infant-psychotherapy/

The School of Infant Mental Health

Duration: 2-4 years – depending on previous qualification and experience

Eligibility: Professional qualification

Further details: https://infantmentalhealth.com/parent-infant-psychoanalytic-psychotherapy/

Infant-parent psychotherapy course – Au-Milieu

Duration: 2 years p/t

Eligibility: existing psychoanalytic psychotherapist

The first cohort will be in January 2024. Placements in South West London

Further details: Infant-Parent Psychotherapy Course - Au Milieu (au-milieu.org)

OxPIP Parent-Infant therapist training

Duration: 18 months

Eligibility: professionals who have a recognised professional clinical registration

Further details: https://www.oxpip.org.uk/extended-course/parent-infant-therapist-diploma

Child Psychotherapy

4-year courses accredited by the Association of Child Psychotherapists in 5 different centres across the UK. – can include a parent-infant specialism.

Further details of accredited centres: https://childpsychotherapy.org.uk/training-events-0/clinical-training-schools

Further pathway details: https://childpsychotherapy.org.uk/training-events-0/how-train-child-and-adolescent-psychotherapist

2. Other specialist parent-infant training

Advanced Parent-Infant Practitioner Training

OXPIP: Oxford Parent-Infant Project

Eligibility: Professional qualification e.g. social work, health visitor

Duration: one year

Further details: https://www.oxpip.org.uk/extended-course/advanced-parent-infant-practitioner-training

Observing Early Relationships: A Psychoanalytic Approach

Tameside & Glossop Early Attachment Service

Includes a year of infant observation.

Eligibility: Professional qualifications e.g. psychologists, social workers, health visitors

Duration: one year

Further information: Contact Katie Reid, kreid5@nhs.net

Postgraduate Certification in advanced Practice in Infant Mental Health and Wellbeing

Northampton University

Eligibility: Professional qualification e.g. social work, health visitor

Duration: one year

Further details: https://www.northampton.ac.uk/courses/postgraduate-certificate-in-advanced-practice-in-infant-mental-health-and-wellbeing/

Infant Mental Health- Postgraduate taught: Online distance learning (MSc/PGDip/PGCert)

University of Glasgow

Eligibility: At least 2:1 honours in relevant degree or registered healthcare professional qualification also considered

Duration: MSc- 36 months part time, PGDip- 24 months part time, PGCert- 12 months part time

Further details: https://www.gla.ac.uk/postgraduate/taught/infant-mental-health/

Understanding Infant Mental Health and Development- Postgraduate Taught: Microcredential

University of Glasgow

Eligibility: Suggested to have at least Undergraduate level education and an IELTS equivalent of 6.5.

Duration: 10 weeks

Further details: https://www.gla.ac.uk/study/microcredentials/understanding-infant-mental-health-development/

Infant Mental Health Postgraduate Course

University of Sunderland

Duration: 10 weeks

Further details: https://www.sunderland.ac.uk/study/north-east-workforce-skills/infant-mental-health/

Infant observation in the perinatal period

Eligibility: Multi-disciplinary practitioners

Duration: 12 weeks

Further details: https://tavistockandportman.ac.uk/courses/infant-observation-in-the-perinatal-period/

3. Short courses in Parent-Infant Relationship work

OxPIP has a range of short courses that develop skills and knowledge in Parent-Infant work

https://app.sheepcrm.com/oxpip/events/e/training

The School of Infant Mental Health runs a series of workshops and webinars for parent-infant clinicans

Workshops | Parent Infant Centre (infantmentalhealth.com)

Appendix 2

COST OF SCALING UP PAIR TEAMS OVER 5 YEARS					
	25/26	**26/27**	**27/28**	**28/29**	**29/30**
Number of teams operating fully from 1 April that year[32]	45	80	135	202	400
Labour costs of teams fully operational[33]	£12,715,032	£23,282,637	£40,468,133	£62,368,888	£127,207,830
Number of teams coming into operation over the year	35	55	67	198	-
Labour costs of teams coming into operation[34]	£4,944,735	£8,003,406	£10,042,092	£30,566,930	£ -
Cost of post-qualification training for teams coming into operation[35]	£387,713	£783,825	£1,016,505	£2,527,508	£987,525
Leadership development programme	£ 1,000,000	£ 2,000,000	£ 2,000,000	£ 2,000,000	£ -
Total each year	**£19,047,480**	**£34,069,868**	**£53,526,731**	**£97,463,325**	**£128,195,355**
Children seen per year[36]	8,500	14,750	23,600	40,200	60,000

[32] In 2024, there are 46 full PAIR teams already in operation.

[33] Assumes the cost of a team is £266,336.39 in April 2023 Agenda for Change, with a 3% pay rise per year

[34] Based on half the annual workforce cost to reflect that teams will gradually come on line over the year

[35] Based on the workforce costing in Conti (2019) report, acknowledging that some of the training takes 2 years

[36] Assumes 150 per fully operational team and 50 per new team.