Parent-Infant FOUNDATION

Who is holding the baby?

The development of parent-infant teams in the UK

Authors:
Wook Hamilton
Tamora Langley
Dr Ben Yeo

June 2025

With thanks to the Barbara and Stanley Fink Foundation for supporting the production of this report.

About the Parent-Infant Foundation

We are the Parent-Infant Foundation.

Our vision is of a UK in which all parents and carers are supported to create sensitive, nurturing relationships with their babies to lay the foundation for lifelong mental and physical health.

More than one in ten babies in the UK today are scared and distressed thought to be living in fear, confusion and distress.

Not everyone bonds easily with their baby. Parents can be overwhelmed by trauma from their own childhood. Some are struggling with mental or physical health difficulties.

Parent-infant teams support and strengthen relationships between babies and their parents (or carers).

We are the only national charity driving the growth and quality of parent-infant teams across the UK.

Because every baby deserves a good start in life.

Acknowledgements

We would like to thank all the specialised parent-infant relationship teams who took part in the initial research and whose pioneering practice forms the content of the report and informs its recommendations.

We would also like to thank Sally Hogg for her contributions to help shape the report.

Citation

Parent-Infant Foundation (2025). *Who is holding the baby? The development of parent-infant teams in the UK.*

© 2025 Parent-Infant Foundation.

Parent-Infant Foundation
Office 7, 35-37 Ludgate Hill
London EC4M 7JN

t. 020 3475 8984
e. admin@parentinfantfoundation.org.uk
w. parentinfantfoundation.org.uk

Parent-Infant Foundation, a company limited by guarantee, company no. 8191666
Registered charity England and Wales (1152082)

Executive summary

Five years on from our *Rare Jewels* report, in which the definition of a specialised parent-infant relationship team was first developed, 'Who is holding the baby?' provides an up-to-date picture of the growth of specialised parent-infant relationship teams across the UK.

This report uses research, conducted by the Parent-Infant Foundation with parent-infant teams, alongside findings from Freedom of Information requests about service levels for babies.

A baby's brain develops rapidly during pregnancy and through the first years of life. What happens during this time lays the foundations for future health and happiness.[1] Possibly the most influential factor in early development is the care that babies receive and the relationships they have with their parents or carers.[2]

When there are severe and persistent difficulties in early relationships, this can have a pervasive impact on early development with consequences that can be felt across the life course.[3,4,5]

Some parents struggle to provide their babies with the nurturing care they need to thrive. These babies and parents may need support for their early relationships, and this can have a lasting positive impact on their development.[6] This work can be complex, and professionals need specialist skills and expertise to support the mental health needs of babies and the earliest parent-infant relationships.

Parent-infant teams play a vital role in ensuring that families who need it receive support to strengthen and repair early relationships. They do this by providing direct therapeutic support to families with the highest levels of need, and through providing training, supervision and consultation to enable practitioners in other services to support babies and parent-infant relationships.

A review of the evidence by the Parent-Infant Foundation found that parent-infant teams have a positive impact on strengthening early relationships, improving parents' mental health and supporting babies' social and emotional development.[7]

Findings

1 There has been a rapid increase in the number of parent-infant teams in the UK in the last five years

There were 27 parent-infant teams known to the Parent-Infant Foundation in 2019. There are now 49, with many more services in development. This rapid growth has often been due to local efforts – the dedication of local clinicians and commissioners who have tenaciously worked to develop local provision. This has also been supported by national policy developments (notably Start for Life in England and the Perinatal and Infant Mental Health Board in Scotland) alongside other funding such as 'A Better Start' National Lottery funding in selected areas of England.

2 Parent-infant teams have developed in different parts of the system, with different funders

Parent-infant teams have developed in different ways as opportunities have arisen for dedicated and skilled practitioners to establish and grow provision. Many teams are part of public sector provision and some sit in the voluntary sector. Teams have often been forced to be innovative and agile to survive and grow, so they often do not sit in traditional structures and services.

Despite recent policy developments, there is still no consistent funding stream for the development and delivery of parent-infant teams in most of the UK. Most teams have funding from multiple sources, including public service funding streams in mental health, public health and children's services, and voluntary sector funding. Many teams are funded by health (30/43).

3 Parent-infant teams vary hugely in their size, composition, the work they do and the number of families they see

The number of families seen directly by parent-infant teams in a year also varies, from under 25 families per year in some teams to over 300 in others.

4 Parent-infant relationship support is scarce in other parts of the system

- Perinatal mental health services (PNMH). PNMH services support mothers who have mental health difficulties, usually at the more severe end of the spectrum. Increasingly, there is also parent-infant relationship support offered in these services. However, this reaches a small proportion of the overall need.
- Although there has been an increase in the number of CAMHS services that accept referrals of 0-2s, our new Freedom of Information requests find the number of babies supported in CAMHS is still very low, with most services still only getting fewer than 10 referrals a year.
- Start for Life funding in England has initiated more parent-infant services to develop in the 75 areas that received funding. This has largely been at the universal and targeted level, with less offered at the specialist, more complex level of need.

5 The number of babies seen by parent-infant teams is significantly below the level of need

Based on the data given at the time, it is estimated that parent-infant teams across the UK offer direct therapeutic support to between 4400 and 6500 families each year. It is estimated that the parent-infant teams around the UK are meeting around 4-6% of babies who currently need specialist support.

6 Parent-infant teams offer a range of interventions with a growing evidence base

Parent-infant teams typically offer a range of therapeutic interventions to respond to the different nature and severity of families' needs. The package of interventions offered is individualised and formulation led. The most common interventions offered by teams include video feedback interventions, parenting programmes such as Circle of Security, and individualised interventions such as parent-infant psychotherapy. Many interventions are dyadic, meaning they work with both parent and baby together.

A third of teams also offer some form of therapeutic support for parents to support their own mental health to help them engage with other interventions which support the parent-infant relationship. Many of the interventions used have a strong evidence base, although there is a need to develop the UK evidence base for the other interventions that are commonly used by parent-infant teams.[8]

7 All parent-infant teams join up the early years system through indirect work and, as a result, improve the support offered to many more babies and their families

Parent-infant teams use their expertise to help other local professionals who work with babies to understand and support parent-infant relationships and to identify issues where they occur (and take appropriate action). They do this via joint care planning, training, consultation and supervision. It is estimated that, collectively, over the last year, teams offered consultancy to over 2,000 professionals, supervision to over 1,500 and training to over 40,000.

8 Links between parent-infant teams and perinatal teams

Many parent-infant teams work closely with their local perinatal mental health service. This can take the form of shared cases, care planning, supervision and reflective spaces. Around half of parent-infant teams have shared referral pathways with perinatal mental health teams. This joint working can better enable babies to get the support they need at the right time and place.

9 Parent-infant teams are multi-disciplinary teams including highly skilled mental health professionals

All parent-infant teams are multidisciplinary teams that include mental health professionals with specialist expertise in infant mental health and early relationships. This can include clinical psychologists, child psychotherapists, health visitors, social workers, midwives and other allied professionals.

Teams are generally led by a consultant-level clinician,. Most staff in teams are band 7 and 8a or equivalent. The data illustrates the high levels of skill needed to lead a parent-infant team.

10 Parent-infant teams specialise in working with children from pregnancy to age two

The majority of teams will see babies and young children from pregnancy to age two; 21 teams also see children older than two, some up to the age of five and a few beyond five. Some professionals have commented that when teams work with older children, babies are deprioritised.

11 The focus of teams' work is often with mothers and there is less data about the involvement of fathers and other parents or carers

Nearly all teams work primarily with mothers and their babies, with fathers and other parents or carers engaging to a variable extent in assessments and support. However, there are some good examples of purposeful engagement with fathers in some areas. Sometimes teams have limited information about fathers and their engagement because dads are not recorded as a service user on their systems.

12 Teams have different levels of engagement with families in the child protection system

Babies and young children in the child protection or care system are likely to have experienced the most severe difficulties and disruptions in their early relationships. These vulnerable babies are likely to particularly benefit from support from parent-infant teams.

Nearly all teams accept referrals for babies in the child protection system and for babies who are looked after or adopted. For most of these teams, the families with a baby on a Child Protection Plan were a minority of their service users. However, some teams focus specifically on this group of babies.

Some teams have developed relationships with children's social care which facilitates referrals. This can include offering consultations and participating in pre-birth panels.

13 Teams involve parents in different ways

Around half of teams involve parents in service design and delivery. The ways in which teams work with parents varies. Some have asked parents for user feedback on external facing aspects of the service, such as the service name or parent information leaflet. Other teams had parent voices more embedded into the operation and decision-making across their service.

14 Baby's voice

Baby's or infant's voice is a process of giving due consideration to the perspective of the baby and what their 'voice' would be if they could describe their experience.

Most parent-infant teams said that the baby's voice was central to their work. Many teams consider the baby's voice in a variety of ways in clinical assessments, consultations, decision-making forums and to inform service development.

Conclusion

This report gives a picture of how specialised parent-infant relationship teams have developed across the UK. It shares examples of good practice that have developed within the sector and offers a vision of how teams could continue to improve and develop.

Most importantly, this report underlines that more action is needed to grow the number and capacity of teams so that every baby and family who need support can benefit from a local parent-infant team. The following recommendations have emerged from the report at both a policy and a practice level.

Recommendations

Policy recommendations

- **Government investment should be increased to ensure there are parent-infant teams available to all babies in need across the UK.**
- In England, the next 10 Year Plan for the NHS should prioritise infant mental health and include measurable targets to meet the needs of vulnerable babies.
- All integrated care systems in England should explicitly consider and address the needs of babies and young children in their strategies and joint forward plans.
- All mental health trusts in England should be responsible for providing a comprehensive service for all children, which includes the 0–2 age range.
- In Scotland, service specification guidance for parent-infant teams needs to be developed alongside a continued funding commitment.
- In Wales, the Welsh government should commit to the equitable provision of specialised parent-infant relationship teams across all seven regions.[a]
- The Northern Ireland Executive should build on the aspirations set out in the Infant Mental Health Framework (2016) and commit funding to develop services.

Workforce recommendations

- **Develop a parent-infant relationship competency framework:** Develop a nationally recognised infant mental health or parent and infant relationship (PAIR) workforce competency framework based on the Association of Infant Mental Health (AiMH) Competency Framework.
- **Fund clinical placements in parent-infant teams**: Provide funding for clinical placements in parent-infant teams from relevant professions in order to grow the workforce.

Further recommendations to grow and develop the infant mental health workforce can be found in our paper, Solutions to Growing the Specialised Parent-Infant Relationship Workforce (2024). This paper closely examines the multi-disciplinary parent-infant relationship workforce and recommends practical solutions for growth.

Research recommendations

- **Expand the evidence base for parent-infant relationship interventions:** Further research is needed to develop the evidence base for interventions that are most used by parent-infant teams in the UK.

a. For further recommendations in Wales see our Golden Thread Report.

Practice recommendations for developing parent-infant teams

- **Demonstrate the value of wider indirect work with practitioners in the system**
  The impact of the 'wider indirect work' in the system should be collected and reported to commissioners as a way of demonstrating its value and impact on babies.
- **Reach vulnerable babies through dedicated pathways**
  Babies in the child protection system should be reached by developing specific pathways in partnership with social care.
- **Develop shared pathways between parent-infant and perinatal mental health teams**
  Parent-infant and perinatal mental health teams should develop shared pathways and collaborative working practices to enable babies to get access to support most appropriate to their needs.
- **Babies should be reached as early as possible, including antenatally**
  Parent-infant relationship difficulties should be identified and supported in pregnancy and dedicated pathways with midwives and other professionals established.
- **Collect data on underrepresented groups**
  To effectively address the needs of underrepresented groups, (notably fathers, same-sex parents and ethnicity of the parents in a locality), data should be recorded and analysed by services.
- **Develop engagement activities with fathers and other parents or carers**
  Engagement activities with fathers and other parents or carers who play a caregiving role for their baby should be developed.
- **Use creative co-production methods to help develop services**
  The 'voice of babies' and families should be utilised in co-producing services, including targeting those from marginalised groups.
- **Hold the clinical record in the name of the baby**
  Clinical records should be held in the baby's name where possible and linked to the parent or carers record.
- **Bring the 'voice of the baby' to the heart of all work**
  The perspective of the baby should be incorporated into all aspects of policy and practice.

Contents

The development of parent-infant teams in the UK

Part one
Background and methodology

1. Understanding specialised parent-infant relationship teams[b]

1.1. The importance of babyhood and the parent-infant relationship

Pregnancy and the first years of life are a period of uniquely rapid development. What happens during this time lays the foundations for future health and happiness.[9] Babies' development is shaped by their environment and experiences. Possibly the most important part of these early experiences is the care that babies receive and the relationships they have with their parents or carers.[10]

Interactions between babies and their parents play a crucial role in the development of vital cognitive, social and emotional capacities such as language development and emotional regulation.[11,12] When there are severe and persistent difficulties in early relationships, this can have a pervasive impact on early development with consequences that can be felt across the life course – impacting on achievement, employment outcomes, mental health and physical health across adulthood and into old age.[13,14,15]

Some parents struggle to provide their babies with the nurturing care they need to thrive. These babies and parents may need support to address the challenges they face in building their relationships. Parents might be experiencing stress and adversity (for example, due to domestic abuse, poverty or mental health problems). They might also be affected by experiences of adversity and trauma in their own childhood. Past and present adversity increases the risk that a parent finds it challenging to develop a safe and secure parent-infant relationship.[16]

Population-based research suggests that around 15% of children will develop a 'disorganised attachment' style. This suggests that they have experienced significant parent-infant relationship difficulties which are likely to have a particularly deleterious impact on their development and mental health.[17] This study also showed that prevalence rises significantly in disadvantaged communities.[18]

b. Specialised parent-infant relationship teams are also known by other names in different parts of the UK. These include infant mental health teams, parent-infant mental health teams, PIEWS (Parent and Infant Emotional Wellbeing Service) Early Attachment Service, PAIRS (Parent and Infant Relationship Service).

1.2 How parent-infant teams can help

Professionals can support babies and parents to improve their early relationships, and this can have lasting positive impacts on an infant's development.[19] This work can be complex. Professionals need specialist skills and expertise to support the mental health needs of babies and to support their earliest relationships.

Specialised parent-infant relationship teams (also known as parent-infant teams) play a vital role in ensuring that families experiencing difficulties receive the support they need. They do this by providing direct therapeutic support to babies and their families with the highest levels of need, and through providing training, supervision and consultation to build capacity in the early years system and supporting staff in other services to support babies and parent-infant relationships.

The definition of a specialised parent-infant relationship team

- **Specialised parent-infant relationship teams are multi-disciplinary teams.** They include highly skilled mental health professionals such as clinical psychologists and child psychotherapists, with expertise in infant and parent mental health and in supporting and strengthening the important relationships between babies and their parents or carers.
- **They are experts and champions.** They use their expertise to help the local workforce to understand and support all parent-infant relationships, to identify issues where they occur and take the appropriate action. This happens through offering training, consultation and/or supervision to other professionals and advice to system leaders and commissioners.
- **They offer direct support for families who need specialised help.** This includes targeted work with families experiencing early difficulties whose needs cannot be met by universal services alone and specialist therapeutic work with families experiencing severe, complex and/or enduring difficulties in their early relationships, where babies' emotional wellbeing and development is particularly at risk.
- **They assess families and offer individualised programmes of support to meet their needs,** drawing on a toolkit of both professional practice and evidence-based programmes.
- **Their focus is on the parent-infant relationship.** They do not work only with an individual child or parent(s) but with the dyad or triad (although there may be particular sessions in which parents see a therapist on their own).
- **There is a clear referral pathway to enable families who need support to access the service.** Families are referred because of concerns about difficulties in their early relationships, which is putting or could put babies' emotional wellbeing and development at risk. Unlike other mental health services, there does not need to be a clinical diagnosis in the adult or child for families to be eligible for the service.
- **They accept referrals for children aged two and under and their parent(s).** Some work from pregnancy, others from birth. (Some services see older children too.)

