Sandwell Family Hubs
Helping Families Thrive

Sandwell Metropolitan Borough Council

Research Sandwell
www.researchsandwell.org.uk

Perinatal mental health and parent-infant relationships

needs assessment – Sandwell

2025

For more info contact us on 0121 522 5210
www.sandwellfamilyhubs.com

Project team:

Dr Daniel Lange, Public Health Speciality Trainee
Kimberley Maynard, Family Hubs Programme Officer
Mudassar Dawood, Research and Intelligence Specialist in Public Health
Debbie Crosk, Public Health Information Analyst
Jason Copp, Principal Research and Intelligence Specialist

With supervision of:

Dr Lina Martino, Consultant in Public Health
Dr Rebecca Russel, Consultant in Public Health

Acknowledgments

Every member of staff who contributed by providing quantitative data as well as participating in interviews.

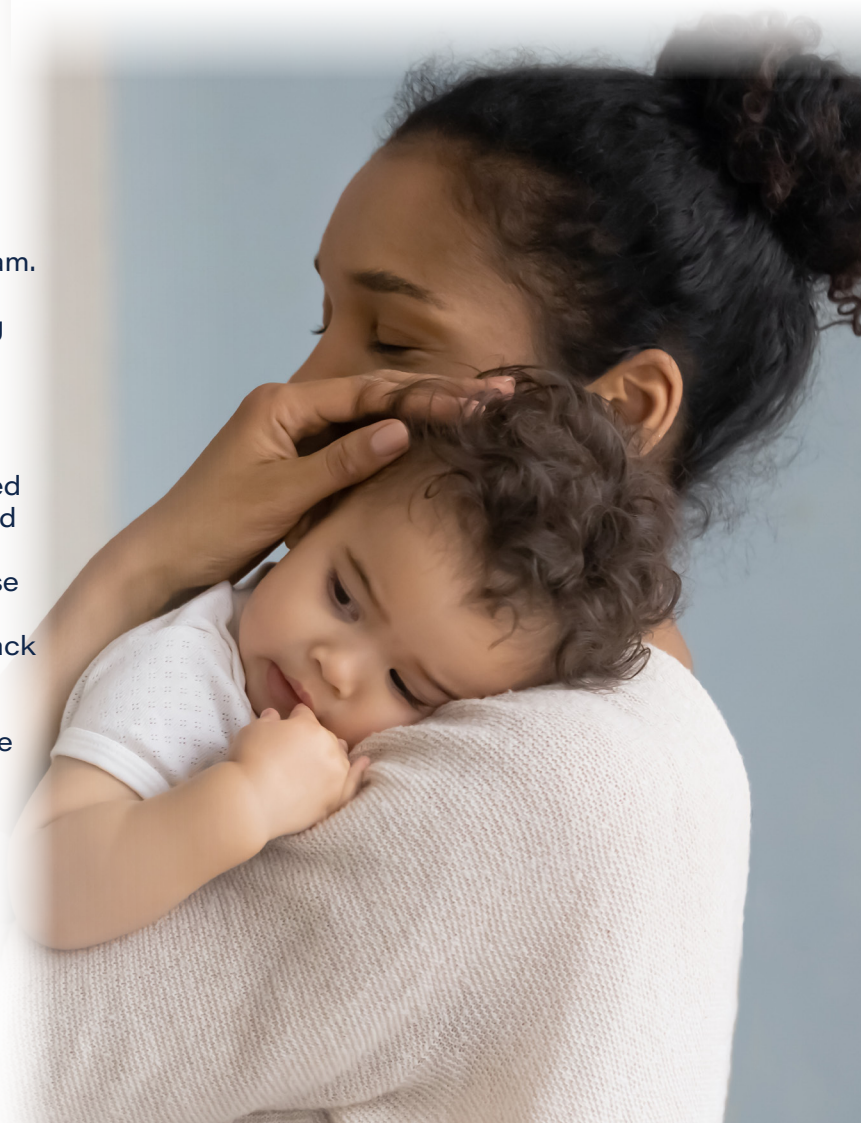
All parents and carers who shared their experiences by participating in discussions and focus groups

Dr Clare Nuttall and Dr Cristina Osborne for providing advice and sharing experiences learnt from conducting a needs assessment of parent infant relationship help and support in Birmingham.

Dr João Martins for providing advice and sharing experiences learnt from conducting a perinatal mental health rapid needs assessment in Wolverhampton.

The Parent-Infant Foundation who have produced extensive resources to guide the assessment and support of parent-infant relationship need. In particular Wook Hamilton for guidance on the use of the parent-infant relationship service demand modelling tool and Ben Yeo for continued feedback throughout this project.

The Dudley Knowledge Services for the literature search performed.



Contents

Project team 2
Contents 3
Language and terminology 4
Executive Summary 5
Recommendations 6
Introduction 7
An overview of parent-infant mental health 8
What is perinatal mental health? 9
What are parent-infant relationships? 10
- Why is this important? 11

Section 1: Understanding the population of Sandwell and its needs
- Local demographics 13
- Population profile 14
- Parent and infant profile 15
- Perinatal and infant vulnerability in Sandwell 19
- A snapshot of Changes activities from Summer 2023 26

Section 2: Perinatal mental health and Parent-Infant relationship support across the system 32
- Service mapping and analysis 33
- Consultation with local practitioners and managers 35
- Brief service presentations 36
- Views and perspectives from service managers and practitioners 39

Section 3: Parents and carers' voices 46
- Mothers with experience of the Perinatal Mental Health Service 48
- Discussion 54
- Recommendations 55
- Limitations 57

Bibliography 58
- Appendix 1 61
- Appendix 2 62
- Appendix 3 64

Language and terminology

Parents	The term "parents" is used to refer to any adult in a parenting role, including foster, adoptive, kinship and stepparents.
First 1001 days	The period from conception to a child's second birthday. This is a critical period in which the building blocks for lifelong emotional and physical health are laid down.
Infant	In this report this term is used to refer to a child in the first 1001 days.
Perinatal mental health	The mental health of parents during pregnancy and the postnatal period.
Infant mental health	Babies' emotional wellbeing and development. It is impacted on by the baby's environment and experiences, which in the case of infants are primarily dependent on their relationship with carers.
Parent-infant relationships	The quality of the relationship established between babies and their parents or carers. Healthy parent-infant relationships foster secure attachments and form the basis for optimal infant mental health and healthy social, emotional and cognitive development.

GP	General Practitioner (Doctor)
OCD	Obsessive Compulsive Disorder
NHS	National Health Service
PTSD	Post Traumatic Stress Disorder
JSNA	Joint Strategic Needs Assessment
ONS	Office for National Statistics (NOMIS is a service provided by ONS)
IDACI	Income Deprivation Affecting Children Index
CIN	Child In Need
UK	United Kingdom
CDC	Child Development Centre
CAMHS	Child & Adolescent Mental Health Service
SEND	Special Educational Needs & Disability
SEMH	Social Emotional Mental Health
OHID	Office of Health Improvement and Disparities
QOF	Quality Outcomes Framework
NICE	National Institute for health Care and Excellence

Executive Summary

The development of a healthy and resilient population is inextricably linked to the mental health, wellbeing, and relationships established by its parents and infants. This report explores Sandwell's needs concerning perinatal mental health and parent-infant relationships, evaluating existing support mechanisms, and assessing their effectiveness in meeting these needs.

Sandwell's predominantly urban and ethnically diverse population is younger and has higher fertility and maternity rates than national averages. The borough faces higher rates of indicators associated with perinatal/infant mental health and parent-infant relationship difficulties, such as unplanned or unwanted pregnancies and neonatal and infant deaths. Families in Sandwell face substantial adversity, with a high proportion of children living in households affected by deprivation and higher prevalence of domestic abuse and substance misuse. Taken together, these data point toward a likely higher need for perinatal mental health and parent-infant relationship support.

Local service data show either increasing perinatal mental health needs or better recognition, but infant mental health support referrals are lower than expected, suggesting under-identification of needs in this population group.

Consultation with representatives from services supporting parents and infants in Sandwell highlighted strengths and limitations in the current support system:

- Partnership working was deemed foundational.
- Poor information sharing, a fragmented system, and strained services due to staffing issues, financial constraints, and complex caseloads. Cultural and language barriers, along with stigma, further hinder access to support.
- Suggestions for improvement included enhancing community engagement, facilitating peer support, investing in preventative measures, and ensuring staff training and continuity of care.
- The significant limitation in current provision for families experiencing complex parent-infant relationship difficulties.

Representatives of parents who had previously contacted perinatal mental health services, and migrant mothers highlighted barriers such as lack of awareness of support available, misconceptions, and stigma. Many parents felt ashamed and hesitant to seek help, with varied experiences when accessing support. Migrant mothers faced additional challenges, including language barriers and cultural taboos.

Recommendations

1. Improve data collection and sharing

- Enhance awareness and evaluation of data collection within local services.
- Develop guidance on data capture and create a joint resource profile for Sandwell.

2. Enhance coordination and access to current services

- Promote regular events for service knowledge sharing and networking.
- Evaluate existing support directories and service accessibility for underrepresented groups.
- Create a whole system pathway for parent-infant relationship support.

3. Strengthen identification and assessment of parent-infant difficulties

- Ensure parents are listened to throughout the perinatal period.
- Ensure the emotional and physical needs of babies and their parent-infant relationships are considered by all practitioners during the perinatal period, including in pregnancy.
- Train the workforce in recognising, screening and assessing perinatal mental health and parent-infant difficulties.
- Train the workforce in recognising, screening and assessing perinatal mental health and parent-infant difficulties.

4. Continue developing universal services

- Ensure timely mandated routine checks and visits to all families.
- Update and disseminate parent-facing literature on perinatal mental health and parent-infant relationships.

5. Consider developing a specialised parent-infant relationship team

- Develop a specialised parent-infant relationship team offering direct interventions to families with complex parent-infant relationship needs and consultation, supervision, training and collaboration for practitioners.
- Ensure the parent-infant relationship team is integrated with the existing system and has secure funding.

6. Advocate for vulnerable groups

- Understand the experiences and needs of vulnerable groups, including babies and young children.
- Include these groups in service co-production and ensure representation in mental health strategies.

7. Raise public awareness

- Co-produce an information campaign with parent/carer and service representatives.
- Address stigma using culturally appropriate language, particularly in communities where mental health is taboo.

While much is already in place to support parents and infants, this report underscores Sandwell's substantial unmet needs in perinatal mental health and, in particular, parent-infant relationships.

Addressing these requires improved data systems, enhanced service coordination, targeted support for vulnerable groups, and increased public awareness, ensuring a well-resourced and specialised support framework.

Introduction

Outline and purpose of this report

This report seeks to give an overview of the mental health of parents/carers and parent-infant relationships from conception to age two in Sandwell. It describes the needs of this population, how they are currently being supported in Sandwell, and how that support can be strengthened in future.

The work that informs this report was undertaken by the Public Health team at Sandwell Metropolitan Borough Council and is intended to inform the operationalisation of the Family Hubs and Start for Life Programme in Sandwell.

Report findings has been structured in three main sections:

Section 1: Understanding the population of Sandwell and its needs

A wide range of local and national data is presented in order to characterise the profile of perinatal mental health and parent-infant relationships in Sandwell.

Section 2: Perinatal mental health and Parent-Infant relationship support across the system

Public and voluntary services supporting Sandwell residents with their perinatal mental health and parent-infant relationship needs are categorised. The views and experiences of representatives from some of these services are also presented in this section.

Section 3: Parents and carer's voices

A sample of Sandwell parents' perspectives on their perinatal mental health and parent-infant relationship needs are explored as well as their experience of receiving support for these.

This is followed by a final discussion section in which findings are summarised and critically appraised, and recommendations made in alignment with these.

This report is by no means an exhaustive analysis of all data available on indicators of perinatal and infant mental health and the support available to families within the first 1001 days in Sandwell. It uses a variety of proxy measures where routinely collected data are not available. Furthermore, data collection and analysis was limited by time and resource constraints in which this project was completed.

An overview of parent-infant mental health in Sandwell from conception to age two.

What is perinatal mental health?

Pregnancy and the transition to parenthood bring about considerable biological and psychosocial changes that are known to be associated with increased symptoms of anxiety, depression and discomfort [1]. Perinatal mental health problems are defined by NHS England as those occurring during pregnancy or in the first year following the birth of a child.

These include, among others, depression, anxiety disorders and postpartum psychosis, maternal obsessive-compulsive disorder and postpartum posttraumatic stress disorder [2]. While some of these are similar in nature, course and potential for relapse as mental health problems occurring at other times, this is not always the case (e.g. there is an increased rate of first presentation and relapse for bipolar disorder in the postnatal period) [3].

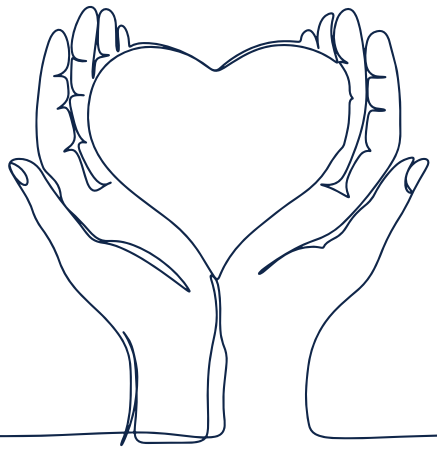
Research into individual risk factors for the various perinatal mental health illnesses is ongoing. Image 1 presents a summary of risk factors for antenatal and postnatal depression adapted from a systematic review on non-psychotic mental disorders in the perinatal period [4] (N.B. while some risk factors are broadly considered to impact most mental health illnesses, this is not always the case).

Social risk factors
▪ Low socioeconomic status ▪ Exposure to trauma, negative life events, and stress ▪ Domestic violence ▪ Migration status ▪ Relationship and social support (e.g. low marital support, marital difficulties) ▪ Reproductive intention
Psychological risk factors
▪ Personal traits: high neuroticism ▪ Prior psychopathology: depression, anxiety, PTSD, substance misuse
Biological risk factors
▪ Age ▪ Genetic and hormonal susceptibility ▪ Chronic diseases ▪ Medical diseases ▪ Pregnancy complications (e.g. preterm birth, low birth weight)

Image 1: Risk factors for antenatal and postnatal depression (Adapted from a systematic review on non-psychotic mental disorders in the perinatal period [4])

Some mental health issues, such as depression and anxiety have been found to affect both potential mothers and fathers [5]. Common mental disorders such as depression and anxiety are known to affect new and expectant mothers and fathers with the prevalence of depression in mothers having been estimated at 11% during pregnancy and 13% in the postnatal period [4], and for fathers 10% and 9% for the same periods respectively [6]. Mental illness during the perinatal period can lead to difficulties in adjustment to parenthood and attachment with the newborn and, when untreated can impact infant's development [7].

Perinatal mental health problems occur during pregnancy or in the first year after birth, including depression, anxiety, and postpartum psychosis.



What are parent-infant relationships?

Infants' wellbeing and development are impacted upon by their environment and experiences, which, in the early stages of life, are primarily determined by relationships established between infants and their caregivers. Image 2 gives an example of what aspects of these relationships might look like at different stages of an infant's development.