1.3 The evidence for parent-infant teams

Several evaluations have assessed the impact of individual parent-infant teams and have found improvements in a range of outcomes. In addition, there is a wealth of robust evidence about the impact of many of the specific interventions offered by teams. A review of the evidence by the Parent-Infant Foundation found that parent-infant teams help babies and their carers across three interrelated domains, which are critically important for the healthy development of babies now and for future outcomes.[20]

- **Strengthening early relationships:** The interventions typically offered by parent-infant teams are highly effective at supporting carers to be more responsive, sensitive and attuned to their baby's needs. The evidence from local research and service evaluations of parent-infant teams is consistent with the research about evidence-based and effective interventions from national and international research.
- **Improving parents' mental health:** The evidence of interventions and local service evaluations suggests that levels of anxiety, depression and stress in parents and carers can be significantly reduced through involvement with parent-infant teams.
- **Supporting babies' social and emotional development:** Local service evaluations indicate that services can support babies to meet developmental milestones and that risks to babies and young children, including those with serious safeguarding concerns, can be decreased through involvement with a parent-infant team.

2. Methodology

2.1 Background to the Parent-Infant Foundation's role with parent-infant teams

The Parent-Infant Foundation is the national charity that supports the quality and practice of specialised parent-infant relationship teams across the UK and works to grow the number of teams. In 2013, the charity began by directly funding six pioneering teams to set up or expand their existing services. In 2019, it expanded its strategic purpose to include supporting and advocating for all parent-infant teams across the country.

The Parent-Infant Foundation runs the Parent-Infant Teams Network, which brings together established and emerging parent-infant teams around the UK to share good practice. In 2023, the Foundation opened up its Network to include other parent-infant relationship services in the UK, in recognition of the growth in the sector and the need for support for new services. The Foundation also uses the expertise in specialised teams to offer consultancy to these new service developments in their journey towards becoming a full parent-infant team.

2.2 *Rare Jewels* report

In 2019, the Foundation conducted the first research to understand the prevalence of parent-infant relationship service provision in the UK and the extent to which children's mental health services were able to meet the needs of babies and young children. That research was written up in the report *Rare Jewels*, which explained for the first time what specialised parent-infant relationship teams are and developed the definition used in this report.[21,c]

c. The title was inspired by a quote from a commissioner and captured the fact that teams were small and valuable but scarce.

2.3 Survey of teams in 2023

In 2023, the Foundation carried out a data collection exercise with all established parent-infant teams in its Network to capture the latest practice. A questionnaire[d] containing qualitative and quantitative questions was sent to all parent-infant teams in the Network and was completed by 43 of the 46.[e] Most were in England, with four teams in Scotland, two in Wales and one in Northern Ireland.

In addition to the questionnaire, further quotes and good practice examples were collected from teams to illustrate key points. Between the time of the initial data collection and the publication of this report, one team in NI has closed, and there have been four new teams developed, bringing the number of teams in the UK up to 49.

2.4 Freedom of Information requests (FOIs)

In 2019, the Foundation sent Freedom of Information requests (FOIs) to clinical commissioning groups (CCGs) in England and to several mental health trusts. We asked if CCGs commissioned services for children aged two and under, to see how 'comprehensive' mental health services were, from the perspective of very young children.[f]

Five years on, in March 2024, to see if things had improved, we sent Freedom of Information requests to the 50 mental health trusts that now cover England. See Annex 3 for details of this FOI.

The findings in this report describe the work of the teams that currently exist in the UK, the strengths in current provision and where there are gaps and challenges. This is intended to help those working in the sector to reflect on their practice, as well as inform the decisions of commissioners and policy makers in this expanding area of practice.

d. A copy of the questionnaire can be found in Annex 1.
e. A list of all the teams who completed the survey can be found in Annex 2.
f. Rare Jewels report p.39.

Part two
The strategic context of specialised parent-infant relationship teams

1. Specialised parent-infant relationship teams and the parent-infant sector

This report focuses on specialised parent-infant relationship teams that meet our definition. There has been a rapid increase in the number of parent-infant teams in the UK over the last five years. In 2019, there were 27 teams known to the Parent-Infant Foundation and now, at the time of writing, there are 46 teams. In addition to these full parent-infant teams, there is a growing sector of parent-infant services in different parts of the system. This includes many smaller services – some working at just a universal/targeted level and some at a specialist level. Many of these are part of our network and aspire to becoming full parent-infant teams if funding were available.

The rapid growth in teams and services has often been due to efforts at a local level – the dedication of local clinicians and commissioners who have worked tenaciously to develop provision in their area. This has also been supported and enabled by the following national policy developments and funding streams.

2. The policy context

- **In England**, the NHS Long Term Plan acknowledged back in 2019 that 'a loving family' was a factor that significantly influenced a young person's health and life chances and that 'the NHS plays a crucial role in improving the health of children and young people: from pregnancy, birth and the early weeks of life; through supporting essential physical and cognitive development before starting school.' It promised to 'extend current service models to create a comprehensive offer for 0–25-year-olds.' However, no targets were included specifically for babies or the under-fives. The government is currently consulting on a new 10 year plan for health. We have submitted evidence[g] and recommended a new target to reach vulnerable babies is included.
- In 2021 the Start for Life (SfL) programme was announced for England, with the goal of 'ensuring the best support throughout the first 1,001 critical days, setting babies up to maximise their potential for lifelong emotional and physical wellbeing.' The programme funds 75 local authorities to improve support for babies, toddlers and their families. It was allocated £300 million over three years (22/23–24/25) which included £100 million for perinatal and parent-infant relationship support. Another year of funding is confirmed for 2025–26. The programme guidance states that funding should be used on '*primarily universal parent-infant*

g. NHS 10-Year Health Plan consultation response – Parent-Infant Foundation.

relationship support' but that local areas could 'go further' to support parent-infant relationships by expanding existing provision or developing new specialist support.[22]

The Parent-Infant Foundation has provided consultancy to several local SfL areas, many of whom are keen to develop parent-infant teams. We have seen the programme contribute to the growth and development of parent-infant relationship services in some Start for Life areas.

- A Better Start – National Lottery ten-year funding has helped to fund four parent-infant teams in England.

- **In Scotland:** The 2018 to 2019 Programme for Government in Scotland included a commitment to improving perinatal and infant mental health. The Scottish Government established a Perinatal and Infant Mental Health Programme Board to manage delivery, and between 2019 and 2022, £3.2 million was invested in infant mental health services.[h] This funding was used to develop a range of services designed to meet local need. The Programme Board dissolved in 2023. Infant mental health services are now overseen by a Joint Strategic Board for Children and Family Mental Health.

  The Parent-Infant Foundation has been working in Scotland to support the development of parent-infant services. Some teams now meet the criteria for parent-infant teams and have joined our UK-wide network.

- **In Wales:** The newly published Welsh Mental Health and Wellbeing Strategy 2025–2035[i] highlights the importance of the first 1000 days, and babies' and children's developmental period. The strategy recognises that, '*it is vital that effective interventions are offered at this young age to mitigate future emotional challenges and to support a happy and healthy childhood*'. There are three parent-infant teams in Wales and more in development. The Parent-Infant Foundation has been working in Wales since late 2023 as part of a lottery-funded project to promote the development of teams across Wales.

- **In Northern Ireland:** the 2021–2031 Mental Health Strategy included commitments to '*ensure that the needs of infants are met in mental health services*'.[j] The latest delivery plans for the strategy do not include specific actions to deliver this. Until recently there were two parent-infant teams in Northern Ireland, but one closed in 2024.

h. Scottish Government. (12 January 2023). Perinatal and Infant Mental Health Services Update.
i. Welsh Government (2025) Welsh Mental Health and Wellbeing Strategy 2025–2035.
j. Department of Health NI. (2021). Mental Health Strategy 2021–2031.

3. The structure and funding of parent-infant teams

3.1 Organisational structure

Parent-infant teams across the UK are based in different parts of the system. Teams have developed in different ways, responding to opportunities for dedicated and skilled practitioners to establish and grow provision. Many teams are part of public sector provision, some are part of NHS services, others sit in local authorities and some teams are part of the voluntary sector. Teams have often needed to be innovative and agile to survive and grow and often do not sit in traditional structures and services. Another reason for this variation in where teams sit is because their work intersects with the work of several sectors.

3.2 Differences between parent-infant teams and other mental health services

In many senses, parent-infant teams are mental health services in that they are led by mental health professionals and support the mental health of babies and their parents. However, the specialised work they do makes them different from conventional mental health services in the following ways:

- Parent-infant work is dyadic or triadic (it works with babies, parents and their relationships), whereas most mental health services work with individuals.
- Mental health needs in babies and young children look different to how they display in older children and adults. Babies and young children can experience dysregulation, relational, emotional and behavioural problems (such as withdrawal, separation anxiety, feeding and sleeping difficulties) which are rooted in the parent-infant relationship.
- Parent-infant teams take referrals based on challenges in early relationships, whereas most mental health services take referrals on the basis of symptoms and diagnoses of mental health conditions only.
- In order for referrals to happen, therefore, parent-infant teams need to be closely connected to health visitors, midwives and other professionals who work with babies and their families.
- To reach babies, parents and these other professionals, parent-infant teams often offer services in community settings rather than asking families to attend clinical settings.
- To meet the specialist needs of babies and local systems, parent-infant teams are delivered by a range of providers that are sometimes distinct from children's mental health services.

3.3 Parent-infant teams work across a whole system

'Parent-infant teams are the glue in the early years system.' Practitioner quote from our survey

Parent-infant teams work across the whole system to ensure that services are integrated and coordinated and able to respond effectively to the needs of vulnerable babies.

Babies move rapidly through a range of services as they enter the world. From the more intensive and high-frequency contact in hospital settings, most are discharged into the community soon after birth. From that point, the extent of contact with public services varies.

In England, at the universal level, the Healthy Child Programme mandates a minimum number of health checks and is intended to identify additional needs, when these have not already been picked up during antenatal or postnatal maternity services. But for vulnerable babies and families who need specialist support with parent-infant relationships, a range of additional services and input from multi-disciplinary teams is needed. For example, social care, perinatal mental health, early help, peer support and specialist support from a parent-infant team.

Partnership working, effective information-sharing and shared pathways are key to coordinate and integrate across the range of public services involved and the voluntary sector. This avoids parents having to repeat their story multiple times, helps build trusted relationships and ensures that issues identified are shared with relevant services to keep babies safe.

To enable joined-up working, there needs to be a common approach and 'buy-in' at each level of decision-making (neighbourhood, place and system level).[k] Typically parent-infant teams will proactively work to join a system up to ensure babies are reached wherever they come into contact with services.

3.4 The funding and commissioning context

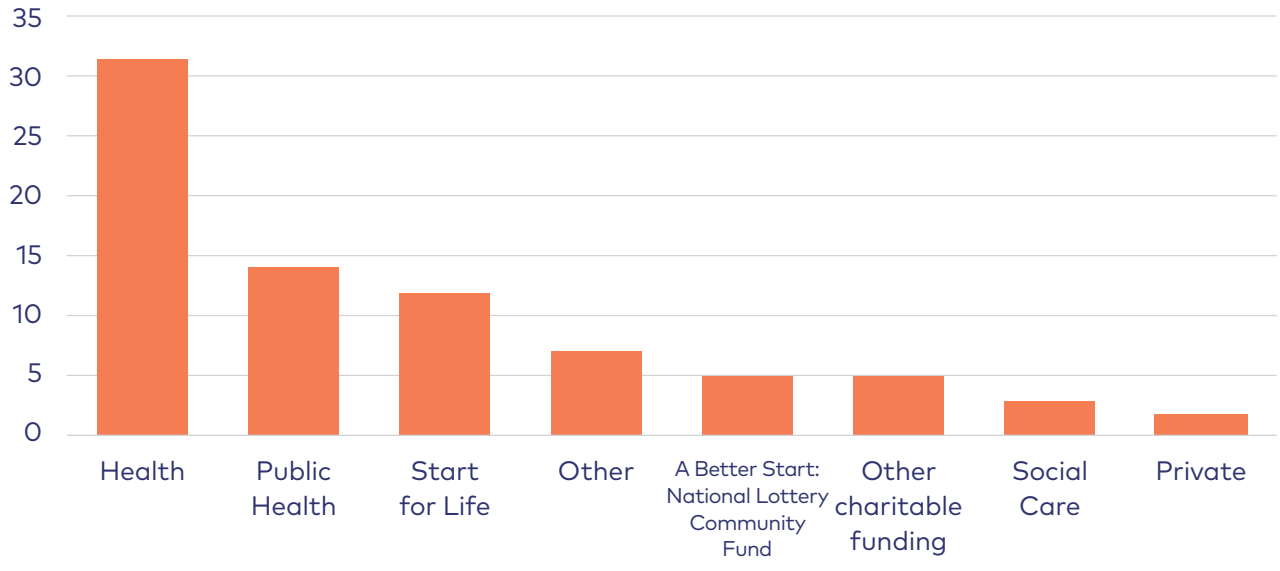
Despite recent policy developments, there is still no consistent funding stream for the development and delivery of parent-infant teams in most of the UK, nor any clear accountability for their existence. Scotland is an exception to this, with every health board providing some funding for infant mental health services. As a result, several services in Scotland have developed into full parent-infant teams. However, some health boards do not have a full team but have rather a smaller service and/or a single professional responsible for service development. Although accountability for funding is therefore clear, Scotland would benefit from a more detailed plan to develop services.

Parent-infant teams do not clearly fit into the traditional service delivery and commissioning landscape. Their work and the outcomes they promote sit across a number of policy areas, including mental health, public health and children's services. This brings both challenges and opportunities. No single commissioner or public body is held to account for the provision of services, but where local commissioners and health and social care leaders are committed to developing a team, they can potentially draw on a number of different funding streams to do so.

3.5 Current funding and commissioning arrangements for parent-infant teams

Our findings show the wide variety of funding sources and commissioning arrangements across the UK. Most teams are funded by health budgets (30/43). However, only half of these are funded solely by health. The majority of teams have funding from multiple sources, including public health and children's services, as well as some voluntary sector funding.

Figure 1: Funding sources for teams



k. These levels are explained in the King's Fund publication: Integrated Care Systems Explained | The King's Fund.

Figure 2: Numbers of teams with sole and joint funders

Teams with one funder (n=19)	Teams with two or more funders (n=24)
Health (15)	Public Health and Health (4)
Local Authority (including Public Health) (3)	Start for Life and Public Health (3)
A Better Start: National Lottery Community Fund (1)	Start for Life and A Better Start: National Lottery Community Fund (2)
	Start for Life and Health (2)
	3 or more sources (13)

Teams in England, Wales and Northern Ireland get funding from a variety of sources. Twelve teams in England told us they were able to expand with funding from the Start for Life programme. Many more Start for Life areas have services in development and aspirations to develop into full teams. Seventeen teams in England cite their commissioner as their Integrated Care Board (ICB). Other commissioners cited across all three nations were public health, local authorities and CAMHS.

The four teams in Scotland who answered the survey cited their commissioner as the Scottish government (via the health boards).

'I've advocated for many years that parent/infant relationship and infant mental health services need to be joint commissioned and joint funded. When what we are talking about [..Infant Mental Health], becomes everyday conversation across – and the responsibility of – all public health, specialist health (i.e. CAMHS, AMH, perinatal MH), midwifery, paediatrics, education, Early Years etc, we then truly will be making a difference.'
Alan Wilmott, specialist practitioner for perinatal parent/infant mental health, Torbay

3.6 Team location

Parent-infant teams typically work closely with other local services to reach and engage families who need support. Some teams co-deliver services with other partners, including the voluntary sector, to help build on existing trusted relationships these services might have with families. Others are co-located in community settings, such as family hubs and children's centres which helps them to better reach the families who need their support.

For example:

The Norfolk PAIRS provides enhanced liaison to the local family hubs and has link workers to support the family hub services through providing consultation and supervision to staff in the family hubs and providing joint assessment and direct work with families where it is required.

'Historically we have seen a lack of referrals for under 2's, but we are seeing a change in this trend since starting to provide enhanced liaison to the Family Hub workforce. This includes having a practitioner with specialist attachment expertise aligned to each Family Hub site, providing consultation and supervision centred around mild to moderate support.' Norfolk and Waverley PAIR team

- Kensington & Chelsea and Westminster Under 5s Service is co-located at four family hubs across the area in order to be accessible to the most vulnerable families.

3.7 Provision for babies aged 0–2 within a service offer for a wider age range

Many parent-infant teams have either developed their 0–2 service offer within an existing service for a wider age range or have been asked by commissioners to expand their existing 0–2 service to include older children. This latter scenario is particularly the case for teams that are located within CAMHS, and this reflects the developing focus on the needs of the 0–5 cohort within the NHS.

We know anecdotally from CAMHS 0–5 services (many of whom are part of our Network, but do not all meet our definition of a parent-infant team), that when a service also works with older children, the needs of the babies and the youngest children can sometimes be deprioritised.

The table below shows the different age thresholds within the parent-infant teams we surveyed. About half of all teams (21) also see children older than two, some of whom are much older. In some places, there is a specialist parent-infant team within a broader service.

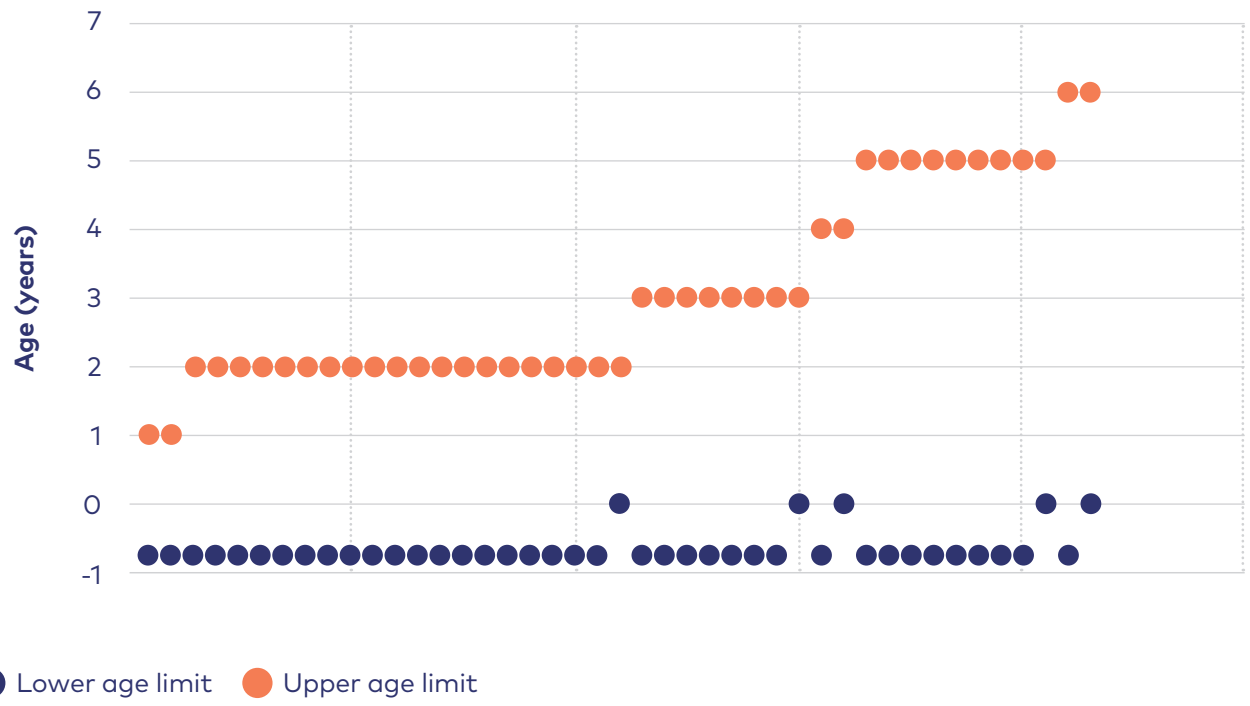
Although there is a need to join up services across age groups, it is also important that parent-infant teams are not drawn into work with older children in ways that might jeopardise their specialist focus and expertise in babies and the youngest children.

To read more about examples of parent-infant offers within a service for wider age range see:

Appendix A: The Leeds Infant Mental Health Service that expanded a 0–2 service to include 3–5 years.

Appendix B: The Norfolk and Suffolk NHS Foundation Trust PAIRS team that works with infants and young children aged 0–4 years.

Figure 3: Age range of children eligible for support in each service



4. The sufficiency of provision

4.1 Do services meet the needs of babies?

Research into the prevalence of the mental health needs of babies and young children at a population level is at an early stage.

Although the picture is incomplete, the data we have assembled through Freedom of Information requests, our survey of parent-infant teams, and our ongoing work with parent-infant services across the system show that only a tiny fraction of the estimated need is being met.

4.2 Prevalence of need

Different approaches have been used to estimate the prevalence of mental health needs of babies and young children and to inform commissioning and service planning:

- The government's Start for Life programme estimated that 10% of babies each year are at risk of disorganised attachment, which is associated with the worst developmental outcomes.[23] This equated to 56,000 babies in England in 2023.

- Other research has often estimated that 15% of babies are at risk of developing a disorganised attachment style.[17]

Based on our experience of developing new teams who offer support to babies at risk of both disorganised and insecure attachment, we estimate 56,000 babies in England, would benefit from support from a parent-infant team, with up to 400 parent-infant teams needed to meet this need. This is based on offering a service to 5% of the 0–2 population.

4.3 Size of teams

Responses to our survey showed that teams vary in size from one to more than eight WTE staff. Teams also vary in the intensity and nature of interventions they offer, the families they target and the balance of direct and indirect work undertaken. Some teams work across large areas; others are targeted at specific disadvantaged communities.

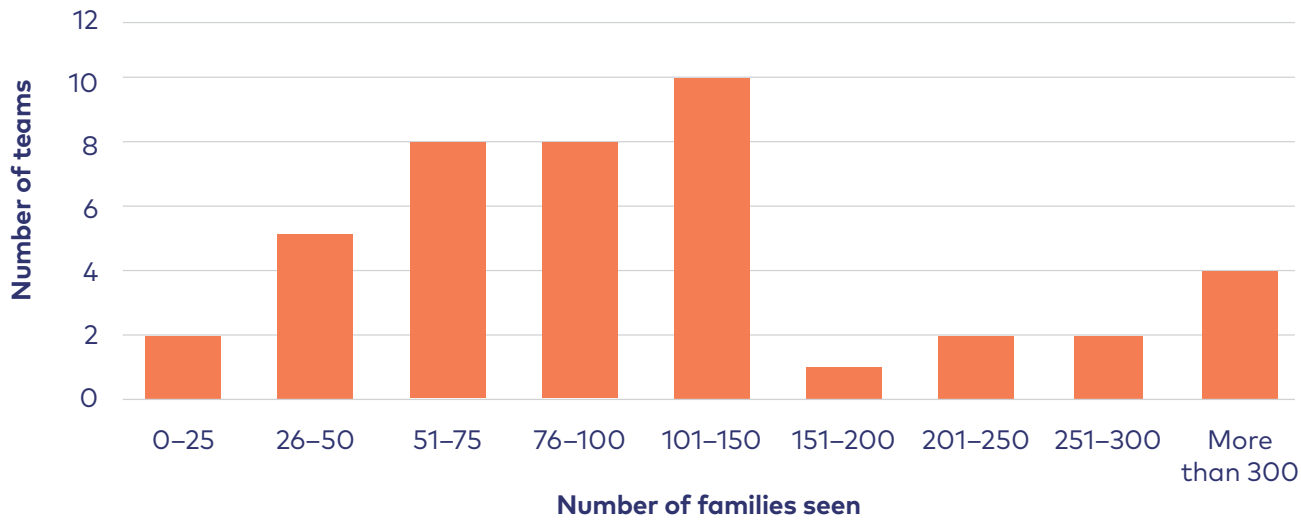
4.4 Service capacity of parent-infant teams

The number of families seen directly by parent-infant teams in a year varied, from under 25 families per year in some teams to over 300 in others.

In the survey, teams were not asked to report on the size of the population they serve, so there is not enough data in this instance to know whether service levels in teams meet the need in their respective localities.

Based on data collected at the time, it is estimated that parent-infant teams across the UK offer direct therapeutic support to between 4,400 and 6,500 families directly each year. This means that the parent-infant teams around the UK are meeting around 4-6% of babies who currently need specialist support.

Figure 4: Distribution of total number of families seen by parent-infant teams in the last 12 months



4.5 Service offers for babies and young children within Child and Adolescent Mental Health Services (CAMHS)

The 2019 NHS Long Term Plan included a commitment to provide a comprehensive mental health service from 0-25 and many CAMHS do now include an Infant Mental Health pathway. Many parent-infant teams have grown out of a CAMHS context and others have developed pathways in partnership with CAMHS.

To understand the scale of these changes, we sent Freedom of Information (FOI) requests to mental health trusts in a repeat of research we previously undertook in 2019 for our '*Rare Jewels*' report:

- Our 2019 FOI's found that services were skewed towards older children – 42% of areas in England did not accept referrals for children aged 0-2. Five years on, this has improved, but still 20% of mental health trusts do not accept referrals of 0-2s.

Our 2019 FOI's found that services were skewed towards older children – 42% of areas in England did not accept referrals for children aged 0-2.

Five years on, this has improved, but 20% of mental health trusts still do not accept referrals.

However, in most CAMHS the numbers of babies seen is still very low, especially when there is no parent-infant team embedded within the service:

- 19 out of 36 trusts that take referrals for 0–2s only receive between 0–10 referrals a year.

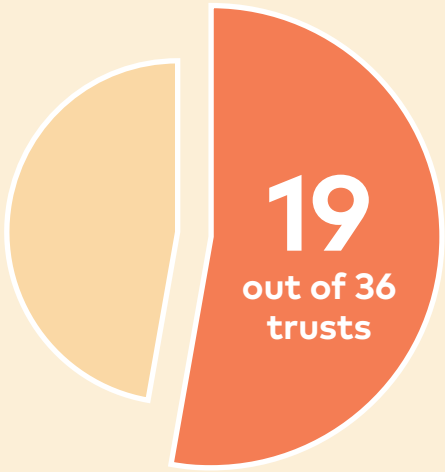
There is a wide disparity in the numbers of referrals received; and areas with the highest numbers of referrals for 0-2 year olds are those that have parent-infant teams:

- Greater Manchester, Cornwall and Tavistock had the highest numbers of referrals for 0-2 year olds, with between 0.2-1.4% of all referrals of children 0-18 years from babies (0-2 years). These areas all have a parent-infant team integrated within the CAMHS service.

These findings illustrate the variability in CAMHS provision for 0–2s in different parts of England. The low levels of referrals for this age group also illustrate the challenges of reaching vulnerable babies when parent-infant services are not integrated into the wider early years system.

Although we know that more babies are being helped outside of CAMHS through other services including perinatal mental health, local authority and voluntary sector services, data on this is not being collected or shared consistently. This lack of visibility means a lack of accountability in terms of whether we are meeting the needs of vulnerable babies, and which service, if any, is 'holding the baby'. However, the low number of referrals suggests there continues to be an extremely limited service for babies and young children.

The number of babies seen by Children and Adolescent Mental Health Services is very low.



The majority of trusts that take CAMHS referrals for 0–2s only receive between 0–10 referrals a year.

Parent-infant strategies

In England, integrated care systems were formally established in 2022 to join up health and care services and enable system-working across health, social care, early years and education. Some Integrated Care Partnerships cite early intervention as a strategic priority and the Start for Life programme in their joint forward plans.[l, 23]

However, an analysis[24] of ICS strategies has found, there is wide variation in how the needs of babies and children are considered, and this can lead to variation in the related delivery plans. Start for Life areas are expected to develop a local perinatal and parent-infant relationship strategy.

l. DHSC should consider how babies, children and young people with major and long-term conditions should be more clearly considered in updated ICP strategies and ICB JFPs.

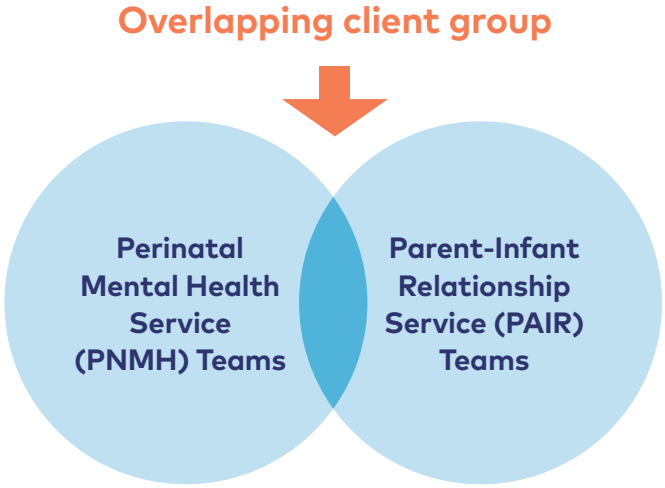
Although 17 teams cite the Integrated Care Board as their commissioner, system-level plans rarely mention infant mental health, parent-infant relationship services or teams. The result is a patchwork of provision in different parts of England.

4.6 Parent-infant relationship support within perinatal mental health teams

Over the last decade, there has been a growth in the number of perinatal mental health teams in the UK. The primary purpose of these services has been to support the mental health of mothers. In the last few years there has been an increase in parent-infant relationship support offered within perinatal services.

However, we estimate that only between 10% and 30% of families in need of parent-infant relationship support will be eligible for support from a perinatal mental health team. The Birmingham Women's Hospital (2022) Nurturing our Future estimates 10% of babies in need of parent-infant support are eligible through PNMH. This is because maternal mental health is only one of the causes of parent-infant relationship difficulties.

Furthermore, only women with moderate to severe mental health needs are likely to meet thresholds for perinatal services.



This means that, although perinatal teams are addressing some unmet need, most vulnerable babies will not be eligible for support from these services.

4.7 Service offers for babies and young children in other sectors

Other parent-infant service offers have also developed in some areas, with a range of delivery models. The catalysts for this varies according to location. In England, the Start for Life programme has driven developments, alongside the move for some CAMHS services to develop their 0–5 offer. In Scotland, the rollout of infant mental health services has been the main driver. Many of these services are also part of our Parent-Infant Network.[m]

4.8 The inconsistency and insufficiency of the offer for babies and families

Parent-infant teams vary in size and offer different intensities of interventions to the populations they serve; provision of other parent-infant services is inconsistent across the UK. There is therefore a patchwork of offers available to babies and families at different levels of need. Without a parent-infant team in place, or a parent-infant relationship pathway developed across the system, babies and their families are not guaranteed to access the right level of support that meets their individual needs.

It is clear that the reach of parent-infant teams and other parent-infant services combined are only meeting a fraction of the estimated mental health needs of babies and young children across the UK.

Figure 5: The overlapping client groups of perinatal mental health (PNMH) and parent-infant relationship (PAIR) Teams

m. Map of teams and services across the UK.