Image 2: Examples of being mentally healthy in babies, adapted from: [8]

Parent-infant relationships form the basis of optimal development, infant mental health and the ability to endure the adversities of life [9] [10]. They set a template for later relationships and enable infants to feel safe, enabling them to learn and explore [11]. Where this relationship is negatively impacted, babies' can experience high levels of distress and their emotional and cognitive development can be damaged, as well as having long term effects on their mental and physical health [12]. Parent-Infant Relationship difficulties arise from a variety of causes, including difficulties with conception, complications during pregnancy and delivery, loss of previous babies, intergenerational trauma, developmental delay in babies, parental mental health issues, and the socioeconomic context in which families live [13].

It is important to note that complex parent-infant relationship difficulties may not always be underpinned by severe mental health difficulties in the parent. A report in Birmingham [40] suggests there is a significant gap in provision (over 85%) for families with children under two experiencing the most significant parent-infant relationship difficulties, who are not eligible for a service from the Perinatal Mental Health Service.

Why is this important?

A 2014 UK report [14] placed the long-term cost to society of perinatal depression, anxiety, and psychosis at around £8.1bn for each one-year cohort of births in the UK (equivalent to just under £10,000 for every birth in the country). Three-quarters of this cost relate to adverse impacts on the child, over a fifth (or £2,100 per birth) falls on the public sector.

Treatment of perinatal mental health illness such as psychotropic medication and psychological treatment is known to be effective [15].

Additionally, interventions delivered in the perinatal period have been shown to have a protective effect over parent-infant relationships and positively impact infants' development and socio-emotional outcomes [16]. A 2022 systematic review [17] of the cost-effectiveness of mental health interventions in the perinatal period highlighted that, despite a notable lack of studies on this subject, the limited evidence available points towards good overall value for money.

Parent-infant relationships have been increasingly recognised as a critical shaper of early development [18]. Although a person's life outcomes are not determined by the age of two, several domains are closely linked and impacted on by the emotional wellbeing and relationships established in the earliest years of life [19] [20]. These include education [21] [22] [23], emotional and social skills and mental and physical health [24] [25] [26], capacity to establish trusting relationships, manage emotions and engage in positive behaviour [27] [28] and even future earning [19] and parenting ability [29].

The first 1001 days of life have been identified as a critical opportunity to improve people's health and social wellbeing. As the human brain's capacity to change and adapt throughout life decreases with age, and its sensitivity to learning about emotional regulation varies, not only is it easier to influence a child's development and wellbeing by intervening earlier in life, but late intervention can be too late [30] [31]. Furthermore, there is a strong economic case for investing in early years interventions as they reduce the need for remedial spending on complex interventions and, where difficulties are developed, their seriousness and lessened and responsiveness to less intensive interventions is increased [32] [33].

Despite the importance of perinatal mental health and parent-infant relationships and their far-reaching impact, there is a lack of routinely collected local data to inform our understanding of local need and guide the planning and delivery of supporting services.

Therefore, this report aims to address this gap in knowledge and stimulate further thinking and discussion on how best to meet the mental health and wellbeing needs of Sandwell's parents and infants. This project employs a broad view of the term "mental health", whereby people's emotional wellbeing and capacity to endure the pressures of life are considered, rather than focusing solely on clinically diagnosed cases of mental ill health.

The first 1001 days of life have been identified as a critical opportunity to improve people's health and social wellbeing. Not only is it easier to influence a child's development and wellbeing by intervening earlier in life, but late intervention can be too late.

Section 1: Understanding the population of Sandwell and its needs

Local demographics

Sandwell profile

Sandwell is a metropolitan borough of the West Midlands which comprises of 6 towns (Oldbury, Rowley Regis, Smethwick, Tipton, Wednesbury, and West Bromwich) and 24 wards (Image 3). It is predominantly urban and is surrounded by other conurbations of the Black Country region and Birmingham [34].

Image 3: Map of Sandwell Metropolitan Borough showing wards, towns and surrounding boroughs

Population profile

Compared to England, Sandwell has a relatively young population with under 16s accounting for 22.2% of its population. Average age varies across the borough with Smethwick town having the youngest and fastest growing population of all Sandwell towns. Relative to England, Sandwell has a higher proportion of 0-15- and 25–40-year-olds and less over 60s (Image 4).

Image 4: Percentage in each age group in Sandwell compared with England (2021) (Image source: ONS)

Sandwell's population is growing (21% increase seen since 2001) largely from births and international migration. While the majority of residents are White British (52%), the last decade has seen notable increases in the proportion of non-White ethnic groups (Image 5)

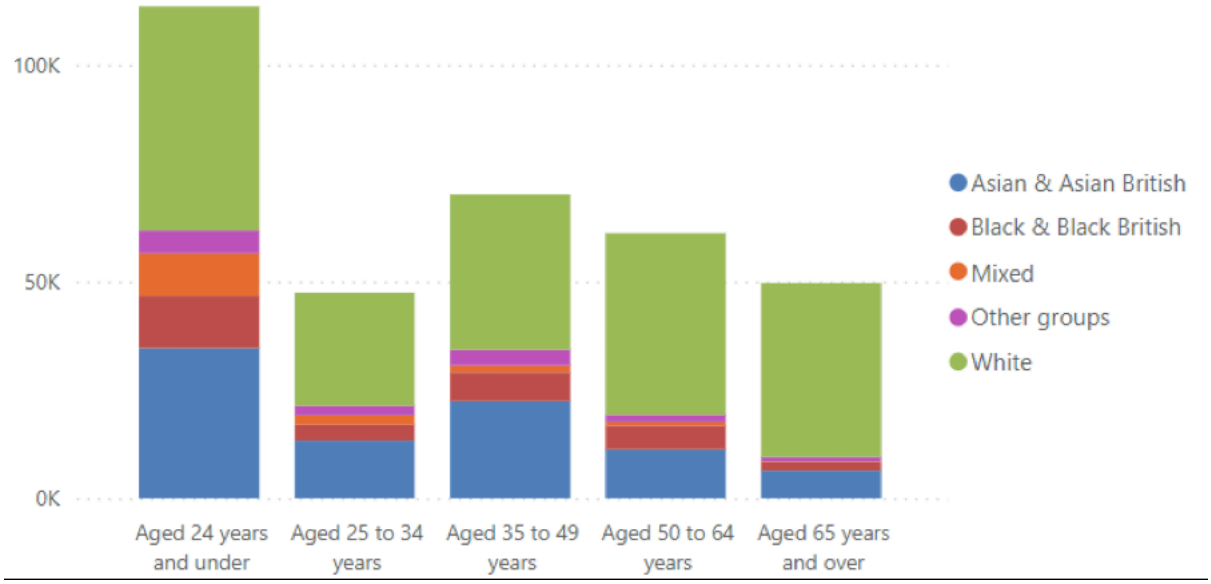


Image 5: Sandwell population by age and broad ethnic group (2021) (Image source: JSNA)

Overall, Sandwell has high levels of deprivation spread across the whole of the borough. It is currently the 12th most deprived local authority of England (out of a total of 317) with 60% of its Lower layer Super Output Areas (LSOAs) within the worst 20% nationally (deciles 1 and 2) (Image 6).

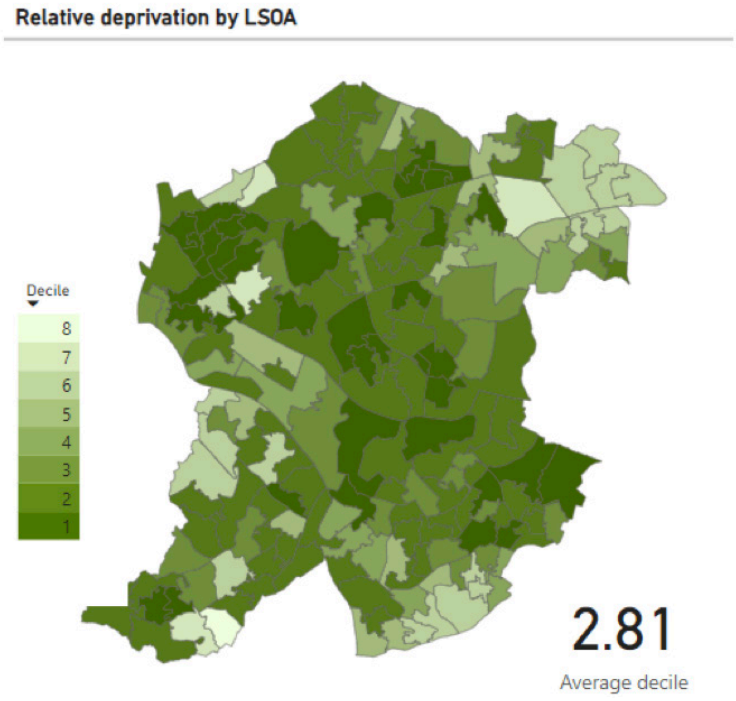


Image 6: Relative deprivation by LSOA for Sandwell (2019)
(Image source: JSNA)

Parent and infant profile

Sandwell has a younger population than the national average. While the proportion of women of childbearing age in Sandwell (20.4%) has remained relatively stable over the last decade, the average age of mothers (29.5 years) has been increasing, similarly to what has been seen in England (19.5% and 30.9 years, respectively).

However, as shown in Table 1, conception (89.6 per 1,000), maternity (60.2 per 1,000) and general fertility (61.7 per 1,000) rates in Sandwell are substantially higher than those seen at a national level. While conception has remained stable in Sandwell over the last years, maternity and fertility rates have been following a downward trend.

Indicator		Sandwell	West Midlands	Parents
Average age of mothers (2021)[1]	Standardised mean age of mothers (years)	29.5	30.3	30.9
Women of childbearing age (2022)[1]	Number of women aged 15-44 years	70,130	1,144,636	11,120,293
	Women aged 15-44 years as a proportion of the total population (%)	20.4	19.0	19.5
Conceptions (2021)[2]	Number of conceptions	6,266	88,073	785,656
	Conception rate per 1,000 women aged 15–44-year-olds	89.6	78.1	71.5
General fertility rate (2022)[3]	Number of live births in a year per 1,000 women aged 15 to 44 years [95% CI]	61.7 [59.9, 63.6]	55.4 [54.9, 55.8]	51.9 [51.8, 52.0]
Total fertility rate (2021)[2]	Average number of live children that a group of women would have if they experienced the age-specific fertility rates throughout their childbearing lifespan	1.79	1.65	1.55
Average age of mothers (2021)1	Number of maternities	4,212	63,308	590,211
	Number of live births	4,212	63,846	595,948
	Maternity rate per 1,000 women aged 15 to 44	4,212	56.1	53.7
Average age of mothers (2021)1	Number of deliveries to women from ethnic minority groups	2,145	17,020	130,598
	Percentage of deliveries to women from ethnic minority groups (%) [95% CI]	53.4 [51.9, 55]	31.1 [30.7, 31.5]	25.3 [25.2, 25.4]

Data sources: 1 – NOMIS, 2 – ONS, 3 – Fingertips

An estimated 2.5% of Sandwell's population is aged under 2, ranging from 1.8% in Bristnall to 3.4% in Soho and Victoria. This figure has been gradually decreasing over the last decade, bringing it closer to the national average (Image 7).

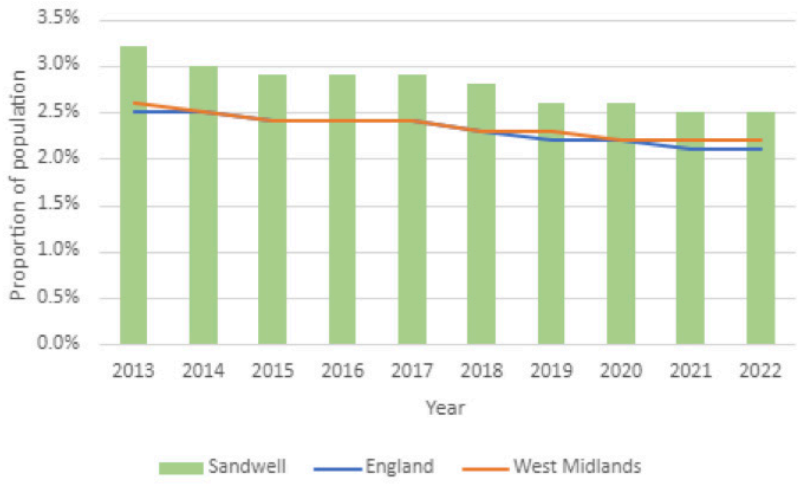


Image 7: Trends in infants as a proportion of the population in Sandwell, the West Midlands and England (2013-2022) (Data source: NOMIS)

The population of children and young people in Sandwell is more ethnically diverse than the older population in the borough and this diversity increases with each cohort of children born. As shown in Table 1 and Image 8, the percentage of deliveries to women from ethnic minorities is considerably higher in Sandwell compared to regional and national figures and has seen an increase in recent years. As of 2021, 60.4% of under 2's in Sandwell had ethnic minority backgrounds, compared with 35.6% in England (Image 9). However, this varies considerably across the borough ranging from 27.3% of under 2's in Rowley having an ethnic minority background and 95.1% in Soho and Victoria.

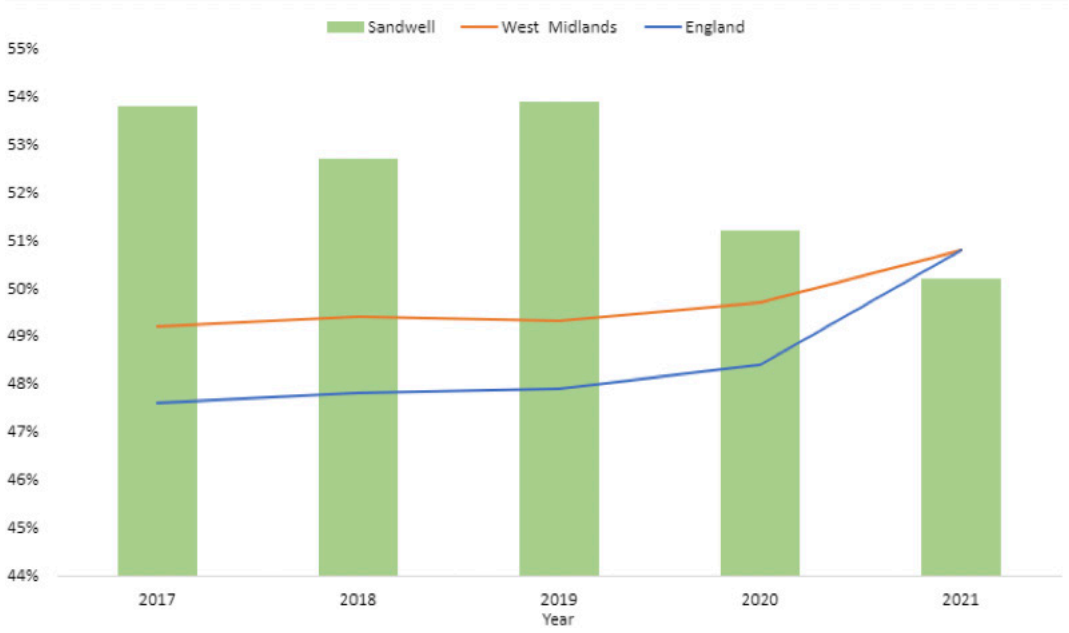


Image 8: Trends in percentage of deliveries to women from ethnic minority groups in Sandwell, the West Midlands and England (2017-2021) (Data source: ONS births)

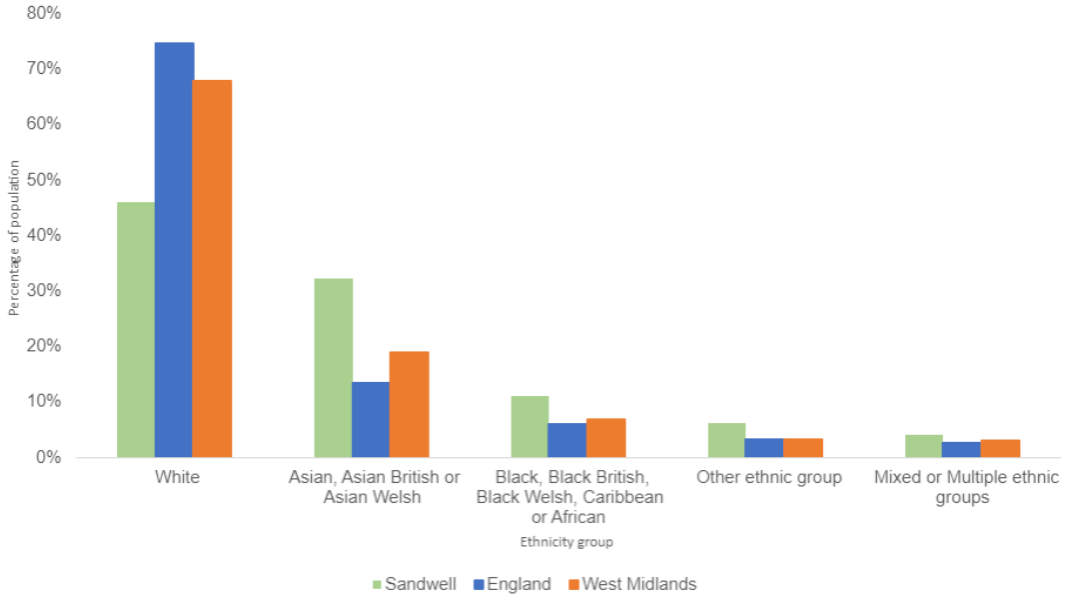


Image 9: 0- to 2-year-olds as a percentage of the population by broad ethnic group for Sandwell, West Midlands and England (2021) (Data source: NOMIS)

Sandwell is also among the local authorities with the highest proportion of children living in income deprived households [35]. Despite some of the wards with the highest infant rates also having higher Income Deprivation Affecting Children Index (IDACI) scores (e.g. Soho and Victoria and Princess End), this pattern is not consistent across the borough. (Image 10). No strong correlation was found between IDACI scores and percentage of infants by ward, most likely due to relatively high IDACI scores across the whole of the borough.

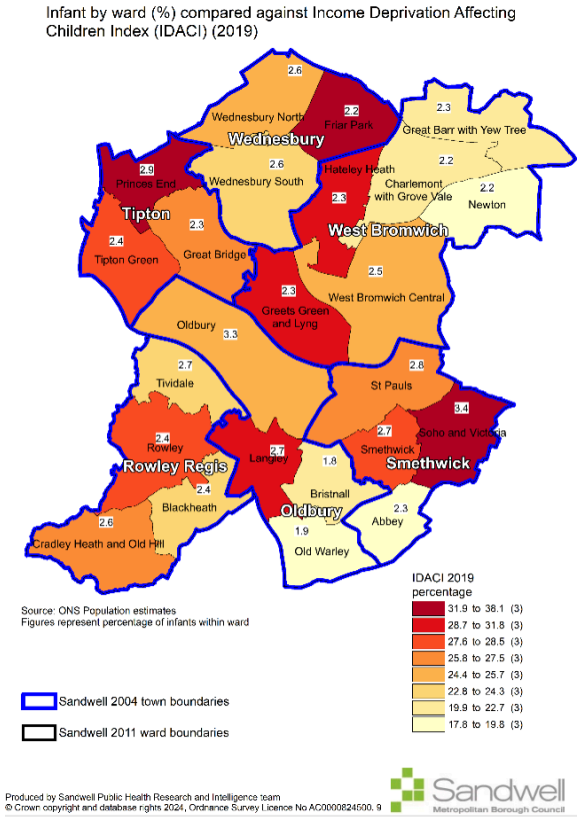


Image 10: Infant rate per 1,000 compared against IDACI by ward in Sandwell (2019) (Data source: ONS)

Unlike national estimates, the rate of infants per 1,000 population in Sandwell is expected to remain constant over the next years, with the number of under 2's rising by 2.6 % in 2031 compared to 2021 (last Census) (Image 11)

Image 11: Projection of infant population in Sandwell, the West Midlands, and England (2021-2031)(Data source: Nomis)

Perinatal and infant vulnerability in Sandwell

Indicators of perinatal mental health and parent infant relationships are often not routinely measured or recorded. Thus, estimating the level of need in these areas can be challenging. A variety of methods have been employed in this report:

- **Analysis of indicators of adversity:** These indicators range from those directly related to pregnancy, birth and physical health of parents and infants, as well as others concerning the context in which these take place. They allow us to build a picture of the context in which parents and infants in Sandwell are living.
- **Analysis of routinely collected data on prevalence of mental health diagnoses:** Some data on mental health diagnoses in general, as well as perinatal mental health diagnoses are routinely collected and are available at a local level. These are analysed here.
- **Analysis of local service data:** Where available, local service data has been used to provide a picture of the need and demand for support for perinatal mental health and parent infant wellbeing.
- **Estimation of local need based on national figures:** National estimates on the prevalence of perinatal mental health issues are available from a variety of sources. These have been applied to the Sandwell population to obtain an estimate of local prevalence of these conditions.
- **Application of Parent Infant Foundation tool for assessment of parent-infant relationship need and demand:** Guidance was sought from the Parent Infant Foundation on modelling of need and demand of parent-infant relationship support. This method is further described later in this report.

Indicators of adversity

There are multiple risk factors for developing perinatal mental health and parent-infant relationship difficulties. The indicators in this section have been chosen as proxies for some of these risk factors and can be used to provide a picture of the context in which people in Sandwell are born, grow up and become parents.

Where possible, links between risk factors and perinatal mental health conditions have been reported, referencing the relevant literature. Several of the risk factors for perinatal mental health issues and parental mental ill health can negatively impact parent-infant relationships.

Pregnancy and maternity risk factors

These risk factors allude to women's general health as well as their reproductive intention, previous pregnancy history, and pregnancy and foetal complications. Table 2 provides a summary of these data for Sandwell, the West Midlands and England, and explains what risk factor it can be considered a proxy for, as well as the perinatal mental health issues it has been associated to.

Women's life expectancy at birth in Sandwell has gradually declined over the last decade, reaching 80.6 years in 2020-2022, compared with 82.8 years nationally.

The rate of conceptions in under 18-year-olds has more than halved over the last decade. However, in Sandwell and the West Midlands, it is higher than what is seen in England (14.1, 15.2 and 13.1 per 1,000, respectively). Approximately half of these pregnancies lead to an abortion, in line with national figures. These indicators can be interpreted as a proxy for unplanned or unwanted pregnancies. While there is a lower percentage of births to mothers over 40-years-old in Sandwell (4.0%), the percentage of birth to mothers under 20-years-old is higher (3.4% in Sandwell compared to 2.2% in England), indicating a higher proportion of first-time mothers and young mothers. There is also a significantly higher percentage of mothers who smoke at the time of delivery in Sandwell (9.8%) compared to England (8.8%). Furthermore, while this percentage has gradually decreased nationally and regionally, in Sandwell it has remained somewhat steady. All these indicators can be associated with risk factors for antenatal depression and anxiety.

Sandwell's rate of premature births, although not significantly different, appears to be higher than the national rate (82.3 and 77.9 per 1,000). However, the percentage of babies born with low birth weight is significantly higher (3.5% in Sandwell and 2.8% in England). These indicators can be associated with risk factors for postnatal depression.

Despite a modest decrease in recent years, neonatal and infant death rates (4.3 and 6.1 per 1,000 live births, respectively) in Sandwell remain substantially higher than national rates (2.8 and 3.9 per 1,000 live births, respectively). Sandwell's rates are in keeping with those seen in the West Midlands region. Both neonatal and infant death can be considered proxies for risk factors associated with postnatal PTSD.

"Indicators of perinatal mental health and parent-infant relationships are often not routinely measured or recorded, making it challenging to estimate the level of need in these areas."

Table 2: Indicators of adversity associated to pregnancy and maternity risk factors for perinatal mental health issues in Sandwell, the West Midlands and England

Indicator		Sandwell	West Midlands	England	Proxy for	Risk factor for
Conceptions, 15-44 years (2021)[1]	Count	6,266	88,073	785,656	Unplanned or unwanted pregnancy	Antenatal depression/ anxiety
	Rate per 1,000	89.6	78.1	71.5		
	Percentage leading to abortion	31.7%	28.2%	26.5%		
Conceptions in <18s (2021)[2]	Count	93	1,587	12,361		
	Rate per 1,000 [95% CI]	14.1 [11.4, 17.2]	15.2 [14.5, 16.0]	13.1 [12.9, 13.3]		
	Percentage leading to abortion (%) [95% CI]	52.7 [42.6, 62.5]	51.4 [49.0, 53.9]	53.4 [52.5, 54.3]		
Abortions (2021)[2]	Total abortion rate per 1,000 female population aged 15-44 years [95% CI]	30.1 [28.8, 31.5]	21.9 [21.6, 22.2]	19.2 [19.2, 19.3]		
Births to mothers aged <20 (2021)[1]	Count	142	1,738	12,928	First-time mother	Post-partum psychosis
	As a percentage of all births (%)	3.4	2.7	2.2	Young age	
Births to mothers aged >40 (2021)[1]	Count	167	2,614	29,517	Older age	Antenatal depression/ anxiety
	As a percentage of all births	4.0%	4.1%	5.0%		
Smokers at time of delivery (2022/2023)[2]	Mothers known to be smokers at time of delivery as a % of all maternities with known smoking status (%) [95% CI]	9.8 [8.9, 10.7]	9.1 [8.9, 9.3]	8.8 [8.7, 8.8]	Current or past smoking	
Multiple births (2021)[2]	Count	38	812	8086	Multiple births	Postnatal depression
	Rate per 1,000 maternities [95% CI]	9 [6.4, 12.4]	12.8 [12, 13.7]	13.7 [13.4, 14]		
Premature births (2019-2021)[2]	Count	1069	16,685	140,031	Preterm birth	
	Rate of stillbirths and premature live births per 1,000 live births and stillbirths [95% CI]	82.3 [77.5, 87.4]	85.9 [84.6, 87.2]	77.9 [77.5, 78.3]		
Low birth weight (2021)[2]	Low birth weight (<2,500g) of term babies as a % of all live births [95% CI]	3.5 [3, 4.2]	3 [2.9, 3.1]	2.8 [2.7, 2.8]	Low birthweight	
Deliveries by CST (2021/2022)[2]	Percentage of deliveries by caesarean section (%) [95% CI]	34.0 [32.6, 35.5]	34.7 [34.3, 35.1]	34.7 [34.5, 34.8]	Pregnancy complications	Postnatal depression
Stillbirths (2020-2022)[2]	Count	76	840	7028	Infant complications	
	Rate per 1,000 maternities [95 Rate of stillbirths for all maternal ages per 1,000 births. [95% CI]% CI]	5.9 [4.6, 7.3]	4.4 [4.1, 4.7]	3.9 [3.8, 4.0]		
Neonatal deaths (2019-2021)[2]	The number of deaths under 28 days, per 1,000 live births [95% CI]	4.3 [3.3, 5.6]	4.3 [4, 4.6]	2.8 [2.8, 2.9]		
Infant deaths	Infant deaths under 1 year of age, per 1,000 live births [95% CI]	6.1 [4.9, 7.6]	5.6 [5.3, 6]	3.9 [3.8, 4]		

1 – ONS, 2 – Fingertips

Social risk factors

As pointed out in the foundational Marmot review [36], the conditions in which people are born, grow, live, work, and age, as well as the inequalities in money, power, and resources they experience, impact on their health outcomes. Indicators discussed in this section represent the effect of wider determinants of health on the mental health and wellbeing of parents in the perinatal period, as well as the relationships they establish with their babies.

The context into which babies are born

As summarised in Table 3, compared to national figures, there is a higher percentage of births in Sandwell to teenage mothers, outside of marriage or civil partnerships, and to non-UK parents. Domestic abuse and homelessness are also greater issues in Sandwell than seen in England. All of these indicators point toward babies in Sandwell being born in contexts of greater adversity for perinatal mental health and the development of parent-infant relationships.

Indicator		Sandwell	West Midlands	England	Proxy for	Risk factor for
Domestic abuse (2020/21-2022/23)[1]	Rate of referrals to Black Country Women's Partnership for domestic abuse-related incidents by population aged 13 and over	1.0%	-	-	History of abuse and domestic violence	Antenatal depression/ anxiety Postnatal depression
Teenage pregnancy (2022/23)[2]	Percentage of delivery episodes, where the mother is aged under 18 years (%) [95% CI]	0.75 [0.50, 1.04]	0.80 [0.73, 0.88]	0.61 [0.58, 0.63]	Unplanned pregnancy	Antenatal depression/ anxiety
Births outside of marriage or civil partnership (2021)[3]	Percentage of live births outside of marriage or civil partnership (%)	52.2	50.8	50.8	Low partner support Marital/relationship difficulties Single marital status	Antenatal depression/ anxiety Postnatal depression Postpartum PTSDa
Births with sole registration (2021)[3]	Percentage of live births outside of marriage or civil partnership recording only the mother's details (%)	7.10	5.90	5.10		
Births to non-UK parents (2017)[2]	Percentage of live births where one or both parents were born in a non-UK country (%)	43.20	-	34.80	Migration status	Postnatal depression
Statutory homelessness (2017/18)[2]	Crude rate of homeless people per 1,000 estimated total households, all age	0.5	-	0.8	Adverse life events and high stress Low social support Low socioeconomic status	Antenatal depression/ anxiety Postnatal depression

Data source: 1 – Family Hubs, 2 – Fingertips, 3 – ONS
[a] low partner support during childbirth only

Table 3: Indicators of adversity associated with social risk factors of perinatal mental health in Sandwell, the West Midlands, and England

The context in which babies and children grow up

The home and family environment in which babies and children grow up, plays a profound role in shaping the relationships they establish with their parents. Table 4 presents the counts and rates of social factors of adversity identified in Child in Need (CIN) assessments in Sandwell. As these figures are derived from data provided by a local partner (Sandwell Children's Trust) it is not possible to directly compare them with national estimates that use differing methodological approaches to measuring these indicators. However, they provide an indication of the frequency with which we can expect to see instances of domestic abuse, mental health, substance misuse and emotional neglect in families with at least one infant or young child in Sandwell.