Policy and Commissioning Recommendations

- **Government investment should be increased, to ensure there are parent-infant teams available to all babies in need across the UK.**
- In England, the next NHS 10 Year Plan to prioritise infant mental health and include measurable targets to ensure the health service meets the needs of vulnerable babies.
- All Integrated Care Systems in England should explicitly consider and address the needs of babies and young children in their strategies and joint forward plans.
- All mental health trusts in England should be responsible for providing a comprehensive service for all children, which includes the 0–2 age range.
- When commissioning mental health services for the 0–5 age group, the specialist and unique nature of a 0–2 service needs to be protected.
- In Scotland, service specification guidance for infant mental health teams should be progressed alongside a continued Scottish government funding commitment and clear strategic plan to assist health boards support existing services, build capacity and expertise.
- In Wales, the Welsh government should commit to the equitable provision of specialised parent-infant relationship teams across all seven regions.
- In Northern Ireland, to build on the aspirations set out in the Infant Mental Health Framework, to include funding commitments to develop services.

Specialised parent-infant relationship teams accept referrals for children aged two and under and their parent(s). Some work from pregnancy, others from birth.

Part three
The work of teams

1 Interventions used by specialised parent-infant relationship teams

Specialised parent-infant relationship teams see families and offer individualised programmes of support to meet their needs drawing on a toolkit of both professional practice and evidence-based programmes.

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

1.1 Therapeutic interventions for families

Specialised parent-infant relationship teams typically offer a range of assessments and therapeutic interventions to respond to the different nature and severity of families' needs. The types of interventions offered by teams also depend on the skills within the team, what programmes they have been trained to deliver, and what they are required to do by their commissioners.

Typically, a team will offer specialist short- or long-term dyadic (or triadic) interventions, working with the baby and parent(s) together, such as parent-infant psychotherapy and/or other specialist formulation-led interventions.[n] Alongside this, they will offer group and individual manualised interventions.[o]

To select the most appropriate intervention, there will typically be an assessment, and the multi-disciplinary team will reflect on the needs of the baby and family to develop a formulation.[p] Working in partnership with the family, a care plan and a package of support will be offered. What makes parent-infant teams unique is how the support they offer is tailored around the needs of each baby and parent-infant relationship referred to them.

n. In formulation-led interventions, therapists draw on theory, insights and observations to set out a hypothesis of why a service user is experiencing particular problems (the formulation), and this informs the support that they provide.
o. Manualised programmes are interventions that are prescribed in a programme manual.
p. Psychological formulation makes sense of a family's difficulties in the context of the relationships, social circumstances, life events and their own understanding of them. A multi-disciplinary team will use the different professional lenses of the team to develop a holistic shared understanding.

The box below describes three commonly used interventions to illustrate the type of support provided to families.

Video interaction guidance involves a practitioner recording video clips of a parent and a baby interacting together. The practitioner then selects clips from the film which they watch with the parent, observing what is happening and identifying strengths to build on. This is typically repeated through a number of sessions.

The Circle of Security Parenting (COS-P) programme is a targeted, attachment-based parenting education programme. It helps parents of children aged four months to six years build positive relationships with their children, and to understand how their own experience of growing up affects their parenting. This is a group programme delivered in eight sessions, using a range of resources such as videos.

Parent-infant psychotherapy is a specialist clinical intervention which focuses on the parent-infant relationship in order to support the baby's development. The therapist works directly with babies and parents and carers to help understand more about the challenges and strengths of their relationship and to find new ways of relating.

Parent-infant psychotherapy considers patterns of relating, often unconscious, which are rooted in the legacy of the parent's earlier childhood or parenting experiences, especially when these experiences have been traumatic. Parent-infant psychotherapy is delivered by practitioners with a specialist training and can be offered postnatally and antenatally in a range of settings.

In the questionnaire we asked teams to choose from a list which interventions they offer and to add any others not on the list. There are at least 37 different interventions being used across teams. Most teams were using at least six different interventions. A full list of interventions used by teams can be found in Annex B.[q]

q. We are developing an interventions toolkit which will be available later in the year on the Parent-Infant Foundation website.

The table below shows the 12 interventions most offered by teams replying to the questionnaire.

The prevalence of different interventions can reflect many things alongside clinical preference. This includes the cost of training and the requirements of delivery, the clinical expertise available in the local the workforce and the needs of the local population.

In some cases, local commissioners or national policy makers might recommend or expect specific interventions to be offered by the team. These drivers can facilitate access to training for some interventions, making it more likely that these will be delivered. For example, nearly 90% of teams offered video interaction guidance (VIG). This is an intervention that all staff can train in, irrespective of their professional background. In addition, in 2023 the Department of Health and Social Care and the Department for Education have provided VIG training for free to practitioners in the 75 Start for Life authorities in England.

We also know anecdotally that some areas have struggled to recruit parent-infant psychotherapists, which will then impact on whether this can be offered in a team.

Figure 6: 12 Interventions most commonly offered by teams, in order of popularity

	Interventions	Number of teams delivering this intervention (n=43)
1	Video Interaction Guidance (VIG)	38
2	Parent-Infant Psychotherapy	31
3	Circle of Security Parenting	29
4	Watch Me Play	22
5	Neonatal Behavioural Assessment Scale (NBAS) and Newborn Behavioural Observation (NBO)	20
6	Watch, Wait and Wonder	19
7	Other specialist formulation-led psychological interventions	18
8	Child-Parent Psychotherapy	13
9	Solihull Approach	8
10	Video Interaction Positive Parenting – Sensitive Discipline (VIPP-SD)	7
11	Incredible Years Baby & Toddler	6
12	Therapeutic Baby Massage and Baby Yoga	4

1.2 Evidence base of interventions offered

The interventions commonly used by parent-infant teams have a growing evidence base for supporting babies and their families, with several examples cited in the box below.

Parent-infant psychotherapy

A systematic review of international evidence examined the effectiveness of psychoanalytic, psychodynamically informed and attachment-based interventions for babies and young children. The review suggests that psychodynamic and psychoanalytic interventions, including parent-infant psychotherapy, have a positive impact on babies and families including improving infant attachment and emotional wellbeing, parental depression and reflective functioning.[25]

The findings also suggest that parent-infant psychotherapy is effective for families with high levels of complexity and need, including socially disadvantaged groups.

Video feedback approaches

A Cochrane systematic review found that video feedback including video interaction guidance (VIG) appears to be an effective method for improving parental sensitivity. The findings suggest that video feedback approaches can be provided to parents and babies with wide-ranging challenges and in many settings.[26]

There is good evidence that attachment-based interventions work for young children at risk of or experiencing severe attachment difficulties.[27,28] Local research and service evaluations of parent-infant teams show the positive impact of interventions and clinical outcomes on local populations and incorporate a wide range of perspectives, including the experiences of families and practitioners.[29]

The evidence base is growing with new research in the pipeline; NHS England has commissioned a review of the evidence of what works to support early years mental health and parent-child interaction.

However, there remain gaps between research and practice. For example, many of the interventions used in parent-infant teams are highly valued by families and practitioners, but they have not been subject to randomised controlled trials in the UK. That does not mean these methods are ineffective, rather it indicates that more or different types of research are needed to strengthen the evidence base. Drawing on a diverse range of knowledge and evidence can build a stronger picture of what works for whom and in what contexts, which will ultimately improve outcomes for babies.

'Currently, practice is not following research, and research is not being done to properly evaluate current practice. We need to improve the evidence and the way it links to practice.'[30]

The *Early Intervention Foundation Guidebook* (EIF)features some of the interventions used by parent-infant teams. However, many interventions have either not yet been assessed or have not yet conducted an evaluation of the intervention to be able to submit it for inclusion to the Guidebook. Video interaction guidance (VIG), for instance, is not in the Guidebook but is recommended for use by the National Institute for Health and Care Excellence (NICE) and the 2019 Cochrane Review. A manualised version of infant-parent psychotherapy (IPP), which is mainly delivered in the USA, is included in the EIF Guidebook and is shown to improve outcomes for young children and achieves a Level 3+ evidence rating. The EIF Guidebook, at time of writing, is due to be updated.

In addition to some of the more commonly used interventions, some teams also used some newer interventions. For example, the Blackpool PaIRS team reported that they were trained by Art from the Start (which is run by an art psychotherapist) in using art and creative methods as a vehicle to support and explore parent-infant relationships.

Families describe how the positive impact of parent-infant teams extends beyond the direct clinical interventions they are offered. Families feel helped by the ways teams engage with them through care planning and joining-up the wider system.[31] Therefore, future research could explore how parent-infant teams work with families and the wider system.

Recommendation

- **Further research into parent-infant relationship interventions**

  Further research is needed to develop the evidence base for interventions that are most used by parent-infant teams in the UK.

1.3 Parent-focused interventions

In addition to offering relationship-focused interventions, a third of teams also offer some form of therapeutic support for parents to support their own mental health in ways which will help them to engage with and benefit from other interventions which support the parent-infant relationship.

For example, five teams offer compassion-focused therapy (CFT). CFT is a form of psychotherapy, which was developed for people who have mental health problems primarily linked to high shame and self-criticism, which can make it hard for them to engage in traditional therapy. CFT helps people to develop a more compassionate 'inner voice'.

Some parent-infant teams offer parent-focused interventions even when there is a perinatal mental health team in their local area. For example, if a parent or carer does not meet the threshold for a secondary mental health service, **Little Minds Matter: Bradford Infant Mental Health Service** offers adult interventions such as EMDR (Eye Movement Desensitising and Reprocessing) Therapy, Cognitive Analytic Therapy and Family Therapy.

2 Influencing and shaping the early years system through wider indirect work

Parent-infant teams are experts and champions. They use their expertise to help other local professionals who work with babies, young children and families to understand and support all parent-infant relationships and to identify issues where they occur and take the appropriate action.

This happens through offering training, consultation and/or supervision to other professionals and advice to system leaders and commissioners.

This element of parent-infant teams' work exemplifies a move away from a model where specialist services only work with families with the highest level of need to one where specialist expertise is deployed across a system to benefit all families, although it is most intensively used where need is highest. This has been described as the 'two triangle model', as illustrated Figure 7.[32] In this model, specialists are working most intensively and directly with families with most need, but they work right across the system, building capacity and bringing their expertise to benefit families with low and medium levels of need.

This way of working enables parent-infant teams to play a role in ensuring that all babies' and children's needs are identified and supported as early as possible. Teams provide training and support to practitioners working at a universal level to build their capacity to promote good outcomes; prevent problems emerging and identify and act on any issues that do arise. Parent-infant teams also provide support, such as supervision and consultation, to professionals working with families with increasing levels of need. In addition, some may also provide joint appointments or offer families some time-limited additional support, such as group interventions.

The two triangle model of support also helps local systems move away from a deficit-focused, late-intervention model to enable more prevention and early intervention. The quality of universal and targeted services should improve as a result of receiving additional support from specialists, and this should mean that babies and young children get timely support before issues become entrenched or escalate. This model also helps to embed a shared understanding and common approaches across different services in a local area.

Figure 7: The two triangle model of specialist support

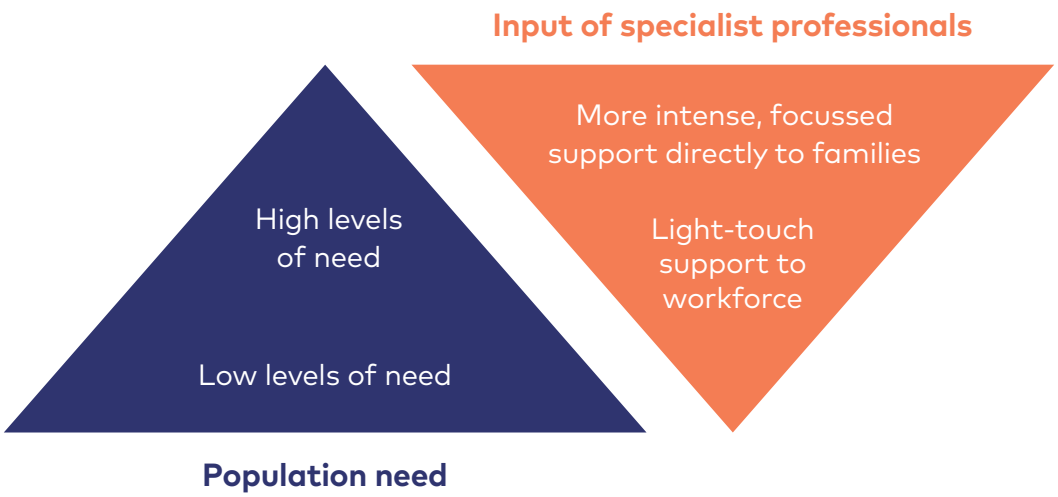
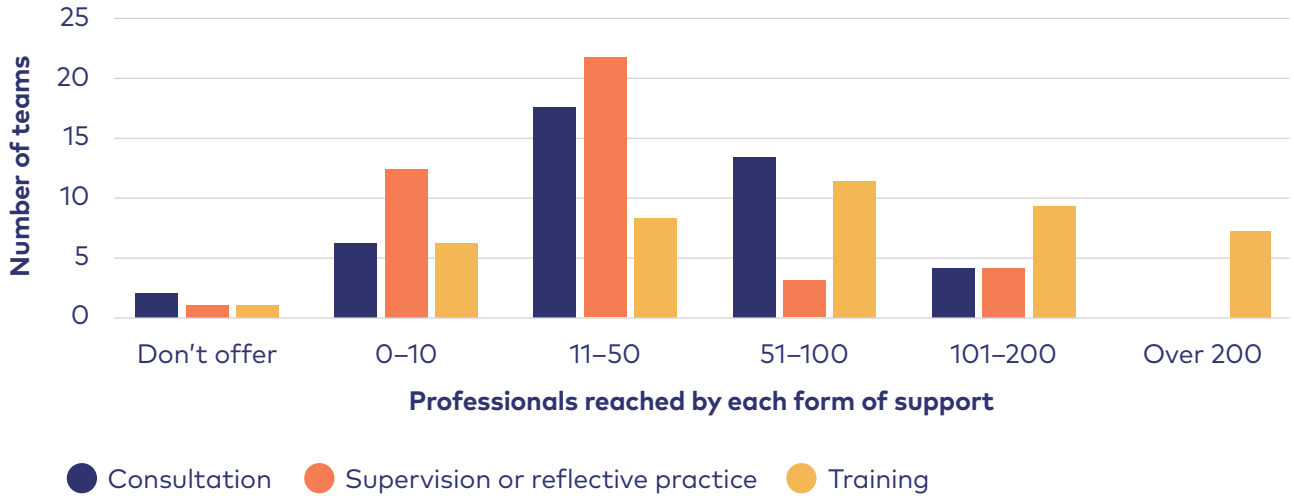


Figure 8: Graph to show the number of professionals reached by indirect support from parent-infant teams



2.1 The extent of 'wider indirect' work done by parent-infant teams

The results from the questionnaire showed that all teams do some form of indirect work across their local system. Of the 43 teams who provided data, 41 (95%) offer consultation, 42 (98%) offer supervision and 42 (98%) offer training.

Teams were asked how many professionals they reached in their training, consultancy and supervision offers. The distribution is shown below. It shows, perhaps unsurprisingly, that training reaches more people, compared to supervision and consultation.

Based on these figures, it is estimated that collectively over the last year, teams offered consultancy to over 2,000 professionals, supervision to over 1,500 and training to over 40,000. This means they improved the services provided to hundreds of thousands of babies. Health visitors, for example, generally have upwards of 250 children on their caseloads, so training 100 health visitors could influence services provided to 25,000 children.

Collaboration is not just with public services, many teams reported working with, training, consulting and co-delivering services with voluntary sector partners too.

'We offer a specialist parent infant group intervention in partnership with Local Authority staff. We attend ante-natal and other community events to raise awareness of Parent Infant Mental Health. We offer consultation to neonatal; early years staff and other professionals who work with parents and infants.'

Gwent Parent-Infant Mental Health Service

For further good practice examples of work with the wider early years system see:

Appendix C: Little Minds Matter in Bradford: Offering training and consultation to the wider system.