Table 4: Counts and rates of social factors of adversity mentioned in Child in Need assessments in Sandwell (2024)

Risks mentioned in CIN	Metric	Sandwell
Children in need	Rate per 10,000	10.1
Domestic abuse		
Children aged 0-1 in households where parent suffering domestic abuse (2024) [a]	Count	240
	Rate per 10,000	282.1
Children aged 0-4 in households where parent suffering domestic abuse[a]	Count	510
	Rate per 10,000	230.3
Mental health		
Households with 0–1-year-olds where parent/carer suffers from severe mental health problem[a]	Count	163
	Rate per 10,000	191.6
Households with 0–4-year-olds where parent/carer suffers from severe mental health problem[a]	Count	330
	Rate per 10,000	148.92
Substance misuse		
Children aged 0–1 year living in household where there are concerns around substance misuse[a] [b]	Count	102
	Rate per 10,000	119.9
Children aged 0–4 years living in household where there are concerns around substance misuse[a] [b]	Count	325
	Rate per 10,000	146.66
Toxic trio (parental substance misuse, mental ill health and domestic abuse)		
Children aged 0-1 year in households with all 3 of so called "toxic trio" [a]	Count	84
	Rate per 10,000	37.9
Emotional abuse		
Children aged 0-1 year living in household with emotional abuse[a] [c]	Count	56
	Rate per 10,000	65.82
Children aged 0-4 years living in household with emotional abuse[a] [c]	Count	184
	Rate per 10,000	83.03

[a] Data source: Sandwell Children's Trust. Counts and rates as of May 2024
[b] Child in need (CIN) episodes with substance misuse by a parent/someone else in household identified as a factor at CIN assessment (excluding looked after children)
[c] - Children with emotional abuse identified as a factor at CIN assessment during the year (excluding looked after children)

The home and family environment in which babies and children grow up, plays a profound role in shaping the relationships they establish with their parents. Table 4 presents the counts and rates of social factors of adversity identified in Child in Need (CIN) assessments in Sandwell. As these figures are derived from data provided by a local partner (Sandwell Children's Trust) it is not possible to directly compare them with national estimates that use differing methodological approaches to measuring these indicators. However, they provide an indication of the frequency with which we can expect to see instances of domestic abuse, mental health, substance misuse and emotional neglect in families with at least one infant or young child in Sandwell.

Table 5: Percentile rank score of Sandwell for social factors of adversity

Indicator	Definition	Percentile rank (0=lowest rate)
Emotional abuse (2019)[1]	Children aged 0–1 year in households where parent suffering domestic abuse	9.3
Mental health (2019)[1]	Households with 0–1-year-olds where parent/carer suffers from severe mental health problem	52
Substance misuse (2019)[1]	Children aged 0–1 year living in household where there are concerns around substance misuse	78
Toxic trio (2019)[1]	Children aged 0-1 year in households with all 3 of so called "toxic trio"	88
Emotional abuse (2019)[1]	Children aged 0-1 year living in household with emotional abuse	73
Data source: 1 - Children's Commissioner Report [37]		

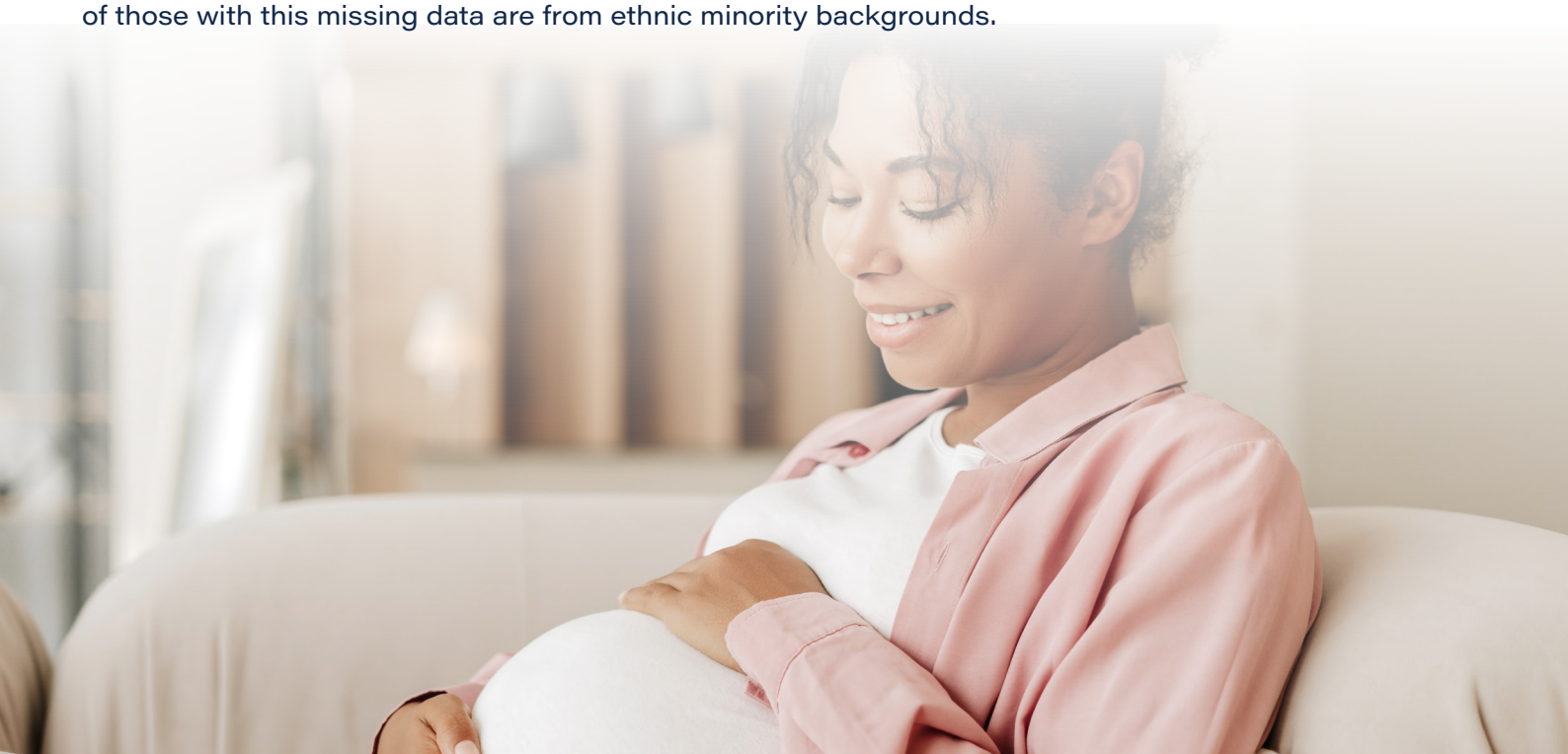
Sandwell appears to have a high count of CIN assessments identifying emotional abuse, substance misuse and the toxic trio, relatively to other local authorities. It is unclear why the inverse is seen for domestic abuse, but data of the last 3 years, provided by the Sandwell Children's Trust show a year-on-year increase in mentions of domestic abuse in CIN assessments. One possible explanation is that, historically, it has not been as reliably identified as some of the other indicators.

Local service data

A few local services were able to provide data on their caseload with regards to perinatal mental health and/or parent-infant relationships. Due to time constraints, data governance restrictions and, in some cases, small numbers of cases and the risk of breaking anonymity, the data available are limited. The following are summary points of some of the services contacted. Descriptions of the scope of some of these services is provided later in the report.

Perinatal mental health service

Image 12 presents a summary of referral data from the perinatal mental health service for the last 3 years, thus allowing us to gain some understanding of the demand for this service within Sandwell. From the data available, the number of referrals received by the service appears to be increasing from year to year. However, analysis over a longer period of time would be necessary to ensure a more accurate description of trends. The age distribution of referrals into the service appears to roughly correspond with the average age of mothers in Sandwell (29.5 years). However, mothers from an ethnic minority background appear to be underrepresented in this sample, in particular, mothers from of Asian ethnicity. A recent evaluation [38] conducted by the perinatal mental health service found that approximately one third of service users did not have ethnicity recorded on their clinical and administrative data. It is possible that a larger proportion of those with this missing data are from ethnic minority backgrounds.



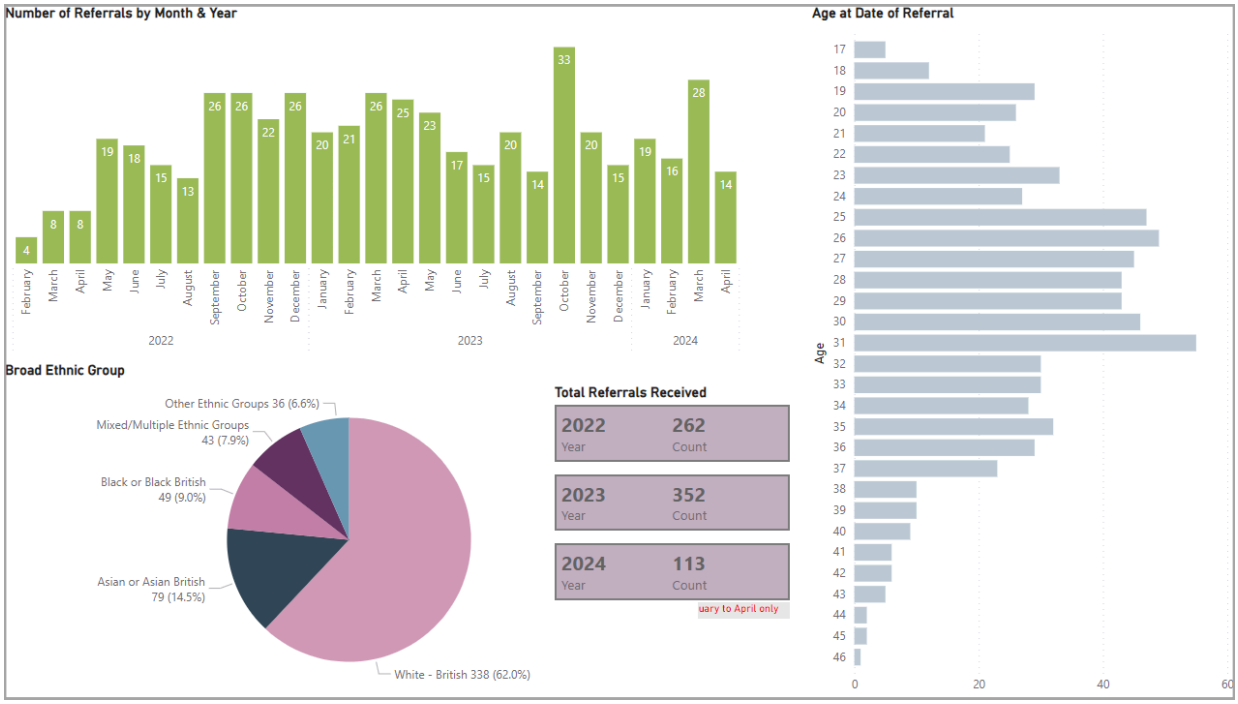


Image 12: Number of referrals received by the perinatal mental health team by date, age and broad ethnic group for Sandwell residents (2022-2024). Note data for 2024 covering only January to April. Sandwell residency determined by patients registered with a GP in Sandwell.

Early years and Child Development Centres (CDC) and Child and Adolescent Mental Health Services (CAHMS)

Data on referrals into this early years CDC detail that there were only 3 cases 2-year-olds-or-under referred with social, emotional, and mental health (SEMH) needs in the last 3 years in Sandwell. It is important to note that this is a special educational needs and disability (SEND) specific service.

As for CAMHS, the NHS service that assesses and treats children and young people 0-18 with moderate to severe mental health difficulties, in the last 12 months, there were only 2 referrals into the Sandwell service for babies in the first 1001 days.

Representatives for both services which cater for children from 0 to 5 years of age commented on how referrals tend to rise for cases in the latter part of this age range. This may point toward emotional and mental health needs of infants not being routinely and reliably identified until they are older.

Changes

Changes is a programme that supports educational and wellbeing activities for families across Sandwell. A summary of educational and wellbeing activities provided through Changes and attendee details is presented in Image 13. These suggest that, while there appears to be demand for this offer, it is attended primarily by women. This may be partly explained by societal trends, such as mother most frequently being the parent who takes a more prolonged period of parental leave.

A snapshot of Changes activities from Summer 2023

Image 13: Number of courses provided, demographic details and user feedback of Changes Sandwell (Summer of 2023).
1 Quotes retrieved from user evaluation forms.

Perinatal mental health

Quality Outcomes Framework (QOF) data indicates that prevalence of mental health diagnoses for all ages in Sandwell does not vary significantly from that observed nationally (1.02% and 1.00% in 2022/23, respectively). Interestingly, as per QOF data, the prevalence of depression in over-18-year-olds in Sandwell (10.9%) appears to be significantly lower than in England (13.2%)

Some routinely collected data on the estimated local numbers and prevalence of perinatal mental health diagnoses have recently become available on the OHID Fingertips dashboard (Table 6). However, these are based on national estimates and do not take into account the impact of wider determinants of health (e.g. socioeconomic factors) or differences in service delivery. As previously mentioned, Sandwell experiences high rates of indicators of adversity for risk factors of perinatal mental health and, therefore, the true prevalence of these conditions in Sandwell is likely to be higher than those calculated from national estimates.

Table 6: Estimates of prevalence of perinatal mental health issues in Sandwell

Indicator	Estimated count for Sandwell (n)	Estimated national rate (per 1,000)
Women with postpartum psychosis (2017/18)1	7	2
Women with chronic serious mental illness in perinatal period (2017/18)1	7	2
Women with severe depressive illness in perinatal period (2017/18)1	107	30
Women with mild-moderate depressive illness and anxiety in perinatal period (2017/18)1	355 (lower estimate)	100 (lower estimate)
	533 (upper estimate)	150 (upper estimate)
Number of women with PTSD in perinatal period (2017/18)1	107	30
Number of women adjustment disorders and distress in perinatal period (2017/18)1	533 (lower estimate)	150 (lower estimate)
	1066 (upper estimate)	300 (upper estimate)
Data source: 1 - Fingertips		

Parent-infant relationships

Given the paucity of routinely collected data on the prevalence of issues concerning infant mental health and parent-infant relationships, there is a need to rely on estimates from published literature as well as experience from those working in the field. Guidance was sought from the Parent Infant Foundation on how best to estimate the level of need and demand for parent infant relationships in Sandwell. The following describes the application of a modelling tool they have developed for this purpose to the Sandwell population. This tool has previously been used to describe population level need in clinical services across the UK (Cwm Taf Morgannwg, Wales [39] and Birmingham Women's and Children NHS Foundation Trust [40]).

Underpinning rationale

International and national research on parent-infant relationship disorders is replete with divergent constructs. However, the concept of "attachment" is the most extensively researched, as well as the one that holds the largest amount of longitudinal evidence to demonstrate lifelong outcomes. While it is far from a perfect measure, it can provide an estimate of parent-infant relationship needs. Furthermore, since it has been used in estimating need in other areas of the UK, its employment in this report will allow for comparison with similar areas (e.g. Birmingham).

Ainsworth and Main described attachment classifications as "secure", "insecure" (a combination of avoidant and ambivalent), and "disorganized". Despite this being a simplification of parents and children's relationships, long-term outcome research largely relies on this framework from the 1970s, allowing us to better understand which types of difficulties are associated with specific later life outcomes [41] [42]. When this approach is used to describe needs at a population level, it aligns well with clinical services, such as the Greater Manchester model of parent-infant mental health services [40]. In what has been described as a "typical research population of white, middle-class families", attachment styles follow the approximate distribution depicted in Image 14.

Secure (around 55–60% of babies)

These babies can reliably seek and receive comfort from their caregivers when stressed. They are typically at the lowest risk of later social, emotional, and behavioural difficulties.

Insecure (around 25–30%)

These babies appear to either manage their own distress by not strongly signalling their needs or are unable to manage their distress and are not soothed when comfort is offered. They often express anger, resistance, or avoid contact with a caregiver after separation. This group has a higher risk of mental health problems at a later point.

Disorganised (around 15%)

This attachment pattern refers to children who, due to unpredictable or hostile care, have not developed a consistent way of relating to their caregiver. They may exhibit unpredictable responses to relationships and care, including being overly familiar, aggressive, showing limited emotion, or persistent emotional dysregulation. These children are at the highest risk of later emotional, social, and behavioural difficulties.

Image 14: Distribution of attachment styles [39]

	International average (white, middle-class population with low average adversity)	**Proposed average for Sandwell** (white, middle-class population with low average adversity)
Secure	55-60% babies	Decreased to 50%
Insecure	25-30% babies	Increased to 30%
Disorganised	15%	Increased to 20%

Children with disorganised attachment, often resulting from unpredictable or hostile care, are at the highest risk of later emotional, social, and behavioural difficulties.

Children facing adversity, including poverty, parental mental health struggles, and substance misuse, are at a higher risk of developing disorganised attachment, with research indicating that around 80% of maltreated children fall into this category (NICE).

Estimated prevalence of attachment styles in Sandwell

Higher levels of adversity, such as family and community affected by racism, poverty, mass unemployment and the trauma of asylum-seeking are associated with higher levels of attachment insecurity and disorganisation. Higher prevalence of disorganised attachment has been described in babies of teenage mothers, low-income households, children of mothers misusing substances/alcohol, and children of depressed parents. According to NICE, about 80% of children who suffer maltreatment are classified as having disorganised attachment [43].

As already highlighted in this report, Sandwell experiences high levels of children living in deprivation, as well as health and social inequalities. It ranks highly in terms of children living in households with parental severe mental illness, parental substance misuse, toxic trio (mental illness, substance misuse and domestic abuse) and emotional abuse.

Therefore, adjustments have been made to the predicted distribution of attachment styles based on a more affluent and less diverse population (Table 7). These adjustments mirror those carried out in Birmingham on a similar piece of work [40].

Estimated prevalence of attachment styles in Sandwell

Observed demand for parent-infant relationship support is expected to be lower than its predicted need. In order to estimate how many families will access support, the following assumptions have been made based on guidance from the Parent-Infant Foundation, which has extensive experience in this area:

- Parents and infants with secure attachments will only require universal support.
- Despite most likely benefiting from targeted/enhanced parent-infant relationship support, only a third of parents and infants with insecure attachments are likely to contact or come to the attention of services.
- Among insecurely attached babies receiving support, those with more severe attachment insecurity are likely to benefit from short-term specialist parent-infant intervention: 8% at a targeted level and 2% at a specialist level.
- Approximately a third of parents and babies with disorganised attachment may be able to make use of and access specialised therapeutic work.

Image 15 depicts the application of these estimates of demand to the population of under 2s in Sandwell while also considering the distribution of attachments previously described. The image highlights that Sandwell could have approximately 612 infants in 2024 in need of direct work from a specialist parent-infant relationship team, some of these will be picked up indirectly through the perinatal mental health team however with only 2 referrals in to CAMHS in 2023 this highlights a significant gap in support.

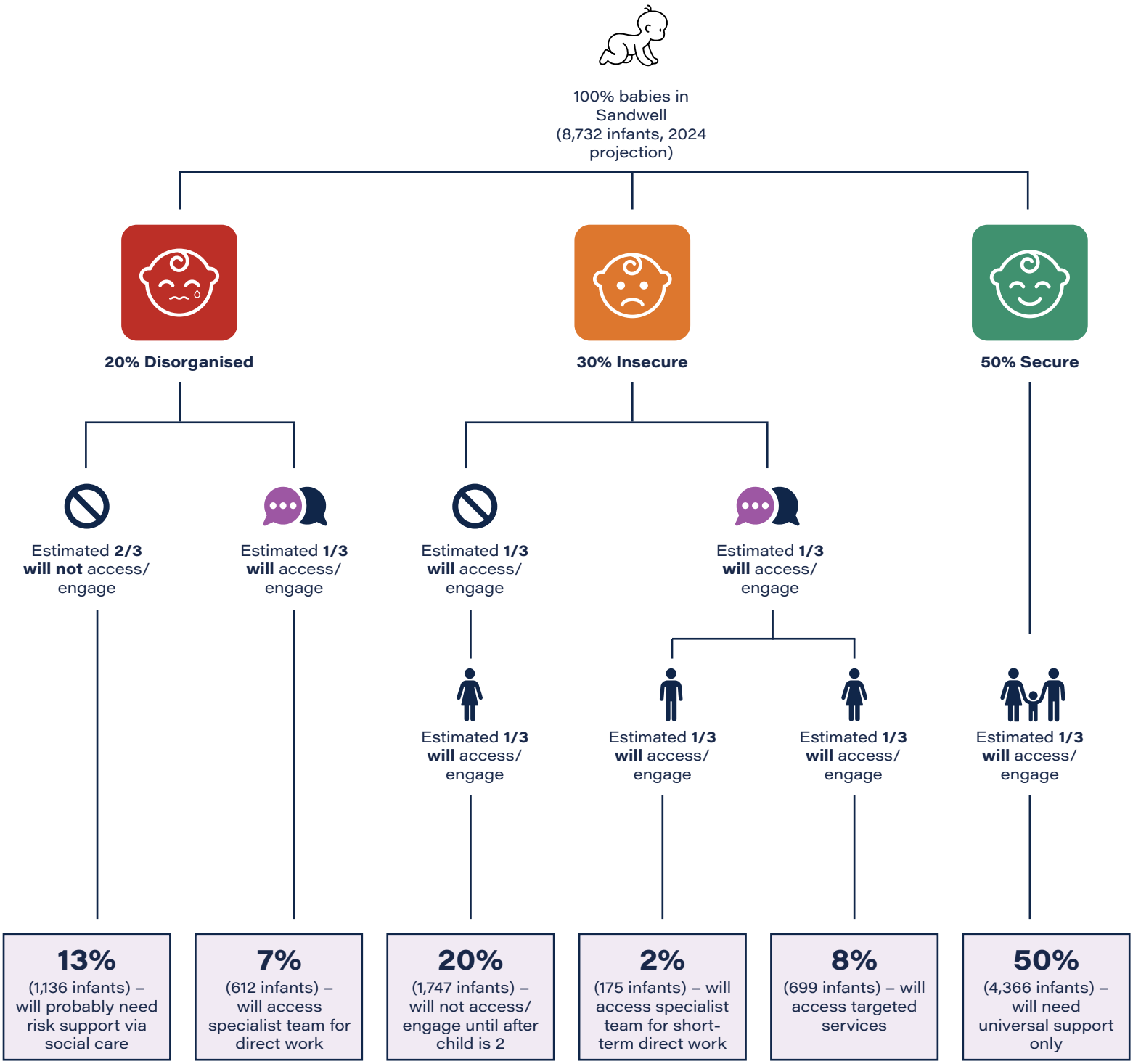


Image 15: Projected demand on parent-infant relationship support services based on estimates of insecure and disorganised attachment prevalence for Sandwell

Section 2: Perinatal mental health and Parent-Infant relationship support across the system

The aim of this section is to describe the existing public and voluntary services currently available to Sandwell residents which help and support parents/caregivers and infants with their perinatal mental health and parent-infant relationship needs from conception to age two. As well as categorising each service by the level of support it offers, a selection of these have been briefly analysed to provide insight into the needs of the population they encounter, as well as barriers and enablers to offering and delivering support.

Service mapping and analysis

The THRIVE Framework (Image 16), initially developed in 2014 by the Tavistock and Portman NHS Foundation Trust and the Anna Freud National Centre for Children and Families [44], offers a needs-based, person-centred approach to mental health services for children, young people, and families. It categorises need into five groups: Thriving, Getting Advice and Signposting, Getting Help, Getting More Help, and Getting Risk Support. The framework emphasises mental health promotion and active family involvement in care decisions through shared decision-making.

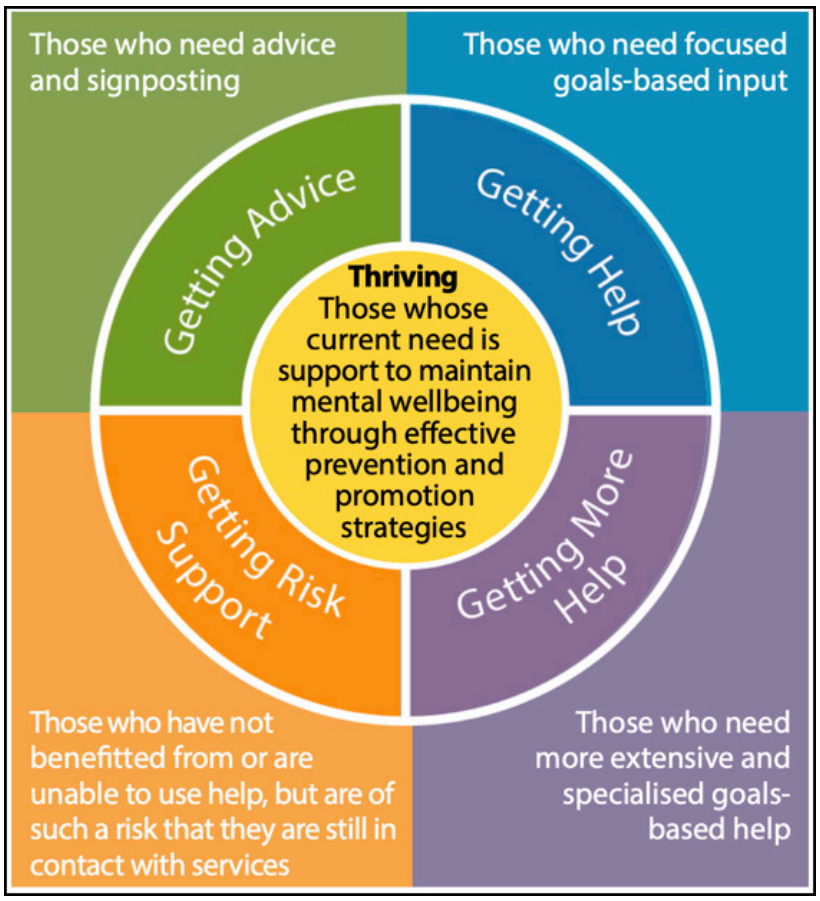


Image 16: Visual depiction of the i-THRIVE framework

Image 17 shows a proposed categorisation of services offering perinatal mental health and parent-infant relationships help and support to Sandwell residents. Given that services often provide a range of support that covers multiple areas of the THRIVE framework, there is, necessarily some overlap. Given the constant change in support provided and service structures, this image provides a snapshot of help and support available at this present time. Furthermore, this is by no means a fully comprehensive depiction of all services available in Sandwell and is primarily based on information gathered from those that responded to our invitations to participate in interviews, as well as information already gathered through the council's Family Hubs workstream.

Thriving	Getting advice	Getting help	Getting more help	Getting risk support	
Public health mental health campaigns and strategies					
Family Hubs (Universal offer)					
Changes (Antenatal and Parenting)					
Various voluntary and community sector activities and groups (e.g. Brushstrokes, New beginnings)					
Midwifery (Community and specialist midwifery services)					
Health Visiting (Mandated checks and Best start for life)					
Primary care					
	Infant feeding/ Breastfeeding network				
	Early help[a]				
			Early years Child Develop-ment Centres		
		Talking therapies			
		Neonatal psychology[b]			
		Educational psychology			
			CAHMS 0-5 service		
			Perinatal mental health team[c]		
		Sandwell Children's trust (Strengthening families support)			
			Sandwell Children's trust (Children's social care)		

Services primarily focusing on offering help/support for parent-infant relationships Services primarily focusing on offering help/ support for perinatal mental health

[a] Described in further detail below; [b] PIR only available to acute cases due to capacity; [c] PIR support only provided if need identified secondary to mother's mental health.

Image 17: Services offering help and support for PMH and PIR in Sandwell

Consultation with local practitioners and managers

In order to deepen our understanding of perinatal mental health and parent-infant relationship support across Sandwell, we consulted with a variety of representatives from services operating in this area. Services previously identified through the Family Hubs and Start for Life programme were contacted and data was collected primarily by:

- **Collating and analysing service specific literature**
  This ranged from publicly available materials such as service leaflets and brochures; documents provided by services, including a consultation reports, service operational policies and a service evaluation report; as well as email conversations with service leads and managers.

- **Semi-structure interviews and focus groups**
  Services for whom contacts were available were approached to arrange either one-to-one interviews or focus groups with service managers and/or staff/volunteers. Where feasibly possible, interviews or focus groups were carried out online or in person between April and June 2024. A topic guide was used to guide the conversations (Appendix 1) and services were asked about the scope of the support they offer, the needs of the population they interact with, the challenges in delivering their service and their perception of barriers and facilitators to parents and infants accessing appropriate support. Automatically generated transcripts or field notes from interviews were coded in their entirety and analysed using thematic analysis.

A brief presentation is given for each service that participated, detailing the scope of their work, how it relates to perinatal mental health and parent-infant relationships, and examples of activities or interventions they have previously carried out. Following this, overarching themes expressing the perspectives and experiences of participants are presented and described. An inductive approach was adopted whereby themes were identified based on their saliency and relevance to participants, rather than necessarily the frequency with which they occurred. Where there was disagreement or divergence of opinions expressed by different participants, this has been captured in the description of themes.

As with all qualitative research, it is imperative to acknowledge that information elicited during interviews, as well as its interpretation and analysis are impacted upon by the context in which these processes take place, as well as the experiences, preconceived ideas and sociocultural and professional context of participants and the investigator. A reflexive approach employing critical reflection on these impacts and discussion with colleagues has been implemented throughout this project. Finally, it is important to mention that this analysis is limited by the selection of services which were interviewed and, therefore, fails to incorporate the views and experiences of other services that play a vital role in this area of work, namely, primary care and CAHMS.

Brief service presentations

- **Barnardo's**
  Barnardo's is a national charity which focuses on supporting children, young people and their families. Working in partnership with statutory and voluntary organisations, it offers a variety of services that seeks to support families with early identification and support of children with additional needs, information and advice about appropriate services in the local area, antenatal education and support with children's early language development, among others. Barnardo's is the current commissioned provider of The Family Hubs.