Appendix D: The Lambeth PAIRS team: Reflective Supervision offer to the wider workforce

Recommendation

- **Demonstrate the value of wider indirect work with the system supporting practitioners**

  The impact of the 'wider indirect' work in the system should be collected and reported to commissioners as a way of demonstrating its value and impact on babies.

3 Staffing of parent-infant teams

Specialist parent-infant relationship teams are ideally multi-disciplinary teams that include highly skilled mental health professionals, such as clinical psychologists and child psychotherapists, with expertise in infant and parent mental health and in supporting and strengthening the important relationships between babies and their parents or carers.

3.1 The mix of skills and professionals in teams

All specialised parent-infant relationship teams are multi-disciplinary teams that include highly skilled mental health professionals such as clinical psychologists and child psychotherapists.

All team members, whatever their professional background, will have expertise in infant and parent mental health and strengthening the relationships between babies and their parents or carers. This expertise is typically captured in the sector through the AIM-UK competency framework, with parent-infant team members expected to have attained competency levels 2 or 3. However there is no NHS infant mental health competency framework in existence.

The multi-disciplinary nature of teams is important because it brings a range of perspectives, insights and skills to enable the team to understand a family's needs, to support care planning and risk management, and to offer babies and families a package of support that is tailored to their needs.

'Our Consultation model [...] is multi-agency and multi-disciplinary – every referral goes through this process, and it ensures multi-agency and ecological working together from the outset – think family!'

Questionnaire answer from Thriving Together team in Cornwall and the Isles of Scilly

When teams are made up of people from different professional backgrounds, it also helps them to engage with different services in their local area. A specialist health visitor on the team, for example, is well-placed to liaise with the local health visiting team to develop referral pathways and offer tailored training and supervision.

Similarly, a midwife can facilitate antenatal referrals, which enable effective early work with families. A social worker can support the parent-infant team in child protection issues and can ensure families engaged with social care services can get access to support, which in some cases can prevent babies entering care.

An example team

The service model set out in Greater Manchester suggests that there should be a team of 7.33 FTE staff serving an area with a population of 280,000.[33] This would be made up of:

- 0.33 FTE x clinical psychologist or child psychotherapist at band 8c (cluster lead)
- 1 x clinical psychologist or child psychotherapist at band 8b
- 3 x parent-infant specialist practitioners (e.g. health visitor, midwife, social worker or another form of therapist or mental health practitioner who has gained specialist expertise)
- 1 x peer supporter or family support worker
- 1 x service manager/admin

The range and number of staff in each team can vary. The lack of national standards or workforce development routes has meant that the workforce has developed organically, with professional development driven by a mix of individual interests and local priorities.

Team composition both shapes and is shaped by the local funding and commissioning arrangements, governance arrangements, the families being targeted and the interventions on offer. We know from our Parent-Infant Network that it can often be difficult to recruit clinicians who are already competent at levels 2 and 3 of the AiMH Competency Framework.

3.2 Levels of skill and responsibility

A defining feature of a parent-infant team is that leadership is provided by a senior or consultant-level clinician who has attained AiMH Level Three competencies.[r] This person is usually but not always, a clinical psychologist or child psychotherapist. This research found that the majority of clinical leads were on a pay scale equivalent to NHS band 8b or 8c.

Most staff in teams are on a pay scale equivalent to NHS band 7 and 8a. All teams, except one, had at least one postholder of band 8a and above and ten teams had more than four members of staff at this level. This data illustrates the high levels of skill and experience within parent-infant teams.

Figure 9 shows the number of staff at each NHS band within teams (this is the number of people, rather than FTE). The questionnaire did not ask about the professional qualifications or competencies of these staff.

3.3 Trainees in the team

More than half of teams include trainees. These include placements for clinicians undertaking professional training as well as those on the Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) Recruit to Train programme for 0–5.

Clinical placements are one of the main ways that the workforce of infant mental health specialists is expanded. Given that most relevant professional trainings do not currently include infant mental health competencies many clinicians obtain these additional competencies either through clinical placements whilst in training, or in post-qualification training or experience.[t]

A guide to NHS banding in a multi-disciplinary team

The NHS workforce is organised into bands which indicate levels of experience, responsibility and pay rates as set out in Agenda for Change.[s] There are nine bands in total, with band 8 divided into four sub-bands.

Midwives typically start at band 5 and health visitors on band 6, with opportunities to progress to higher bands. For example, a Specialist health visitor or senior midwife might be band 7 or higher.

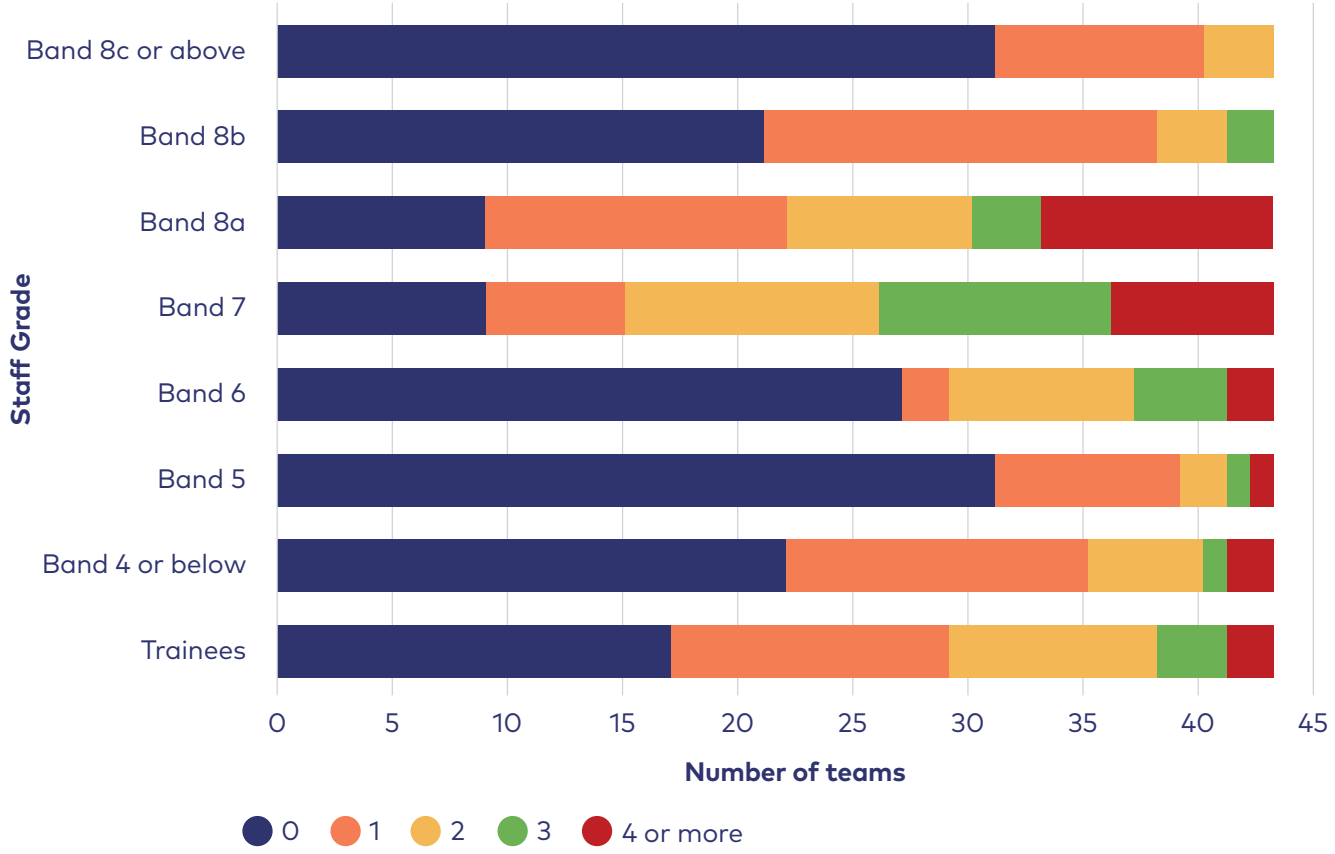
Team managers can range from band 6, 7 to 8a.

Newly qualified clinical psychologists or child psychotherapists start at band 7. Progression to band 8a and 8b often occurs several years post-qualification.

Bands 8c and 8d are consultant-level posts, and band 9 are heads of psychology therapies.

r. https://aimh.uk/wp-content/uploads/2022/11/IMHCF-PDF-Download.pdf
s. https://www.healthcareers.nhs.uk/working-health/working-nhs/nhs-pay-and-benefits/agenda-change-pay-rates
t. With the exception of ACP registered Child and Adolescent Psychotherapists.

Figure 9: Number of teams with different numbers of staff at each grade



'Our trainees to date have been from Clinical Psychology, Child & Adolescent Psychotherapy and Music therapy.'

Clinical Lead, Gwent Parent-Infant Mental Health Service

If half of all parent-infant teams currently have trainees, this also shows that there is capacity within the sector to develop more staff in this way.

One of the main obstacles to parent-infant teams taking trainees is the resource needed to support the placement. Most clinical places do not come with funding, so it can be hard for teams to provide trainees with the supervision and support they need.

Recommendations

- **Develop a parent-infant relationship competency framework**

  Develop a nationally recognised infant mental health or PAIR workforce competency framework based on the Association of Infant Mental Health (AiMH) Competency Framework.

- **Fund clinical placements in parent-infant teams**

  Provide funding for clinical placements in parent-infant teams from relevant professions in order to grow the workforce.

Further recommendations to grow and develop the infant mental health workforce can be found in our 2024 paper which closely examines the parent-infant relationship workforce. **Solutions to Growing the Specialised Parent-Infant Relationship Workforce (2024).**

4 Reaching different groups of vulnerable babies and their families

Specialised parent-infant relationship teams offer direct support for families who need specialised help. This includes targeted work with families experiencing early difficulties whose needs cannot be met by universal services alone, as well as specialist therapeutic work with families experiencing severe, complex and/or enduring difficulties in their early relationships, and where babies' emotional wellbeing and development is particularly at risk.

4.1

The task of reaching the babies and families who need parent-infant relationship support is critical to the work of any parent-infant team. Whilst the indirect work discussed above shows some of the ways these families are reached via the professionals who routinely see them, we also know that many babies and their families will not get the support they need. To ensure vulnerable babies are reached wherever they are, many parent-infant teams have developed strong links with other parts of the system.

'We have a Maternal Mental Health, Perinatal, Neonatal, Midwifery and Parent-Infant Mental Health Steering Group that has been convened to meet monthly.'

Thriving Together, Cornwall

This section looks at some of the ways that parent-infant teams have widened their reach and developed pathways to offer support to different groups of families.

4.2 Antenatal work

The majority of teams support families from pregnancy. All but five teams (38 teams) take antenatal referrals, so will start work in pregnancy rather than only after birth. This underlines that parent-infant relationships begin before birth. Engaging families in the antenatal period can be an effective way to improve parent-infant relationships antenatally and postnatally in high-risk groups.[34,35]

Working with midwives to develop antenatal pathways can improve the early identification of families who need support, enabling support to be offered antenatally or soon after birth.

'The partnership between midwives and PAIRS has led to a significant increase in parent-infant relationship difficulties being supported at the earliest possible stage. Over two thirds of referrals for parent-infant psychotherapy now come in the antenatal period.'

LEAP Lambeth

Antenatal good practice examples

For further examples of how parent-infant teams work antenatally, see:

Appendix E: A strong referral pathway with the continuity of care midwifery team in place in Lambeth

Recommendation

- **Babies should be reached as early as possible, including antenatally**

  Parent-infant relationship difficulties should be identified and supported in pregnancy, and dedicated pathways with midwives and other professionals established.

4.3 Reaching babies in neonatal care

Babies in neonatal care represent some of the most physically vulnerable babies, and the trauma surrounding their birth and postnatal period can put immense stress on parents and impair early relationships. For this reason, many teams have referral pathways specifically for families with babies in neonatal care, offer dedicated support for families in neonatal units, offer consultation and supervision to staff in neonatal units, and/or work strategically to ensure there is joined-up care for these families.

For further examples of good practice in reaching babies in neonatal care, see:

Appendix F: Haringey Parent-Infant Psychology Service (PIPS) working with parents and premature babies

Appendix G: Surrey Parent-Infant Mental Health Service (PIMHS) creating pathway with Psychological Support for Neonatal Units in Surrey

4.4 Reaching families in the child protection system

The needs of babies in the child protection system

Child protection services work with families in which children are at risk of significant harm from neglect or abuse. Typically, this is because there are concerns about parents' ability to care for their children and keep them safe. Babies and young children in the child protection or care system are therefore those who are likely to have experienced the most severe difficulties and disruptions in their early relationships and are most in need of the type of support offered by parent-infant teams.

Babies, children and young people in the child protection and care system require high-quality mental health provision because they have a substantially higher prevalence of mental health problems than other children, often due to their experiences of difficulties at home, and then disruption in subsequent caregiving relationships.[36] Despite efforts to address this, there are still gaps in mental health provision for children of all ages in the child protection system, and where it does exist, mental health support is often not joined up with children's social care services.[37]

The positive impact of working with babies in families engaged with social care

Some parent-infant teams have focused their work on supporting families in the child protection system with the aim of reducing the numbers of babies being taken into care, or to support the reunification of families where possible. In 2015, there was a pilot of a parent-infant team in Norfolk with a specific focus on working with babies on the 'edge of care'.

An evaluation of the service based on 55 families referred in the first year of operation found that 85.4% of the families were enabled to remain or reunite with their child, compared with an estimated 50% edge-of-care cases nationally.[38]

Parent-infant teams and their work with babies in the child protection system

The questionnaire asked teams if they took referrals for babies in the child protection system and for babies who are looked after or adopted. Forty-three teams answered this question. In total, 42 teams would accept referrals for babies where there is a child protection concern (ten of these say they would accept such referrals on a case-by-case basis).

Forty-one would accept referrals for babies in the care system or who are adopted (ten of these say they would accept such referrals on a case-by-case basis).

Some teams do not accept some referrals for families where a baby is on a Child Protection Plan or in care. This can be due to a number of reasons including the nature of their commissioning arrangements. Some teams require adoption or reunification plans to be in place before parent-infant relationship work can begin.

The questionnaire asked teams what percentage of families on their caseload had a baby with a Child Protection Plan. Thirty-seven teams answered this question, and their answers are shown in the Figure 11. The majority of teams who answered this question did support families with a baby on a Child Protection Plan, although for most, these families were a minority of service users.

Some teams who work with children and families in the child protection system, have arrangements in place to facilitate this referral route by liaising with social workers. For example, some teams have specialised social workers in their team to offer support to social workers.

Others participate in pre-birth risk assessment panels to bring their expertise to decisions about what should be done for babies who are known to be at risk of neglect or abuse before they are born.