- **Brushstrokes**
  Operating across Sandwell, Dudley and West Birmingham, Brushstrokes provide a broad range of services for asylum seekers, refugees, and other vulnerable migrants. These include, among others, language and skill-based courses, provision of specialist immigration and integration advice, peer-support projects, and resource provision (including food bank, clothing, and baby packs for new mums). While these services are not restricted to parents and young children, Brushstrokes have well established connections with a vulnerable, often young, population group which are less likely to be accessing other conventional health and care services. Brushstrokes is one of the current commissioned providers of The Family Hubs Peer Support Programme.

  Over the previous year, Brushstrokes supported approximately 4,000 clients (including 1,300 families) across its footprints. Although most clients self-refer, other services across Sandwell have links with Brushstrokes and are able to refer service users to them.

- **Changes: antenatal and parenting**
  Changes support educational and wellbeing activities for families across Sandwell operating in an organic manner, responding to needs identified. Some of Changes' work can be grouped in the following:

  - Changes antenatal: pregnancy sessions and courses for expecting parents delivered face-to-face or virtually, primarily by health visitors and midwives. These cover a variety of topics such as baby growth, bonding and attachment, giving birth, and caring for and feeding a baby.

  - Changes activities: activities offered to families antenatally up to the child's 5th birthday. These are focused on promoting wellbeing and enriching parent/carer's and infant/children's relationships. Examples include sensory play, music sessions and farm visits.

  Sandwell residents can self-refer to Changes and promotional materials are made available in a variety of settings, including libraries, pharmacies, GP surgeries, schools, and online. Health professionals, such as GPs and health visitors, are also able to signpost patients to the activities.

- **Early help**
  Early Help is a support system for families with children and young people. It brings together a variety of professionals and agencies in Sandwell, including health providers, schools, voluntary and community organisations, police and fire services, among others, to provide early support for parents and carers facing problems and preventing children coming to harm.

  Early Help means that if we know of children and families with unmet needs who need additional help, we are all responsible for intervening and making sure that they get help and support to meet these needs. Identifying unmet needs and intervening with the right support, in the right place, at the right time, at the earliest possible opportunity when problems emerge is not optional and is non-negotiable. It is a guiding principle and a responsibility for all of us who work with children.

- **Early years and child development centre**
  The Early Years Inclusive Learning Service works together with other agencies to provide appropriate support packages and methods of early intervention for children with SEND. We carry out a range of in-depth, on-going assessments of children needs through play, where targets are set jointly with Parents/ Carers and Professionals to measure the child's progress which are reviewed regularly. We help parents understand their child's individual needs by jointly planning and modelling appropriate learning opportunities to promote their child's development through play. We provide information, advice and guidance on the best approach to supporting their child, including their child's transition into school.

- **Health visitors**
  The health visiting team supports parents and carers with babies and children under 5 years old. It offers support and advice on a range of health issues, including development, feeding, safety, parental mental health, as well as public health issues such as smoking cessation, safeguarding and domestic abuse. While the universal offer includes a minimum of 5 contacts (phone calls, home visits, clinics) at set times of a child's development (Antenatal contact, Postnatal visit between 10-14 days of birth, Six to eight weeks after delivery, Nine to 12 months, and Two to two-and-a-half-year-old), additional and opportunistic support can be offered should the need be identified.

- **Inclusion support team**
  This multidisciplinary service works across Sandwell to improve the learning, education, mental health and wellbeing of children and young people aged under 25 years old, with a particular focus on those who are vulnerable or have special educational needs. It supports parents, carers and educational settings with assessment and intervention, specialist teaching and advice on a range of needs that may impact children and young people's education. Support offered covers a range of areas, including educational and child psychology, social emotional and mental health difficulties, and sensory support. Children are referred into this team, primarily through schools and early years inclusion services.

- **Midwifery**
  Maternity services provide universal care to all pregnant women (delivered by community midwives) as well as specialist care for women with high-risk pregnancies (provided by obstetricians and specialist midwives). Midwifery services for Sandwell are based at Birmingham City Hospital and tend to be co-located with GPs in primary care facilities to improve care coordination. As part of the care provided by the midwifery team, patients are pre- and postnatally screened for perinatal mental health issues and either supported within the team or referred on to other services (e.g. perinatal mental health team). Parents-to be are also supported in establishing and strengthening the relationship with their infant through a variety of discussions, advice and resources.

- **Neonatal psychology**
  The main neonatal provision in Sandwell is based at Birmingham City Hospital which does not currently have any psychological support. However, some Sandwell families access neonatal care through the Birmingham Women's Hospital, due to preference, a need for intensive care for their infant, or a specialist need related to foetal medicine or obstetric care, where neonatal psychology support is available. This is integrated within the hospital team, often taking the form of direct interactions with families through single sessions and brief interventions, offering support for psychological needs brought about by the baby's admission or medical condition.

- **Perinatal mental health**
  The perinatal mental health team covers Dudley and Sandwell and specialises in the assessment, diagnosis, and short-term treatment of those affected by a moderate to severe mental health illness in the preconception, antenatal and postnatal period. It is a secondary mental health service and, therefore, supports those with antenatal and postnatal needs that cannot be met by primary care services. The team supports people with a range of mental health difficulties including bipolar disorder, puerperal psychosis, depression, anxiety, OCD, and bonding difficulties. The service takes referrals from GPs, midwives, and nursery nurses.

Children with disorganised attachment, often resulting from unpredictable or hostile care, are at the highest risk of later emotional, social, and behavioural difficulties.

Views and perspectives from service managers and practitioners

Working in partnership
When asked about the quality and efficiency of partnerships around perinatal mental health and parent-infant relationships in Sandwell, participants gave mixed responses. While there was an overall positive attitude towards them, there were instances where this was not felt to be the case.

Some participants mentioned barriers in sharing information and seeking input from certain teams, namely, primary care and community mental health. There was a sense that GPs had increasingly been pushed out of maternity care and connections with them had been weakened. It is important to note that no representatives of primary care were interviewed in this project which, while depriving them of an opportunity to input into this discussion, also points to the lack of established relationships between the council and this group. Furthermore, the constant change in service structures, patient pathways and referral systems meant it was often difficult to keep up to date with what support was available and how it could be accessed. Representatives from midwifery mentioned how they had limited knowledge of what support was available in Sandwell for needs around wider determinants of health. A missing community follow-up system for babies that have been discharged following a neonatal unit admission (and are therefore at increased risk of psychological and emotional needs later in life) was also identified as an important gap. The system was described by some participants as being somewhat fragmented across many different services and support groups (that do not always communicate between themselves) as well as geographically (with service users living in border areas being missed out). This, in turn, meant that there was a lack of oversight in the care and support provided to parents and infants. Just as a multitude of services with differing remits and points of access can seem overwhelming for patients, some participants felt it was equally so for those working within the system.

Certain facilitators to partnership work were identified, namely, regular, scheduled meetings between teams, preferably face-to-face. These were seen as an opportunity to network and receive updates on what was happening across Sandwell and beyond. Having a named point of contact with a particular interest in mental health or parent-infant relationships was also seen to be invaluable and, often, partnerships relied on relationships that had been developed with individuals over years, rather than a system-level link between the two services. High turnover of staff in certain professional groups was seen as a barrier in establishing these points of contact. Where there was sharing of information through linked IT systems, this was seen as a crucial asset which not only improved communication between teams, but allowed a more holistic approach to care.

Health visitors were often seen as useful linking point between health services and community and voluntary groups. The latter often mentioned the need for health professionals to endorse their work in order to give service users confidence in the support they offered. On the other hand, some participants from voluntary groups felt that, as a result of being able to spend more time with service users and having a greater understanding of their cultural and social context, they were able to establish deeper relationships with them and wished for the health system to make more use of this by involving them as a point of contact with certain population groups.

Strain on the system impacting on the quality of support offered
An overstretched system that was struggling to deliver the level of care and support it intended to, was commonly identified as one of the main issues affecting perinatal mental health and parent-infant relationships in Sandwell.

Staffing issues were frequently mentioned with several reasons given for it, such as insufficient recruitment, retirement of experienced staff, and poor staff retention. Often this was said to be linked to national staffing issues, particularly in midwifery and health visiting. Poor staff morale and limited staff resilience were also pointed out as issues which often led to people "moving around" for jobs. Financial constraints and budget cuts were also mentioned by several respondents, particularly those in voluntary and community sector. This led to uncertainty of the longevity of different services and initiatives, as their ongoing funding could not be guaranteed. Another driver mentioned was the increasing complexity of caseloads, both from a clinical perspective, with patients with multiple morbidities, as well as increasingly challenging social and family contexts.

Overall, these constraints on the system meant that those working in this area had to scale back the level of support they offered and often found themselves working in stressful situations and relying on staff's goodwill to achieve goals. Some expressed concerns that they were unable to respond to issues in a timely manner, which was particularly problematic for new pregnancies requiring swift interventions or support. Demand was felt to far outweigh capacity to respond to it as exemplified by a study conducted on one of the neonatal units covering Sandwell residents:

- This neonatal unit trialled the use of a screening tool to assess the psychological needs of all families with a baby admitted to the unit [45]. Where indicated, following discharge, families were referred to appropriate services, including specialist psychological interventions. After one month of the tool being trialled, it had to be stopped as there were capacity issues in dealing with all the referrals generated through the pilot study.

As well as the scale, the quality of care and support provided was felt to be compromised. Lack of continuity of care and reliance on bank staff, was mentioned as an important issue, particularly within the health system. This often meant it was harder to establish a relationship of trust between health professionals and service users. Furthermore, it could lead to a compromise in the quality of care provided as changes in patient presentation may not be picked up by staff who have not met them previously.

Further to being unable to deliver highest quality of care and support, participants also felt these constraints impacted on their relationship with service users (as trust was undermined) and inhibited them from undertaking additional work which may be of use, such as analysing routinely collected data.

Accessibility
Making support as accessible as possible to as many as possible was considered a priority for many of the participants who took part in the interviews. The extent to which this could be achieved varied considerably and was dependent on staffing, resources, and flexibility to be innovative.

Groups such as Changes had experience in trialling different formats for their sessions in order to cater for the needs of various population groups. This included holding informal sessions in public spaces such as libraries, making sessions welcoming for children with special educational needs, and running sessions on weekends and evenings across the borough. Given their flexibility, they were able to continue formats which had a good uptake and drop those that did not work out. Brushstrokes gave the example of how they sought to have representatives from services give brief presentations of how to access their support during orientation sessions for new arrivals. Particularly within the health services, participants expressed a wish for support to be more streamlined with number of appointments/contacts minimised and using more of a "one-stop" approach.

In one striking example, representatives from Barnardo's highlighted the importance of the timing of interventions:

- They recounted the case of a new mum who was found to be struggling with mental health and suicidal ideation. Although screening tools used at routine visits and contacts with health services had failed to pick up any mental health issues, she later explained she did not feel ready to disclose her struggles at those points. By implementing an extra check (in a gap between routine health visitor checks), Barnardo's was able to pick this up and offer timely support.

Other participants highlighted the importance of understanding that each parent's journey is different and there will not be one format of support that addresses everyone's needs.

Barriers to accessing support
Several barriers in service users accessing support for perinatal mental health and parent-infant relationship needs were identified. Some of these are detailed below.ent's journey is different and there will not be one format of support that addresses everyone's needs.

Language barriers
The diversity of languages spoken by Sandwell residents was mentioned as a barrier not only to accessing and understanding information, but also when interacting with services. While several services offer written resources in a variety of languages (both printed-out and online), one participant pointed out that several people speak different community languages but are not always able to read them. Changes service is currently seeking to address this issue by ensuring their online resources have an audio option where different languages are spoken (rather than having subtitles, for example). Another issue raised was the fact that some people who communicate using British Sign Language are unable to read written English.

With regards to language barriers when interacting with service users, this tended to vary depending on the type and level of communication required by the support being offered. While stay and play sessions may not require extensive communication between session facilitators and parents, this is not the case for services such as midwifery or perinatal mental health appointments, where an interpreter is essential. Some services expressed being conscious of the need to have a diverse staff team which allows them to cater for different language needs but recognise this is not always possible. One participant mentioned the importance of non-verbal communication and how, in cases of maternity patients who are struggling, this is often what will have the greatest impact in establishing a bond between the patient and the professional. Furthermore, not speaking English was also considered to inhibit service users' ability to advocate for a level of care and support that matched their needs.

Cultural barriers

Different cultural and religious beliefs and practices were frequently recognised as a barrier in accessing support for mental health for parents and infants. Participants often reported how certain communities, particularly some Asian and African families, may struggle to recognise mental health and emotional wellbeing problems, or avoid talking about them due to the stigma and fear associated to them. This was often felt to be closely linked to the negative terminology used to describe mental health issues in different community languages. Some groups, such as Barnardo's and Brushstrokes, pointed out that some of the tools currently used to screen for mental health and wellbeing do not take into account these language and cultural nuances and may, therefore, be failing to appropriately assess mental health needs in certain population groups.

Furthermore, certain cultural practices meant that some service providers struggled to support families as they would like to. Examples included busy multi-generational households where it was not possible to hold a private conversation with a new mum, family dynamics which required all interactions with the health service to be conducted through a male meant it was difficult to directly assess and support women, and communities with high levels of reliance on family and community members' support that were sometimes unwilling to recognise the need for specialist input.

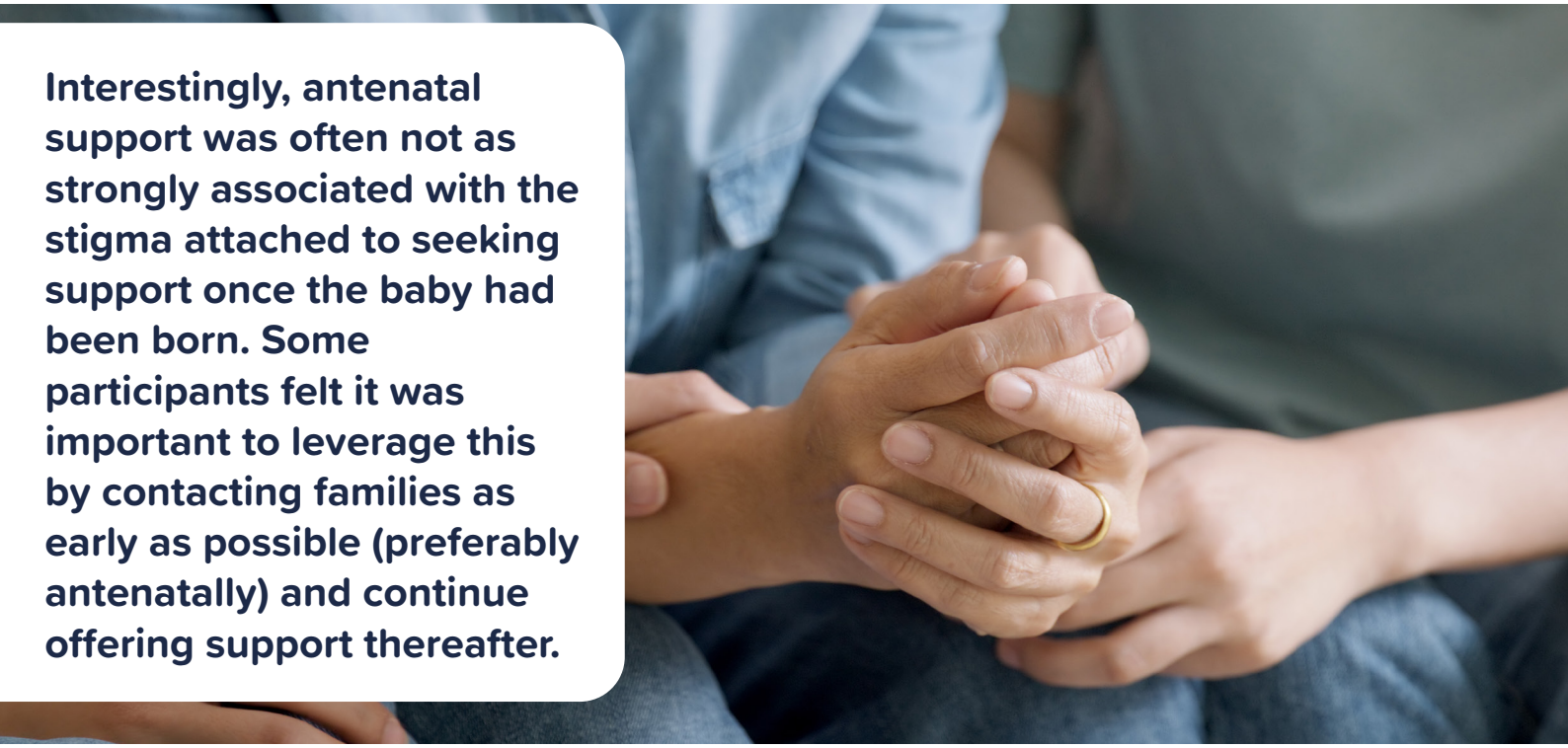
Stigma and fear associated with mental health

The stigma and fear associated to mental health was seen as a major barrier by most participants. This was often particularly an issue in certain cultural groups (as described above) but could also often be associated with parents' previous experience of their own upbringing or that of their friends and acquaintances. While it was felt that there have been some improvements in demystifying mental health and breaking down taboos (younger generations were felt to be more comfortable in talking about mental health needs), this was still identified as an area needing considerable change.

For some parents, seeking support for mental health and wellbeing needs, such as post-natal depression, or advice on how to care for a baby, for example attending a weaning course, implied that they were "bad parents". The pressure not to be labelled as such (whether by themselves, their family, or their community) meant that some would delay or avoid seeking support. Several participants mentioned the importance of using appropriate, non-stigmatising language when talking about mental health. How services and support are presented to the public plays an important part and it is preferrable to convey the message that "parenting is hard and all families need some level of support". Some participants expressed the importance of building trust as an organisation, as well as an individual professional. The key to this was felt to be focusing on the relational aspect of interactions with parents.

Another significant barrier in supporting parents was the perceived association between social services and services offering perinatal mental health and parent-infant relationship support. Many parents limited their interaction with participants for fear of "having their children taken off them".

Interestingly, antenatal support was often not as strongly associated with the stigma attached to seeking support once the baby had been born. Some participants felt it was important to leverage this by contacting families as early as possible (preferably antenatally) and continue offering support thereafter.



Other issues that were not mentioned as frequently included people's perception that they will need to pay for support received and their fears that their GP would fail to keep their information confidential.

Racism
Racism was pointed out by some participants as having a considerable negative impact on certain groups of parents' mental health. While some ethnicities are more likely to experience certain perinatal complications (e.g. premature birth and post-natal depression), this can often be compounded by their experience of being in a system which leads them to feel marginalised. Where parents have previously experienced racism, particularly within the health service, they are more likely to struggle in receiving support for their mental health needs.

Factors impacting the population's needs
Several factors were seen to impact upon the population's perinatal mental health and parent-infant relationship needs. Some of these are described here.

Relationships and support networks
Relationship breakdown, isolation, lack of family support and domestic violence were some of the issues mentioned which impacted on families' mental health and wellbeing. Specific contexts, such as mum's who felt unhappy in an arranged marriage or those housed in contingency hotels who were unsure how long they might stay in one place, were seen as being particularly problematic. Several participants commented that they felt the family context of the people they were encountering in their service was becoming increasingly complex. Other pressures, such as the cost-of-living crisis, were leading to increased tension between parents and a restructuring of family life. Some parents were choosing to live separately in order to be able to claim more benefits, whereas, for others, financial worries were fuelling disagreements regarding termination of a pregnancy.

Where the service provided an opportunity for parents to meet up, this was felt to be of great benefit. The simple fact of providing people with a reason to leave the house with their baby or the opportunity to make friends was often mentioned by service users as providing them with a structure and giving them a sense of belonging.

Finances
The cost-of-living crisis was invariably mentioned as one of the factors that has increasingly been identified to negatively impact the mental health and wellbeing of the families encountered by the services interviewed. One participant expressed that "it's a difficult time to have a baby at the moment". Several participants mentioned that, increasingly, they were coming across working parents who would previously not have needed material support but were now struggling to provide for their family. Worrying about finances was mentioned as having a large impact on parents' mental health both ante- and postnatally. It was also impacting parents' decisions around family planning as they often felt they could not afford another child.

The needs of specific groups
Certain population groups were frequently mentioned as having specific needs or requiring a tailored approach to support. These are described below.

Migrants
People who have recently moved to the UK, whether for work/study purposes, refugees or people seeking asylum, were often identified as having particular needs around mental health. Furthermore, they were described as a group that can often be hard to engage with or adequately support.

In particular for those who have had to flee their home country, several participants mentioned that there was often a history of considerable trauma, including having their life endangered through war and conflicts, as well as rape, sexual violence and previous poor birth experiences. The trauma of these experiences was then compounded by the precarious circumstances in which they were currently living, such as poor-quality accommodation, uncertain immigration or asylum status, poor support networks and a lack of understanding of the English language, local culture and the how to navigate the health system. This led to this group of service users presenting with significant mental health issues which were often very hard to address. Some participants commented on the need to provide them with time and a safe space in which to begin to process their trauma. Some also commented on the importance of persisting with attempts to engage with people from this group, as cultural, language and context barriers may be leading to a mistrust of the health and support systems which can be overcome, albeit gradually.

Those with no recourse to public funds are particularly vulnerable and often suffer from the anxiety caused by their precarious situation. Issues around the safety of caring for a baby when living in shared accommodation with strangers and a lack of private spaces was also mentioned.

One participant mentioned the importance of not labelling immigrant groups or assuming they all have similar experiences or similar perceptions of mental health, as this is not the case and is likely to further hinder efforts in supporting them.

Under-represented groups

Lack of data or robust systems to identify pockets of the population that are not being reached by current services was identified as an issue. When asked about population groups which might be underrepresented in their caseload/contacts, participants often expressed the view that they were likely to exist, but they were unsure who they were. Some groups mentioned were the Roma Traveller community, some Sub-Saharan African and Asian communities, certain faith groups, as well as those who have recently moved to the UK. As mentioned previously, stigma around mental health problems leading to failure to acknowledge them and seek help is thought to be more prevalent in some of these groups. Mistrust in the health system or central organisations was also seen as a factor which made it harder to engage with these communities. The Brushstrokes representative described several ways in which they have attempted to address this issue, including by acting as a point of contact, accompanying people to appointments and acting as a broker of their relationship with the health service.

Particularly when talking about infants, there was mention of people who "slipped through the net" or "were not picked up early enough", indicating that under 2-year-olds themselves are often seen as a "hard to reach" group. Services such as the Early Years and Child Development Centres mentioned how it was common for there to be an influx of cases at the start of the school year. These were infants and children with mental health and emotional needs that were only identified once they had started attending a formal educational setting. This issue was echoed by the Inclusion Support representative who commented how the mental and emotional needs of some of the children they encounter might have been minimised had they been picked up earlier. Babies who have been admitted to a neonatal unit and are therefore at greater risk of having psychological and emotional needs later in life were felt to be unsupported following discharge as there is currently no routine follow-up system for their mental and psychological needs. Other reasons for people who services struggle to get in contact with included people who were registered with more than one GP or who no longer lived in the country.

Groups such as Changes described their experience in making their offer as universal as possible. This included adaptations to languages and format of resources, timings of sessions as well as their format. They also had the opportunity and flexibility to trial interventions aimed at specific groups which had varying degrees of success.

One participant cautioned against the risk of creating "hard to reach groups" by making the health and support systems less accessible, namely, through their digitalisation which often excludes people with limited IT and English and literacy.

Other issues that were not mentioned as frequently included people's perception that they will need to pay for support received and their fears that their GP would fail to keep their information confidential.

Fathers and male carers
Fathers and male carers are often recognised as receiving less support than mothers and female carers. While there have been changes in the last years, notably with some support now offered to male partners through the perinatal mental health team, these are still fairly recent and their effectiveness and impact are still to be assessed.

Several respondents commented on the importance of assessing the need and supporting the family as a whole. Historically, fathers have often been excluded (either out of their own choice or by nature of how the service was set up) from maternity care. However, some participants mentioned the importance of involving them as early as possible in antenatal discussions, alerting to the changes that are likely to happen with the arrival of a baby and the need to safeguard their own mental health and wellbeing. Some commented on how the changes and stress brought about by having a new baby sometimes exposed pre-existing issues in a couple's relationship. There was, therefore, felt to be a need to offer counselling support. Cultural differences in how the roles of men and women are perceived were also mentioned as an important factor to bear in mind when interacting with certain groups.

When commenting on adaptations made to involve fathers more in discussions, several respondents commented on making sessions/appointments available at weekends or out of working hours, as well as making parenting sessions more activity based. Several participants pointed out the lack of male staff in their services as a potential issue, as it is often felt that male-to-male interactions might prove more effective when reaching out to fathers. Some respondents commented on the lack of support/services available to refer fathers to, should needs be identified.

Several respondents commented on the importance of making language used more inclusive of male carers (e.g. "our baby", "what we can expect"). Some also alerted to the risk of, in an attempt to make services more inclusive to male carers, excluding others. Examples included assuming that the working carer is the male one, as well as failing to acknowledge and include same-sex couples.

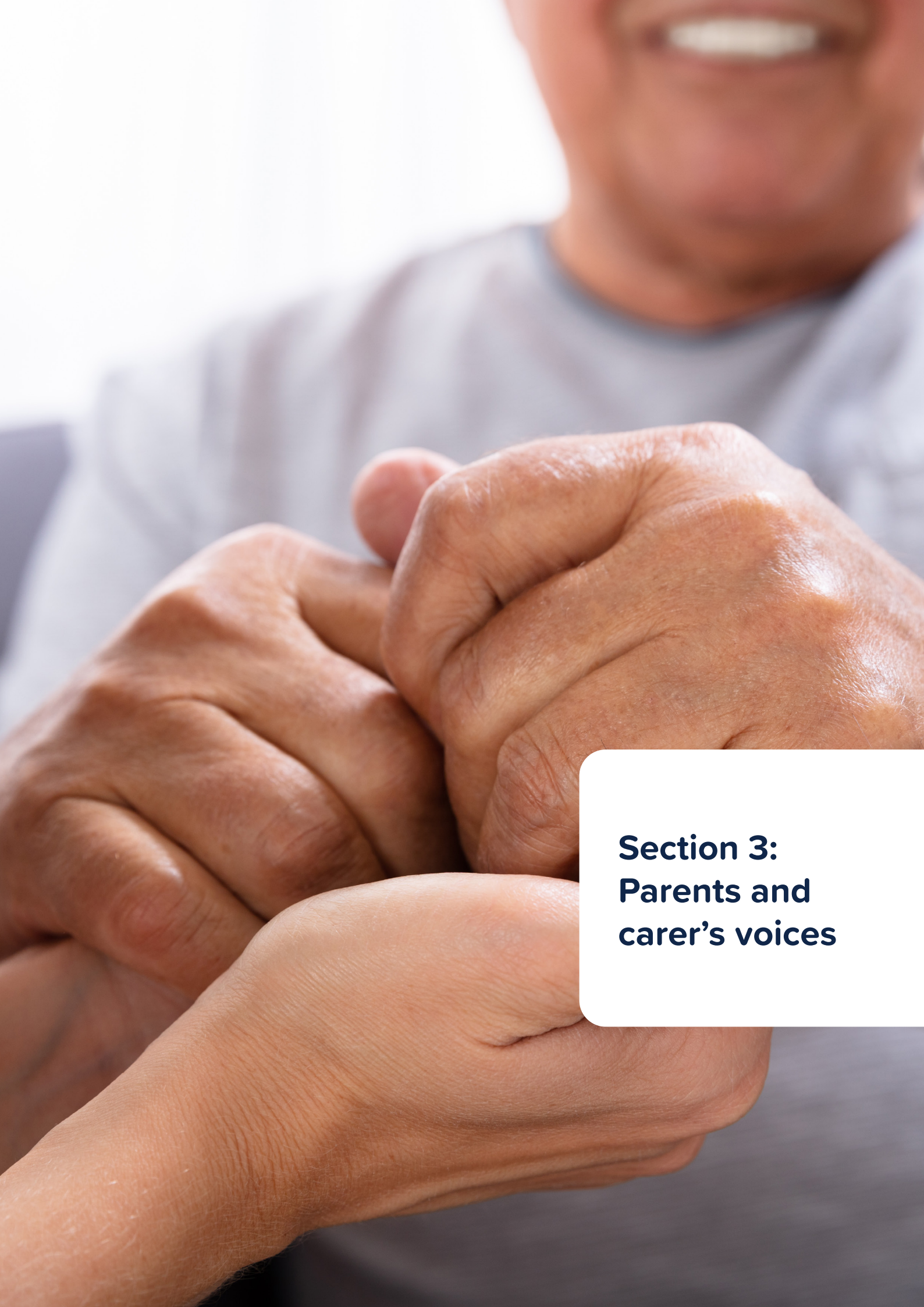
Population's awareness of support available
When asked about people's awareness of the services and support available and how to access them, several respondents mentioned that, although this has improved in recent years and there has been investment in informational campaigns around this, there is still much room for improvement. Particularly for voluntary and community sector groups, word of mouth was felt to be the most effective way of getting information out in the community. They often expressed the opinion that people trusted more in the recommendation of a friend, rather than a glossy leaflet. Initiatives whereby people could self-refer to services (such as self- referral to Child Development Centres and self-reporting of pregnancies to Family Hubs) had had varying degrees of success.

When commenting on the need to break down misconceptions about their service, the perinatal mental health team mentioned the importance of involving those with lived experience in any outreach or promotional initiatives. This is something they are already practising, and they recognise the importance of investing in co-production with this group.

One participant referred to the ethical issues around increasing people's awareness of mental health and mental health issues, while not being able to provide them with an adequate level of support.

Suggested improvements
When asked about improvements they would like to see in this area of work, participants presented a range of responses. While some were specific to their service and challenges they face as professionals, others took a broader view on the needs of this population. Invariably, services expressed that they would like to do what they are currently doing but better resourced and at a larger scale.

Next to this is a word cloud of some of the most commonly mentioned themes in response to this question (Image 18)



Section 3: Parents and carer's voices

This section provides a glimpse into the experiences of parents and carers with regards to struggling with and receiving support specifically with perinatal mental health however there needs to be further consultation and co-production with families where parent-infant relationship issues are a factor. This section aims to provide insight into how this population group experiences need, how well these needs are met by current support provision, and their opinions on what could be improved. This is by no means an exhaustive description and it is not representative of all parents and carers in Sandwell.