Figure 10: Number of teams reporting that they would take referrals for care-experienced babies, and those with child protection concern

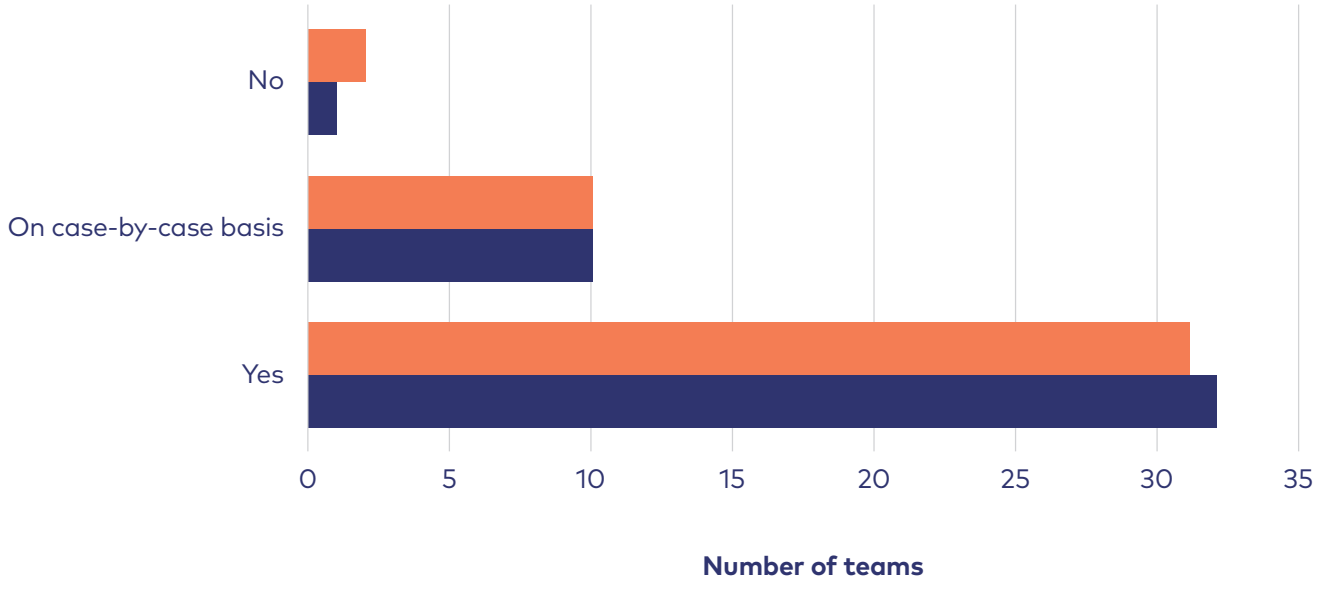
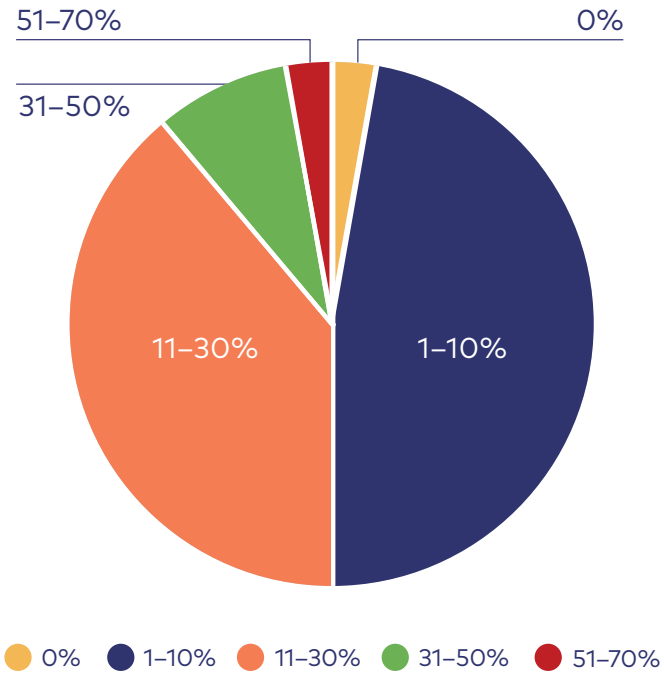


Figure 11: Proportion of caseload where the baby is on a Child Protection Plan (n-37 teams)



For further examples of good practice in working with babies in the child protection system, see:

Appendix H: BABS working in partnership with social care with families in the child protection system

Appendix I: BrightPIP's work with families who have a social worker or who are care leavers themselves

Recommendation

- **Reach vulnerable babies through dedicated pathways**
  Babies in the child protection system should be reached by developing specific pathways in partnership with social care.

4.5 Relationships between parent-infant teams and perinatal mental health

There has been a rapid expansion of specialist perinatal mental health services in the UK in recent years, supported by dedicated funding. Following the publication of new guidance from NHSE in 2023, there has also been an increase in parent-infant relationship support offered within these services.

Consequently, some perinatal mental health teams now have specialist practitioners who work to support early parent-infant relationships. However, this is limited to families where the mother is eligible for perinatal mental health support.

Parent-infant teams have largely benefitted from the development of perinatal mental health teams and the synergies in the work they do. Relationships with perinatal mental health services can be a critical factor in the successful operation of parent-infant teams in local systems.

Around half of parent-infant teams have shared referral pathways with perinatal mental health teams. In some cases, families are allocated to either team depending on which best meets their needs. In other cases, families might be co-worked between the two services, receiving support for both adult mental health needs and parent-infant relationship difficulties. In some places there are staff who work across both services and can share supervision and reflective spaces.

'The Perinatal team host a multi-agency meeting where all services come together to consider the needs of each individual and dyad.' [...]'When thinking about the 'baby blindspot', our service is able to hold the infant in mind, whereas in Perinatal the mothers' needs take priority, this really helps us as two separate services to think about, and be curious about the dyad, therefore demonstrating the importance of joint working.'

Clinical lead, Together with Baby

Figure 12: Relationships with local perinatal mental health services

My team has a shared pathway with the local perinatal mental health team	19
We have a shared reflective space with the local perinatal mental health team	18
We receive referrals for parents with moderate to severe mental health difficulties that are not engaged with the perinatal team	32
We receive substantial referrals from the perinatal team	26

The table above shows how teams currently work with their perinatal mental health service. Teams were given several statements and could select all of those which were relevant to them. A number of teams reported that work is currently underway to improve joint working and develop integrated pathways of care. There are some areas who don't have much contact with perinatal mental health teams and this is an area of practice they would like to develop.

When parent-infant and perinatal mental health teams work collaboratively, clinicians report that more babies and their families are more likely to receive the support they need.

'Services have their own identity but overlap to the greatest possible degree to maximise the effectiveness of the skills available from each service.' Clinician, Greater Manchester

For further examples of good practice in joint working between perinatal mental health and parent-infant teams, see:

Appendix J: Islington Parent and Baby Psychology Service – shared pathway with Perinatal Mental Health Service

Appendix K: Lothian Parent-Infant Relationship Service: Keeping connected and co-delivering.

Appendix L: Together with Baby (Essex) joint working with perinatal mental health and shared digital system

Appendix M: Manchester Greater Manchester Perinatal and Parent-Infant Programme

Recommendation

- **Develop shared pathways between parent-infant and perinatal mental health teams**

  Parent-infant and perinatal mental health teams should develop shared pathways and collaborative working practices, to enable babies to get access to the support most appropriate for their needs.

5 The demographics of babies and their families seen by parent-infant teams

Just as there are differences in the staffing and type of service that teams offer, so there are differences in the numbers of families accessing the service and the demographics of families.

5.1 Siblings and other family members

Some teams work with other members of the family as well as the parent-baby dyad. For example, the SEADS (Specialist Early Attachment and Development Service) in Bradford works with the whole family, including siblings who might be older than the established age range for the service.

5.2 Ethnicity

Teams were asked what proportion of their caseload came from a non-White British background. Their answers ranged from 1% to 86%. Not all teams had data on this and for some it was an estimate or well-educated guess. Teams were then asked how this compared to the make-up of their local population. For those who collected this data, some were reaching the populations mix in their locality, although some were not and given the lack of data collection on this from several teams, it is not possible to get an accurate picture of representation.

However, where there was ethnicity data, the picture was mixed – some teams specifically targeted communities with higher levels of disadvantage and adversity and successfully engaged these communities, and others showed a lack of representation.

5.3 Fathers and other parents or carers

All teams work with mothers and their babies, where mothers are the primary carer. The questionnaire revealed differences in the extent to which services also work with fathers. Teams were asked 'What percentage of your case load in the last year were fathers?' Where data was given, the percentage ranged from 1% to 40%, with an average of 16%.

Only one team said they were only funded to work with mothers. Others did work with fathers, although typically, their work focuses on the mother and baby, with the father engaging to a variable extent in assessments and support. Poor engagement with fathers can be due to:

- societal expectations on families relating to fathers' and mothers' roles and engagement with services influencing parental behaviour
- dads being more likely to be at work and to struggle to make appointments
- dads being less engaged in the family life
- other professionals – such as those in midwifery and perinatal mental health services – being more focused on the mother and so more likely to pick up on her needs and refer her for support
- practitioners' lacking confidence and expertise in engaging fathers

Because fathers were very rarely the sole or primary adult recipient of the service, there was often very little data collected about them and their engagement with the service.

Ten teams had no data at all on dads' engagement. Often this was because either the mother or the baby was the primary recipient of the care, and although dads might attend the service too, they were not recorded as a service user.

For examples of good practice in working with fathers, see:

Appendix N: Dad Matters: A partnership between Greater Manchester Parent-Infant Teams and Home-Start Host

5.4 Same-sex couples

Teams were asked 'What percentage of your case load in the last year were from same-sex families?' Many teams could not provide this information. Where they could, answers ranged between 0% and 5%, which suggests the proportion of same-sex couples is representative of the UK population. (ONS data suggests 0.7% of families are led by a same-sex cohabiting couple.[39])

Recommendations

- **Collect data on underrepresented groups**
  To effectively address the needs of underrepresented groups, (notably fathers, same-sex parents and some ethnic groups), data should be recorded and analysed by services.
- **Develop engagement activities with fathers and other parents or carers**
  Engagement activities with fathers and other co-parents who play a caregiving role for their baby should be developed.

6 The voices of parents and babies

6.1 Parent voices and innovation

The questionnaire asked teams 'Do you involve parents in your service design and development in any way?' Of those that answered, 20 teams reported that they involve parents in their service design and development, and 20 more replied that this work is 'in progress'.

The ways in which teams described working with parents varied. Some had asked parents for user feedback on external facing aspects of the service, such as the name, brand and parent leaflet, but did not seem to have really engaged meaningfully with families about the design and delivery of the service. Other teams had parent voices more ingrained in the operation and decision-making across their service.

A number of parent-infant teams described working with parents in a range of different ways, for example:

- ABC PIP co-produces aspects of its service, such as the name and logo with parents. The team also gave examples of changes driven by parents, for example, they now provide group work because it was requested by parents.
- The Blackpool Parent-Infant Relationship Service (PaIRS) undertook co-production work with parents prior to setting up their team. Parents have also been involved in leaflet and other material design. The team also gave examples of aspects of the service driven by parents, such as establishing a self-referral pathway.
- Bury Early Attachment Service has an expert parents group who meet quarterly and help to steer the service, support recruitment and contribute to pathway/network meetings.
- Thriving Together in Cornwall uses established perinatal peer supporters in all interview panels and service development discussions. Service users from the local Maternity Voices Partnership group attend steering group meetings. The service is setting up focus groups with service users.

For further examples of good practice in co-production see:

Appendix O: Blackpool Parent and Infant Service and Co-production

Recommendation

- **Use co-production methods to help develop services**

  The 'voice of babies' and families should be utilised in co-producing services including targeting those from marginalised groups.

6.2 The voice of the baby

The baby's voice in parent-infant teams

Baby's or infant's voice is a process of giving due consideration to the perspective of the baby and what their 'voice' would be if they could describe their experience. In answer to a question about infant voice on the questionnaire, many teams wrote that babies are at the centre of what they do, and they make efforts to keep the baby's voice/experience in mind in all they do.

Teams gave a number of examples of this:

- The Little Minds Matter team use 'voice of the child' statements in their notes, letters and other communications with other professionals. Babies are also involved in the staff recruitment process.

  'We have introduced a parent-infant panel as part of recruitment, with the parent rating how they experienced the candidate's interactions with both them and their baby, and how they thought their baby experienced the candidate. This is an opportunity for service user involvement and ensuring that the experiences of babies are given a platform to be noticed.'

  Clinical Lead, Little Minds Matter, Bradford

- Oldham Early Attachment Service is trialling a goal-based measure for babies which involves helping parents to identify what their babies' goals might be.
- Lothian PAIRS team reported that the team are all trained in observational tools. This enables them to keep the baby's perspective in mind in reflective practice and in consultation and team meetings.
- Norfolk and Waveney PAIRS uses a variety of observation tools to try to understand the infant's experience and tries to promote the infant's voice in its care plans.
- Fife Infant Mental Health Team uses the Lanarkshire Infant Mental Health Observation Indicator Set and has a voice of the infant template to support observation and language to describe what infants may be conveying.

'We are centred on the baby's experience and this is at the heart of all the work and training that we offer.'

Haringey Parent Infant Psychology Service (PIPS)

6.3 Clinical record keeping and the baby's voice

A related issue is whether clinical records are held in the baby/young child's or parent's name, and how parent-infant teams store records.[u] Most teams hold records in the baby's name, some teams hold records in the parent's name, and many have linked records.[v] These differences are related to where the team sits in the system and what database is used.

If records are held in the child's name, it allows professionals to follow the child through the health and social care system. This is particularly important when there are multiple placements (in the care system) and it gives the child access to this history as an adult. Holding the record in the child's name also allows parent-infant teams to monitor and report on the numbers/ages of the babies and young children being seen. Where records are in the parent's name, it allows multiple children of the same parent to be tracked. Working from the baby's clinical record and linking it to the parent is preferable.

Recommendations

- **Hold the clinical record in the name of the baby**

  Clinical records should be held in the baby's name where possible and linked to the parent or carers record.

- **Bring the 'voice of the baby' to the heart of all work**

  The perspective of the baby should be incorporated into all aspects of policy and practice.

u. This question was not asked directly in the questionnaire, so we are not able to report on numbers.
v. This is more likely when the team is linked to a perinatal team where the mother will be the primary client.

Conclusion

This report showcases the work of specialised parent-infant relationship teams in the UK. It gives valuable detail and examples of the work they do with some of the most vulnerable babies.

The report also shines a light on the gaps in service provision for babies and is a call to action to ensure that all parents and carers are supported to create sensitive, nurturing relationships with their babies to lay the foundation for lifelong mental and physical health.

Annexes

Annex 1
The questionnaire sent to parent – infant teams in 2023

1	Name of team/service
2	Geographical area covered. Please list the local authority and/or health board footprint that you cover.
3	a. Which of the following interventions do you currently use? Select all the interventions used by your team and use the text box below to add any not included in the list below b. Describe below any other interventions used by your team.
4	How many (F/T equivalent) clinical staff do you employ?
5	What band (or equivalent) are your staff employed at?
6	a. Do you have any trainees, and if so, how many? b. Do you have any further detail to add to the above answers?
7	What age range of referral does your team accept?
8	Do you accept: a. Self-referrals b. Referrals for infants where there is a child protection concern? c. Antenatal referrals d. Referrals for babies who are Looked After or Adopted Please add any further details here:
9	a. What percentage of your case load in the last year were from a non-white British background? b. How does this percentage compare to the population mix in your area?
10	What percentage of your case load in the last year were fathers?
11	What percentage of your case load in the last year were from same-sex families?

12	Number of families seen in a recent 12-month period
13	Number of families seen for 3–10 sessions?
14	Number of families seen for more than 10 sessions?
15	Approximately, what percentage of your case load in the 12-month period has included infants on a Child Protection Plan?
16	Do you offer any of the following to the early years workforce? If so, how many practitioners did you reach in the last 12-month period? Consultation Supervision or reflective practice Training Other Any further details to add to the above questions?
17	Does your service do outreach work with other services or groups e.g. neonatal clinics, family hubs, groups in community contexts? Please give further details.
18	Do you involve parents in your service design and development in any way? Please give further details below.
19	Does your service take into account infants' lived experience/the infant voice? Please give further details below.
20	Where is your funding from? Select all that apply. If 'other', please specify
21	Who are the commissioners of your service?
22	Finally, are there any other comments you would like to make about any of the answers you have given? Please also use this space to tell us about any recent changes to your team, e.g. staff/roles.

Annex 2
Parent-infant teams that completed the survey

BrightPIP	Brighton and East Sussex
Parent Infant Relationship Service (PaIRS)	Blackpool
Lothian PAIRS	Midlothian and South Edinburgh City
Islington Parent and Baby Psychology Service	Islington, London
Leeds Infant Mental Health Service	Leeds
Healthy Little Minds – Nottingham City Council	Nottingham City
Plymouth CAMHS Infant Mental Health Pathway	Plymouth
Little Minds Matter: Bradford Infant Mental Health Service	Bradford Local Authority
NHS Lanarkshire Infant Mental Health Team	NHS Lanarkshire
PAIRS/CAMHS	Sheffield Children's NHS Foundation Trust
Bury Early Attachment Service	Bury, Greater Manchester
KCW CAMHS Under 5s Service (Kensington & Chelsea and Westminster)	London Boroughs of Kensington & Chelsea and Westminster
ABC PIP	South Eastern Trust , Northern Ireland
Haringey Parent Infant Psychology Service (PIPS)	London Borough of Haringey
Southwark Under 5s CAMHS	Southwark
Cardiff Parents Plus	Cardiff Local Authority
Infant Mental Health Team	Fife
Stockport Infant Parent Service	Stockport ICB
Enfield Parent Infant Partnership (EPIP)	Enfield
PAIRS	SLAM Lambeth

SEADS (Specialist Early Attachment and Development Service)	Bradford District Care Foundation Trust (Bradford, Airedale, Wharfedale, Craven)
Wee Minds Matter (Infant Mental Health Service)	NHS Greater Glasgow & Clyde (includes Inverclyde and W Dunbartonshire)
Oxford Parent-Infant Project	Oxfordshire
Thriving Together	Cornwall and the Isles of Scilly
Building Attachment & Bonds Service (BABS)	Knowsley, Sefton
Perinatal and Infant Mental Health Team	NHS Highland (North)
PAIRS – Parent and Infant Relationship Service (change of name, was formerly known as Point One 0–4)	Norfolk and Waveney
Gwent Parent Infant Mental Health Service (G-PIMHS)	Aneurin Bevan University Health Board, covering five local authority areas: Torfaen, Newport, Caerphilly, Monmouthshire and Blaenau Gwent
DorPIP	Dorset and surrounding areas
Heywood, Middleton and Rochdale Early Attachment Service	Heywood, Middleton and Rochdale
Liverpool Parent-Baby Service, PSS	Liverpool
Essex Parent Infant Mental Health Service – Together With Baby	Essex – 3 ICBs – North Essex and Suffolk, Mid and South Essex and West Essex and Herts
Parent Infant Mental Health Service	Surrey
Newham CAMHS	London Borough of Newham
Tameside and Glossop Early Attachment Service	Tameside and Glossop
Oldham Early Attachment Service	Oldham
Manchester CAPS PAIRS	Manchester
Bolton Parent and Infant Relationship Service	Bolton
LSCFT SPCMHT Perinatal Mental Health Team	Lancashire and South Cumbria
Baby and Infant Bonding Support	Halton and Warrington
Infant Mental Health Team Gloucestershire	Gloucestershire Healthcare
Wigan Building Attachment and Bonds Support (BABS)	Wigan
Whole Family Team with Perinatal Specialism	London Borough of Camden

Annex 3
Freedom of Information Requests

On 21 March 2024, Freedom of Information requests were sent to the 50 mental health trusts listed on theyworkforyou.com. In response, four of these said that they did not commission CAMHS services, as other arrangements were in place in their area. These were:

- Camden and Islington NwHS Foundation Trust told us that Barnet, Enfield and Haringey Mental Health Foundation Trust would hold the relevant data.
- Essex Partnership University NHS Foundation Trust informed us that North East London NHS Foundation Trust would hold the relevant data.
- Dudley Integrated Health and Care NHS Trust informed us that they did not commission CAMHS services.Whilst they did not provide details of which organisation would hold the data for that area, later research showed that it was Black Country Partnership NHS Foundation Trust.
- Sheffield Health and Social Care Trust informed us that Sheffield Children's Hospital NHS Trust would hold the data for that area.

We had already contacted Barnet, Enfield and Haringey Mental Health Foundation Trust, North East London NHS Foundation Trust, and Black Country Partnership NHS Foundation Trust, but following this information we sent a new FOI request to Sheffield Children's Hospital NHS Trust.

The net result was that we sent FOI requests to 47 NHS Trusts responsible for holding data for commissioning CAMHS services, of which 45 responded.

The FOI asked the following questions:

1. Does your CAMHS service take referrals for children (i) aged 0–12 months, (ii) 12–24 months and (iii) 24–36 months?
2. How many children in each of these age groups were referred to the service in 2022–23?
3. How many children in each of these age groups accessed the service in 2022–23?
4. Overall, how many children aged 0–18 were referred to and accessed the service in 2022–23?

Annex 4
Interventions used by parent-infant teams

Intervention used by parent-infant teams	Number of teams using the intervention	Percentage of teams using the intervention
Video Interaction Guidance (VIG)	36	90%
Parent-Infant Psychotherapy	29	73%
Circle Of Security Parenting	26	65%
Watch Me Play	20	50%
Neonatal Behavioural Assessment Scale (NBAS) and Newborn Behavioural Observation (NBO)	20	50%
Watch, Wait and Wonder	19	48%
Other specialist formulation-led psychological interventions	17	43%
Child-Parent Psychotherapy	13	33%
Solihull Approach	9	23%
Incredible Years Baby & Toddler	7	18%
Video Interaction Positive Parenting – Sensitive Discipline (VIPP-SD)	7	18%
Therapeutic Baby Massage and Baby Yoga	6	15%
Compassion focused therapy	4	10%
Mellow Babies	4	10%
Five to Thrive	3	8%
Infant-Parent Psychotherapy (IPP)	2	5%

Intervention used by parent-infant teams	Number of teams using the intervention	Percentage of teams using the intervention
Dyadic Developmental Psychotherapy	2	5%
EMDR	2	5%
SUSI (Social-emotional Under 5s Screening & Intervention)	2	5%
Systemic psychotherapy	2	5%
Theraplay	2	5%
Attachment Bio-behavioural Catch-Up (ABC)	1	3%
Babies in Our Minds from Early Years	1	3%
Baby Bonding	1	3%
Child-Parent Relationship Therapy (CPRT)	1	3%
CRM (Comprehensive Resource Model)	1	3%
Dyadic Art Psychotherapy	1	3%
Family-based therapy	1	3%
GroBrain Baby	1	3%
Individual Child Psychotherapy for Older Infants	1	3%
Mellow Bumps	1	3%
Parent-Infant Psycho-Education	1	3%
PEEP Antenatal and Learning Together Programmes	1	3%
Psychoanalytic Infant and Young Child Observation	1	3%
Specialist OT interventions, e.g. BUSS (informed)	1	3%
Systemic Thinking and Practice, CAT-informed, Parent-led CBT	1	3%
Family Therapy	1	3%

References

1. First 1001 Days Movement, (2021) Evidence Brief Series https://parentinfantfoundation.org.uk/1001-days/resources/evidence-briefs/
2. National Scientific Council on the Developing Child (2004). *Young Children Develop in an Environment of Relationships: Working Paper No. 1.* Retrieved from www.developingchild.harvard.edu
3. National Scientific Council on the Developing Child (2020). *Connecting the Brain to the Rest of the Body: Early Childhood Development and Lifelong Health Are Deeply Intertwined: Working Paper No. 15.* Retrieved from www.developingchild.harvard.edu
4. Straatmann, V. S., Lai, E., Lange, T., et al (2019). How do early-life factors explain social inequalities in adolescent mental health? Findings from the UK Millennium Cohort Study. *J Epidemiol Community Health*, 73(11), 1049–1060.
5. Center on the Developing Child (2007). *The Impact of Early Adversity on Child Development (InBrief).* Retrieved from www.developingchild.harvard.edu
6. O'Farrelly, C., Watt, H., Babalis, D., Bakermans-Kranenburg, M. J., Barker, B., Byford, S., ... & Ramchandani, P. G. (2021). A brief home-based parenting intervention to reduce behavior problems in young children: a pragmatic randomized clinical trial. *JAMA pediatrics*, 175(6), 567–576.
7. Parent-Infant Foundation (2023) *The impact of parent-infant relationship teams, A summary of the evidence.*
8. Wright, B., Fearon, P., Garside, M., Tsappis, E., Amoah, E., Glaser, D., ... & McHale, M. (2023). Routinely used interventions to improve attachment in infants and young children: a national survey and two systematic reviews. *Health Technology Assessment (Winchester, England)*, 27(2), 1.
9. First 1001 Days Movement, (2021) Evidence Brief Series https://parentinfantfoundation.org.uk/1001-days/resources/evidence-briefs/
10. National Scientific Council on the Developing Child (2004). *Young Children Develop in an Environment of Relationships: Working Paper No. 1.* Retrieved from www.developingchild.harvard.edu
11. Weisleder, A., & Fernald, A. (2013). Talking to children matters: Early language experience strengthens processing and builds vocabulary. *Psychological science*, 24(11), 2143–2152.
12. National Scientific Council on the Developing Child (2004). *Children's Emotional Development Is Built into the Architecture of Their Brains: Working Paper No. 2.* Retrieved from www.developingchild.harvard.edu
13. National Scientific Council on the Developing Child (2020). *Connecting the Brain to the Rest of the Body: Early Childhood Development and Lifelong Health Are Deeply Intertwined: Working Paper No. 15.* Retrieved from www.developingchild.harvard.edu
14. Straatmann, V. S., Lai, E., Lange, T., et al (2019). How do early-life factors explain social inequalities in adolescent mental health? Findings from the UK Millennium Cohort Study. *J Epidemiol Community Health*, 73(11), 1049-1060.
15. Center on the Developing Child (2007). *The Impact of Early Adversity on Child Development (InBrief).* Retrieved from www.developingchild.harvard.edu
16. Lotto, C. R., Altafim, E. R. P., and Linhares, M. B. M. (2023) Maternal history of childhood adversities and later negative parenting: a systematic review. *Trauma, Violence, & Abuse, 24*(2): 662–83.
17. Van Ijzendoorn, M. H., Schuengel, C., Bakermans-Kranenburg, M. J.. Disorganized attachment in early childhood: Meta-analysis of precursors, concomitants, and sequelae. *Development and psychopathology*. 1999 Jun;11(2):225-50. 78.
18. IBID.
19. O'Farrelly, C., Watt, H., Babalis, D., Bakermans-Kranenburg, M. J., Barker, B., Byford, S., ... & Ramchandani, P. G. (2021). A brief home-based parenting intervention to reduce behavior problems in young children: a pragmatic randomized clinical trial. *JAMA pediatrics*, 175(6), 567-576.
20. Parent-Infant Foundation (2023) *The impact of parent-infant relationship teams, A summary of the evidence.*

21. Hogg, S. (2019). *Rare Jewels: Specialised Parent-Infant Relationship Teams in the UK*. PIP-UK https://parentinfantfoundation.org.uk/our-work/campaigning/rare-jewels/
22. HM Government, *Family Hubs and Start for Life programme guide*. August 2022.
23. IBID.
24. Children and Young People's Health Policy Influencing Group. *Integrated Care Systems and the health needs of babies, children and young people*. https://www.ncb.org.uk/sites/default/files/uploads/attachments/HPIG%20ICS%20report%20-%2031.01.2024.pdf
25. Sleed, M., Li, E. T., Vainieri, I., & Midgley, N. (2023). The Evidence-Base for Psychodynamic Interventions with Children Under 5 Years of Age and Their Caregivers: A Systematic Review and Meta-Analysis. *Journal of Infant, Child, and Adolescent Psychotherapy*, 22(3), 179–214. https://doi.org/10.1080/15289168.2023.2223739
26. O'Hara, L., Smith, E. R., Barlow, J., Livingstone, N., Herath, N. I. N. S., Wei, Y., Spreckelsen, T. F., Macdonald, G., Video feedback for parental sensitivity and attachment security in children under five years. *Cochrane Database of Systematic Reviews 2019*, Issue 11. Art. No.: CD012348. DOI: 10.1002/14651858.CD012348.pub2.
27. Wittkowski, A., Crompton, C. & Wan, M. W. Manualised Attachment-Based Interventions for Improving Caregiver-Infant Relationships: A Two-Stage Systematic Review. *Clin Child Fam Psychol Rev* (2024). https://doi.org/10.1007/s10567-024-00497-0
28. Wright, B., Fearon, P., Garside, M., Tsappis, E., Amoah, E., Glaser, D., et al. Routinely used interventions to improve attachment in infants and young children: a national survey and two systematic reviews. *Health Technol Assess* 2023;27(2). https://doi.org/10.3310/IVCN8847
29. Parent-Infant Foundation (2023) *The impact of parent-infant relationship teams: A summary of the evidence*.
30. Wright, B, Fearon, P., Garside, M., Tsappis, E., Amoah, E., Glaser, D,, et al. Routinely used interventions to improve attachment in infants and young children: a national survey and two systematic reviews. *Health Technol Assess* 2023;27(2). https://doi.org/10.3310/IVCN8847
31. Moran, P. M., Coates, R., Ayers, S., Olander, E. K., & Bateson, K. J. (2022). Exploring interprofessional collaboration during the implementation of a parent-infant mental health service: A qualitative study. *Journal of Interprofessional Care*, 37(6), 877–885. https://doi.org/10.1080/13561820.2022.2145274
32. Hogg, S. (2024), Rethinking specialist services: The 'two triangle' model a blog for ISOS Partnership retrieved from https://www.isospartnership.com/blog/two-triangles-model
33. Parent-Infant Foundation (2023) *Solutions to Growing the Specialised Parent-Infant Relationship Workforce*.
34. 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), *Health Care for Women International*, DOI: 10.1080/07399332.2022.2129643.
35. https://story-of-leap.leaplambeth.org.uk/wp-content/uploads/2024/11/PAIRS-evaluation-report-Nov-2024.pdf
36. Sanders, R. (2020) *Care experienced children and young people's mental health, ESSS Outline*, retrieved from https://www.iriss.org.uk/resources/outlines/care-experienced-children-and-young-peoples-mental-health
37. Department for Education (2022), *Independent Review of Children's Social Care: Final Report* by Josh MacAlister.
38. McPherson, S., Andrews, L., Taggart, D., Cox, P., Pratt, R., Smith, V., & Thandi, J. (2018). Evaluating integrative services in edge-of-care work. *Journal of Social Welfare and Family Law*, 40(3), 299-320.
39. ONS (2024) *Families and households in the UK: 2023*, retrieved from https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/families/bulletins/familiesandhouseholds/2023

Appendices

Parent-infant teams within a service for a wider age range

Appendix A

Leeds Infant Mental Health Service – expanding a 0–2 service to include 3–5

The Leeds Infant Mental Health Service (IMHS) is a parent-infant team which is part of Leeds Community Healthcare NHS Trust. It is a citywide service commissioned by the West Yorkshire Integrated Care Board (ICB) and Leeds City Council Public Health Department.

Following targeted funding from the ICB, Leeds IMHS ran a successful year's pilot to expand their service from an established 0–2 service to include an offer for 3–5-year-olds. In doing so they have created connected but distinct offers for the two groups.

The service offer is designed so that around 80% of the direct clinical work is retained within the 0–2 service, but the new 3–5 offer includes:

- Direct clinical work, primarily a three session Understanding Your Toddler (UYT) intervention, led by highly trained and experienced clinicians, to help parents and carers better understand the emotional world of their toddlers
- Consultations with professionals
- Reflective case discussions
- Training for professionals working with this age group

The clinicians implementing UYT were highly trained and experienced, and referrals primarily came through the Public Health Integrated Nursing Service Family Health Workers and the 0–19 Specialist Community Public Health Integrated Nurses.

Findings from the pilot showed reduced feelings of invasion and progress towards goals, suggesting that parents and carers began viewing their toddlers through an emotional rather than behavioural lens. Practitioners observed greater attunement and compassion as carers increasingly named and responded to their toddler's emotions.

The team has now expanded professional consultations to support toddlers experiencing harm, prolonged instability and more complex emotional issues.

Additionally, the service introduced the 'Toddler and Beyond' training, aimed at enhancing practitioners' knowledge of relational-based approaches and equipping the workforce to better promote early childhood mental health.

Parent-infant teams within a service for a wider age range *(continued)*

Appendix B

The Norfolk and Suffolk NHS Foundation Trust PAIRS Team working with infants from 0–4

The Norfolk and Suffolk NHS Foundation Trust PAIRS team work with infants aged 0–4 years and the team includes clinicians with training in play therapy, cognitive analytic therapy (CAT), clinical psychology, parent infant psychotherapy and family therapy.

The team also supports the local workforce to understand and support parent-infant relationships. This involves helping clinicians/practitioners to identify issues around bonding and attachment and, where needed, take appropriate action.

Whilst infants who have a primary mental health presentation, e.g. phobia, trauma or ARFID, are not seen within PAIRS, the team works with a wider system of support to identify a service that best meets their needs.

'Historically we have seen a lack of referrals for under 2s, but we are seeing a change in this trend since starting to provide enhanced liaison with the Family Hub workforce.'

Clinical lead, Norfolk and Waverley PAIRS team

Wider indirect work

Appendix C

Little Minds Matter, Bradford: An offer of training and consultation to the wider system

Bradford Infant Mental Health Service, known as Little Minds Matter (LMM), is a parent-infant team working with infants, their families and associated professional networks from pregnancy to two years. In addition to direct clinical work with families, LMM builds capacity in the wider workforce through training and consultation support to professionals, volunteers and students who support families with babies and young children.

In the last reporting year (2023), almost 300 clinicians and practitioners from the wider workforce accessed their workshops or training around infant mental health. The training helps attendees understand the importance of the first 1001 days and reflect on how to incorporate parent-infant relationship interventions into their work.

LMM also works with professionals involved with babies and their families by supporting them to consider the voice/perspective of the most vulnerable babies. This work is further supported by the involvement of LMM in meetings such as pre-birth panels and child protection core groups. In the last year, 320 consultation sessions were facilitated with professionals.

'I feel like I have a new confidence in my ability to work effectively within parent-infant relationships difficulties. I feel like this is because the session made me feel "heard" and supported.' Professional

Wider indirect work *(continued)*

Appendix D

Reflective Supervision offer to the wider workforce from Lambeth Parent and Infant Relationship Service

The Parent and Infant Relationship Service (PAIRS) in Lambeth is a parent-infant team which supports babies and young children (pre-birth to four years old) and their relationships with carers, practitioners and the wider system. The team is jointly funded by the Local Authority and South London and Maudsley NHS Trust.

As well as offering direct therapeutic support for babies, Lambeth PAIRS influences and shapes the local early years system, bringing visibility to the emotional needs of babies. It does this through offering training, consultation and reflective supervision to the local workforce.

Reflective supervision offer

PAIRS has an extensive offer of reflective supervision for the early years workforce. Practitioners reflect with a specialist parent-infant clinician about babies and families in groups they are running and those on their own caseloads.

The team provides reflective supervision for early intervention health visitors, Baby Steps facilitators, facilitators of Circle of Security Parenting and Together Time groups, and this includes practitioners from the Lambeth Parenting, Better Start and Infant Feeding teams.

The reflective supervision offer builds expertise and capacity for practitioners to support parent-infant relationships and the mental health needs of babies and young children.

'Three year olds throwing temper tantrums would take more attention than the baby just lying quietly in a cot all day, because they're not crying, they're fine, but actually it's about the not crying is a problem in and of itself. So, I think it's definitely been helpful to shift that focus and to think more about the babies, and to bring them more in mind when they would normally get lost...' Practitioner accessing Reflective Supervision

Working antenatally

Appendix E

A strong referral pathway with the continuity of care midwifery team in place in Lambeth Parent and Infant Relationship Service

The Parent and Infant Relationship Service (PAIRS) in Lambeth is a parent-infant team which supports babies and young children (pre-birth to four years old) and their relationships with carers, practitioners and the wider system. The team is jointly funded by the local authority and South London and Maudsley NHS Trust. Lambeth PAIRS has built a strong referral pathway with the continuity of care midwifery team. Through this relationship, midwives are able to identify parent-infant relationship difficulties early on and then consult with the PAIRS team to discuss families and to make referrals.

The partnership between midwives and PAIRS has led to a significant increase in parent-infant relationship difficulties being supported at the earliest possible stage. Over two-thirds of referrals for parent-infant psychotherapy now come in the antenatal period. These referrals are reflective of the diverse community of Lambeth, including Black, Asian and multi-ethnic families.

The trusting relationship that expectant parents have with their midwives means they are more likely to engage with Lambeth PAIRS.

Leap Lambeth

Reaching babies in neonatal care

Appendix F

Haringey Parent-Infant Psychology Service (PIPS) working with parents and premature babies

Haringey PIP service is a long-standing parent-infant team based within Whittington Health Trust that helps parents and carers with infants under two years old and those who are expecting a baby. In the East of Haringey there are high rates of social inequalities, poverty and deprivation and high rates of premature babies. There is a vulnerable population whose early care experiences have been largely medicalised and traumatic, with less thought given to the experience of having a baby who is fragile and needs care from a neonatal intensive care unit (NICU) or special care baby unit (SCBA).

The parent-infant team in Haringey (Haringey PIPS) has developed an offer to these families. The offer includes therapy to parents and premature babies and co-facilitating therapeutic groups alongside health outreach colleagues at ABC Parents (a children's community outreach group for local parents and carers). This therapeutic offer developed from consultations with parents who had given birth to premature babies and required special care.

The experience of intensive care is overwhelming for babies and families who experience profound anxieties in a highly medicalised environment whilst having to manage multiple contacts with health care professionals. This can impact the earliest parent-infant relationships. The therapy offered by Haringey PIPS gives time and space to process these experiences and supports parent-infant relationships to grow.

Reaching babies in the child protection system

Appendix G

Surrey Parent-Infant Mental Health Service (PIMHS) creating pathway with psychological support for neonatal units in Surrey

Surrey parent-infant team is a long-standing team working with families with babies up to one year and sits within the Surrey and Borders Partnership NHS Foundation trust

In 2021 Surrey County Council commissioned the team to provide psychological interventions for babies and their parents on the intensive care neonatal units (NICU) and the special care baby units (SCBU) for the four acute hospitals in Surrey.

The service was led by a consultant child and adolescent psychotherapist and comprised two child psychotherapists (who also worked in the Surrey Parent-Infant Mental Health Service) and one specialist health visitor.

A referral pathway was established so that families could continue to access therapeutic support from PIMHS when they were discharged from the NICU.

The child psychotherapists sometimes work directly with babies on their own, with parents and babies together, and with grandparents and siblings. When a baby is in intensive care, particularly for a prolonged period, close family members may feel profoundly affected and this work can support the development of strong bonds and better outcomes for the baby.

The parent-infant service also supports the wider staff team around the baby and delivers training on listening to the baby and developing observational skills.

One member of staff in special care observed that, as a result of parents and babies working with a child psychotherapist, 'mothers are calmer around baby and babies are also calmer.'

Reaching babies in the child protection system *(continued)*

Appendix H

BABS working in partnership with social care with families in the child protection system

BABS (Building Attachment and Bonds) Parent Infant Mental Health services (PIMHS) supports the most vulnerable parents and babies across Merseyside communities to build good bonds, support attachment relationships and mental health, via its strengths-based and 'psycho-social' model of care.

BABS specialises in reaching and working with the most vulnerable babies, many of whose families are engaged with children's social care.

All children's social care (CSC) teams in the boroughs receive BABS service information and the BABS team work hard to build relationships and trust with social work teams. Parent-infant mental health training is delivered to all CSC staff, and BABS professionals regularly attend safeguarding meetings and contribute to CSC assessments and CSC plans.

All CSC staff who refer families are invited to BABS' multi-disciplinary parent-infant team meetings, and once referrals are accepted, the social worker/referrer has the option of carrying out a joint visit during the early stages of BABS' work.

Pre-birth assessments

BABS also works in partnership with CSC to carry out pre-birth assessments on BABS families. The assessments hold in mind parent and infant mental health, attachment and bonding, ensuring that the system around the family is promoting strengths and safeguarding the parent-infant relationship and mental health, as well as identifying risk.

As a key partner, BABS attend legal gateway meetings as consultants in relation to how children's services can effectively safeguard risk, whilst also safeguarding parent-infant relationships and mental health.

All BABS services have priority pathways for vulnerable parents and babies undergoing pre-birth assessments. BABS Experts by Experience are also an integral part of the delivery model. Experts by Experience are all parents who have lived experience of services.

BABS also offers a partnership model with early help and voluntary sector services across the boroughs.

Reaching babies in the child protection system *(continued)*

Appendix I

BrightPIP's work with families who have a social worker

In 2020, BrightPIP was commissioned by Brighton and Hove Children's Services to offer therapy to vulnerable groups of parents and babies who are open to social work or who are care leavers themselves.

The work is led by a clinical psychologist who is co-located with children's services and includes an offer of direct therapeutic support to care-leaving parents and their babies and working with parents and babies with a social worker. Referrals are via social workers and are reviewed jointly by BrightPIP and the baby team to consider appropriateness, timing and positioning of the work in relation to safeguarding practice.

Work with care leavers

The team also have an offer of consultation to practitioners working with care leavers, alongside other service development activities. This indirect work aims to increase the relevance, accessibility, and safety of BrightPIP to the care leavers group whose shared experiences make approaching professionals for help with their children feel extremely risky.

Perinatal Joint Working

Appendix J

Parent and Baby Psychology Service – shared pathway with Perinatal Mental Health Service

The Islington parent-infant team is part of the Early Years Service, a 0–5 service situated in Islington Community CAMHS. Islington's parent-infant team and perinatal mental health service have been working collaboratively to develop a perinatal mental health pathway and have a commitment to develop strong relationships with each other. They have the following shared structures in place:

Attendance at weekly referral meeting

A member of staff from the parent-infant team attends the weekly specialist perinatal mental health (SPMH) referrals meeting where they have the opportunity to discuss patients/families in common and any referrals that can be made to the respective services.

The meeting is also attended by the designated specialist perinatal practitioners from other services such as health visiting, midwifery and IAPT perinatal leads, which offer further opportunities for liaison, consultation and communication about families who may need additional parent-infant relationship support.

North Central London Perinatal Network meeting

The parent-infant team and perinatal team also come together at the termly North Central London Perinatal Network meeting, which is attended by a wider range of professionals from the five boroughs covered by this area.

Perinatal Joint Working *(continued)*

Appendix K

Lothian Parent-Infant Relationship Service: Keeping connected and co-delivering

Lothian's infant mental health (IMH), maternity and neonatal psychological interventions (MNPI) and perinatal mental health (PNMH) in NHS Lothian sit as a suite of services, each standalone but with different ways of trying to keep them connected.

Strategic and clinical mechanisms that enable this connection include:

A quarterly shared service development forum

At this forum, senior clinicians from each of the services and participants with lived experience discuss overarching themes that need to be held with consistency across the suite.

Twice weekly cross service triage meetings

This is where discussions are held to determine which service will best meet individual family's needs. These discussions ensure that referrals move between services efficiently, forge links and further understanding between each team and ensures babies and their parents receive the appropriate support at the most appropriate time from those clinicians who are best skilled to provide this.

Lothian Parent Infant Relationship Service initially covered South Edinburgh and Midlothian, then expanded to over the whole of Edinburgh City thanks to funding from the Whole Family Wellbeing Fund. The service now works in close collaboration with third sector organisations such as Home-Start Edinburgh and Stepping Stones North Edinburgh to run reflective practice sessions and co-deliver group interventions including Circle of Security.

Lothian PAIRS

Appendix L

Together with Baby (Essex) joint working with perinatal mental health

Together with Baby is a parent-infant team in Essex that works very closely with the local perinatal mental health team. Joint working is promoted through the following:

- A shared clinical lead (the clinical lead for Together with Baby is also the lead clinical psychologist in perinatal).
- A shared digital system for recording notes. This system facilitates joint working between clinicians in both perinatal and parent-infant teams.
- Multi-agency meetings with both services. At these meetings, all services come together to consider the needs of each individual and dyad. Interdisciplinary thinking and discussions have been helpful when thinking about the relational and mental health risks separately but also how they impact on one another.

Perinatal Joint Working *(continued)*

Appendix M

Greater Manchester Perinatal and Parent-Infant Programme

The ten parent-infant services and specialist perinatal service in Greater Manchester prioritise both perinatal and parent-infant mental health and give equal attention to mothers, fathers, parents and babies and their crucial early relationships.

Together, the teams in Manchester designed an ambitious whole system approach model which included specialist targeted services, universal services and voluntary sector services. The services have their own identity but overlap to maximise the effectiveness of the skills available from each service. Through collaborative working there is a shared understanding and a shared language around perinatal and parent infant mental health across the whole system.

The teams have nominated clinical leads for various professions and services within the system who lead, inspire and connect across Greater Manchester. They also have champions who train, share and highlight key areas of perinatal and parent-infant mental health within services.

There is integrated leadership at the Greater Manchester Perinatal Parent-Infant Mental Health (PPIMH) Steering Group and reflective sessions for frontline staff. By sharing and integrating their respective expertise in perinatal and parent-infant mental health services are supported to better understand the distinct needs of parents and babies and work more effectively together.

Greater Manchester Perinatal and Parent-Infant Programme

Reaching Fathers

Appendix N

A partnership between Greater Manchester's parent-infant teams and Home-Start HOST

A partnership between Greater Manchester's parent-infant teams and Home-Starts in GM

Greater Manchester's parent-infant teams work in partnership with Home-Starts across the region to support the delivery of the Dad Matters project, supporting dads with parent-infant relationships in the perinatal period. Using a mixture of clinical input, organisational experience and co-production, the Dad Matters project was designed to reach dads universally in numbers not experienced in other services or projects.

Parent-infant teams in Greater Manchester offer consultation, clinical supervision and whole team reflective practice for the Dad Matters project. A referral pathway between teams means that fathers and babies can access specialist parent-infant relationship interventions such as video interaction guidance, and fathers can access one-to-one peer support.

Dad Matters uses a bespoke questionnaire that was developed with the parent-infant team clinical lead to gain a deeper understanding of dads' knowledge of infant mental health.

Co-Production

Appendix O

Blackpool Parent and Infant Relationship Service (PaIRS) and Co-Production

Blackpool parent-infant team was initially set up with funding from the National Lottery Community Fund 'A Better Start' programme. It is now provided by Blackpool Teaching Hospitals and is expanding into a regionwide hub and spoke service.

Blackpool has a strong ethos of co-production when establishing new services. This recognises the value of babies, parents and carers with lived experience being part of service development and systems change.

From its inception through to the present day, Blackpool's parent-infant team has employed a number of different co-production methods to ensure the needs of the most vulnerable babies and families were at the forefront of all developments:

- Parents and their young children were involved in the recruitment of the parent-infant team.
- Parents and young children designed assets and created an animated film about the work.
- Surveys and focus groups were used to gather the views of people with lived experience of disrupted parent-infant relationships.
- A 'lived experience lead' was recruited to provide ongoing expertise.
- Most recently, the 'voice of the baby' (considering and reflecting on babies' experiences) was used to inform the development of the new parent-infant and early years relationship strategy for Blackpool and the wider area.
- The strategy features several case studies written from the perspective of babies and young children.

Parent-Infant
FOUNDATION

www.parentinfantfoundation.org.uk

Parent-Infant Foundation @ParentInfantFdn @First1001days

Registered Charity 1152082, Company Limited by Guarantee registered in England and Wales No. 08191666.