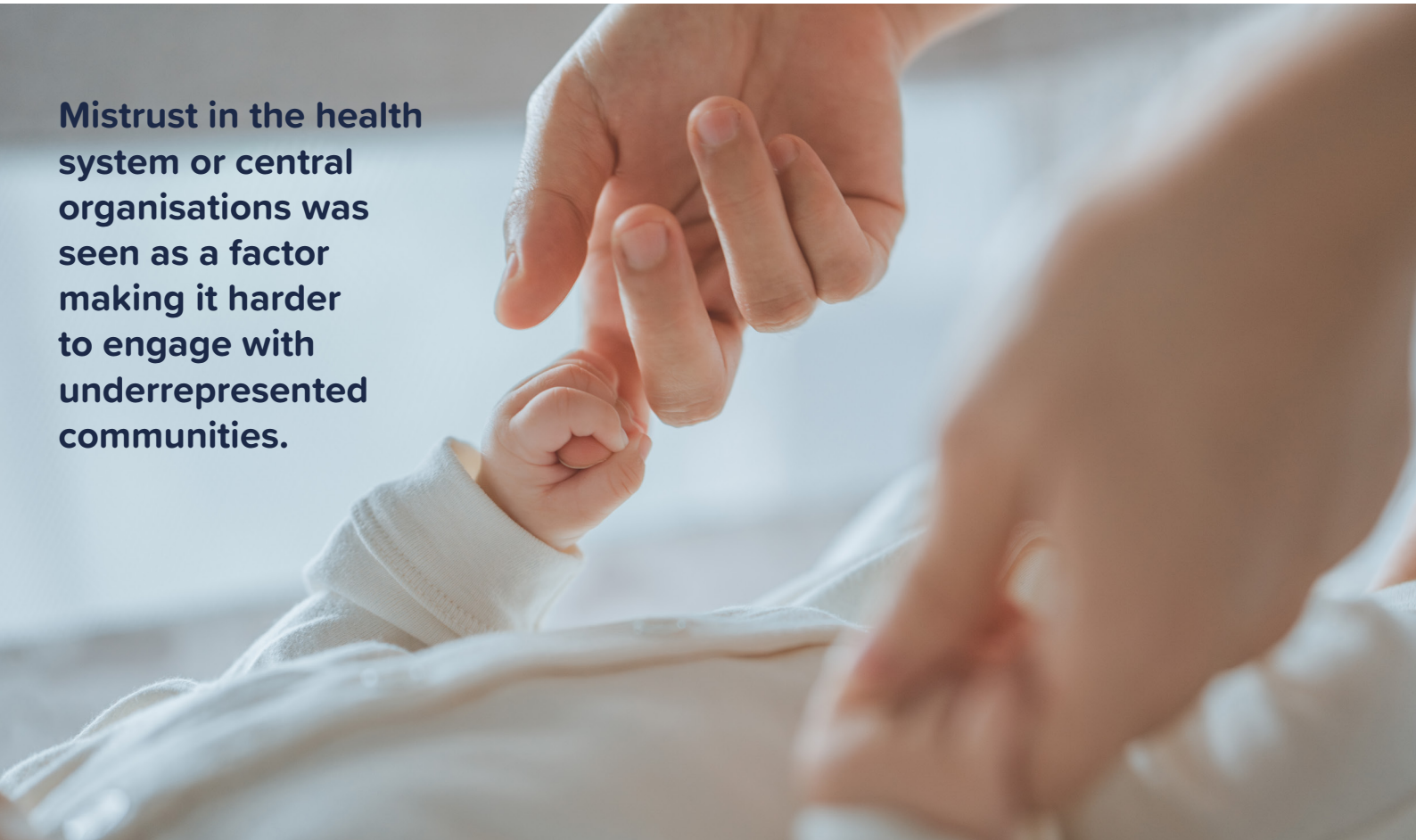
Methods

Several groups of parents were contacted in order to participate in this project. Unfortunately, in view of time a resource constraints, it was only possible to conduct a consultation with some of these:

- **Mothers with experience of the Perinatal Mental Health Service**: With the assistance of the perinatal mental health team, an online focus group was arranged with mothers who had previously had contact with the perinatal mental health service. Five women took part, albeit some had to leave early. The session took the form of an informal discussion where questions were placed to the group and participants were encouraged to share their experience, discuss matters amongst themselves and bring up their own topics for discussion. A topic guide was used (Appendix 2) to guide the discussion and the meeting was recorded for the purpose of the analysis. Automatically generated transcripts were coded, and themes identified using thematic analysis, as described by Braun and Clarke [46].

- **Migrant women:** A consultation exercise was held in one of Brushstrokes women's craft sessions. This group of women meet weekly and use the opportunity to chat and discuss set topics while working on crafts. The group was composed of 9 women and 3 staff, some of whom were mothers and, of these, some had had experiences of parenthood in the UK. A variety of ethnic backgrounds, nationalities and immigration statuses were represented in the group. In order to accommodate for language and cultural requirements, the discussion was facilitated through the session coordinator (who was a member of staff at Brushstrokes). A topic guide (Appendix 2) was loosely followed, and participants were encouraged to talk about their experiences of pregnancy and parenthood to infants in the UK, with a particular focus on their mental health and emotional wellbeing needs. Interactions took the form of group discussions as well as parallel one-to-one conversations. As participants did not feel comfortable being recorded, notes were taken during and after the session in order to capture the main points discussed. These notes have been grouped so as to capture the themes that were most salient to participants and relevant to the topic of discussion.

A broader consultation with parents and carers was conducted by Barnardo's Family Hubs. However, due to late submission a summary of this has not been included in the report. The full consultation report has been included as an appendices below.



Mothers with experience of the Perinatal Mental Health Service

Barriers in accessing support

When looking back at the time when they had first become aware of mental health issues in the perinatal period, participants mentioned several barriers that kept them from recognising the need for or seeking support.

A few participants explained that they had never heard of perinatal mental health and parent-infant relationship difficulties before experiencing it themselves. This lack of awareness caused some to be afraid of the emotions and thoughts they were experiencing and made them hesitant to seek help.

> **"I didn't even know about perinatal mental health. I knew that you could have issues in pregnancy, but I didn't know that you [could feel you] wanted to cut your baby out of you, or be severely depressed, or you can be sectioned. There is nothing out there, and it made me feel (...) feel alienated"**

Some mentioned that this lack of awareness was also present in their relatives and close friends, as well as some health professionals they encountered during their pregnancy. At times, limited understanding was combined with misconceptions and stigma surrounding mental health. This caused participants to feel ashamed, alienated and hesitant about seeking support.

When talking about her relatives, one participant explained:

> **"In their mind, you should just be grateful for being pregnant. And it's not that I wasn't ungrateful. I didn't want to feel that way. I didn't want to not bond with my child. I didn't want to cut her out of me. I wanted to be OK, but nobody actually understands it. And I think that's where I think it comes down to [as with] everything in life with where mental health is concerned, we've got this stigma that a lot of people don't want to talk about it."**

Another participant commented on her experience as part of the Asian community:

> **"From my experience, within our culture, we just have this one umbrella term for all mental health and that's 'mad'. So I think it was, you know definitely not recognised. I was accused by family members of attention seeking. I'm just trying to cause upset to mum and dad and things like that. So I did feel like 'Oh, am I in the wrong?' But it was like thoughts and feelings, behaviours that I couldn't control whatsoever, and it's only until many, many, many years later that I (...) actually have terminology for what I went through"**

One participant recounted an interaction with a relative where she opened up about the fact that she had been struggling with her mental health:

> **I said to her like 'Oh, I'm struggling a bit. They're going to refer me for some help'. And she was like 'Oh, I accessed talking therapies after my son'. And I was like 'Oh my gosh, I didn't even know that about you'. And she was a little bit, not ashamed, but she didn't want to tell people that she'd accessed that, in case they thought she couldn't cope.**

Seeking support

Participants had different experiences of how they first went about seeking support for the mental health issues they were facing. For some, the first person they disclosed their struggles to were family and friends, whereas others first spoke to their midwife, health visitor or GP. Either way, it was often seen as a big step.

> **If I hadn't had the health visitor I had, I don't think I actually would have accessed support. (...) And just the things that I was saying to her, she was like 'Oh, OK, can you tell me a little bit more about that? And have you been having a lot of thoughts like that? And are they every day?' She actually asked those more probing questions. I think if she hadn't, I wouldn't have had the confidence to come forward. When she actually said 'Do you think you need to talk to someone?' I just cried at her because it was the first person who'd actually asked me that**

Unfortunately, when seeking support from health professionals, several participants felt they had been dismissed. For some, they had to push for their concerns to be taken seriously.

> **Community midwives and perhaps the health visitors can sometimes be very quick to brush off how you're feeling. I did get a bit brushed off by my health visitor. It was my peers who were actually like 'No, honey, you need to go get help**

> **[My midwife was my] first point to call. But again, she wasn't listening. So then I was at a bit of a loss**

Receiving support

All participants were very positive about the support they had received from the specialist team. Most found that once the challenge of getting referred into the perinatal mental health service had been overcome, their experience of interacting with the healthcare service improved substantially.

> **As soon as I was assigned to the perinatal team, [the perinatal mental health nurse] gave me her number and she was a point of contact at all stages and anytime I phoned them there was a woman on the end of the phone that always just listened to me, talked me through it and calmed me down. It was the consultants and the midwives that weren't listening. The perinatal [team] got it, it was everybody else [who didn't]. (...) So the perinatal side? Absolutely great experience. But just not before that.**

Some participants mentioned they felt there was a lack of support once they had been discharged from the perinatal mental health team and that they would have benefitted from more comprehensive follow-up.

> **As soon as they saw that I was OK with her - because for me personally, the pregnancy was the issue - they discharged me straight away. And I have to say we have struggled to bond in a way that I've recognised we have. But I just felt that they were too quick to go 'Oh, you look OK. You're holding your baby (..) You're good now'. And it's never been followed up.**

Several participants highlighted the inadequacy of support offered to fathers. Participants explained how their own experience of mental health struggles had significantly impacted their partners and, while participants had received support from the perinatal mental health team, this was not made available to fathers.

> **What gets me is: there is no support for dads. My other half [struggled] with depression. He's had no support whatsoever. He's probably still going through it.**

Seeking support

Participants had different experiences of how they first went about seeking support for the mental health issues they were facing. For some, the first person they disclosed their struggles to were family and friends, whereas others first spoke to their midwife, health visitor or GP. Either way, it was often seen as a big step.

> **If I hadn't had the health visitor I had, I don't think I actually would have accessed support. (...) And just the things that I was saying to her, she was like 'Oh, OK, can you tell me a little bit more about that? And have you been having a lot of thoughts like that? And are they every day?' She actually asked those more probing questions. I think if she hadn't, I wouldn't have had the confidence to come forward. When she actually said 'Do you think you need to talk to someone?' I just cried at her because it was the first person who'd actually asked me that**

Unfortunately, when seeking support from health professionals, several participants felt they had been dismissed. For some, they had to push for their concerns to be taken seriously.

> **If I hadn't had the health visitor I had, I don't think I actually would have accessed support. (...) And just the things that I was saying to her, she was like 'Oh, OK, can you tell me a little bit more about that? And have you been having a lot of thoughts like that? And are they every day?' She actually asked those more probing questions. I think if she hadn't, I wouldn't have had the confidence to come forward. When she actually said 'Do you think you need to talk to someone?' I just cried at her because it was the first person who'd actually asked me that**

> **Community midwives and perhaps the health visitors can sometimes be very quick to brush off how you're feeling. I did get a bit brushed off by my health visitor. It was my peers who were actually like 'No, honey, you need to go get help**

> **[My midwife was my] first point to call. But again, she wasn't listening. So then I was at a bit of a loss**

Most participants also emphasised the role partners had in supporting them, often without adequate understanding of what support was needed.

> **I've got a fantastic husband. And he did support me, but I think that it could have been that he didn't know what to do with me. There should be something that we're given to say 'Right, if the dads need anything - or here's where they go to in order to support us'. Because when we're in this mental state, we've got all these emotions going on and (...) we need to be able to pass this over to our husbands and go 'Right, can you [phone for help]? Can you deal with this?'**

A few participants commented on how they feel they would have benefitted from more peer support, particularly when waiting to be assessed by the specialist team. They expressed that it would have been helpful to have been linked up with other parents who had had similar experiences, as a means of having a safe place to talk and gain some normative guidance. Some mentioned how this focus group had been incredibly helpful in itself.

> **I feel like I like peer support would have helped me a lot in the waiting period. Because [the health professionals looking after me were] so proactive (...) [and] hey were really open with me about, like how long I was expected to have to wait. I think it was around three months. But in that period of time [it would have been great] if I'd have been able to be connected to other people who were maybe feeling a little bit like me**

Like this in itself - I would have loved to have met [the other participants] at that time because then we would have had each other to talk to about it. But why is it taken to now for this to be set up?" (P1)

Migrant women

A period of vulnerability
The perinatal period was described by many participants as a period of particular vulnerability due to the physical and emotional changes brought about by pregnancy and parenthood. For migrant mothers, this is compounded by the uncertainty of their immigration status and insecure living conditions.

Language
Many participants reported having little understanding of English when they first arrived in the UK. This limited their ability to ask for help and understand information presented to them. The topic of mental health posed a particular challenge due to the nuances of how it is perceived and discussed in different cultures and languages. Several participants expressed that they would never have understood a leaflet talking about mental health in English.

Precarious situation
Several migrant women live in precarious situations, marked by uncertainty regarding their immigration status, being moved around the country at short notice, and living in poor-quality accommodation with limited finances.

- One mother described how she had only been in the UK for 2 weeks when her baby was born 2 months prematurely. At that point she did not have a midwife and was staying at a friend's house. While admitted in hospital she lost her accommodation arrangements and no longer had a place to stay.

- Another mother recalled how she had called the hospital when in labour to request an ambulance. She was told she needed to make her own way to the hospital. However, she was staying in contingency accommodation that was far from the hospital and did not have the means to pay for a taxi as she lived on a very small budget (asylum allowance). Eventually she managed to have an ambulance sent to her.

Loneliness and a fragile support network
Several participants reported how, in their country of origin, family plays an important role in supporting and caring for a mother of a newborn baby. However, having moved to the UK, many migrant women no longer have family around them, and few had been able to establish a strong network of people around them. Consequently, many participants reported migrant women often feel lonely in the perinatal period.

- One mother who, looking back, feels she had postnatal depression, said that it was her family who lived back in her country of origin who identified her depression. They encouraged her to spend some time with them so they could support her.

- One participant reported attending stay-and-play groups but felt left out by the other parents. She was one of the few attending who was not White and she felt those in the group had their own friendships and conversation which had little in common with her own experience.

Seeking support
Limited awareness of support available in the perinatal period was raised by participants as being one of the main issues. Often migrant mothers have little understanding of the healthcare system as well as what support is available in their local area. As previously mentioned, this is further aggravated by frequent moving across the country and a poor command of the language.

Regarding antenatal support, several participants expressed a sense of being at the mercy of their midwife. Should the midwife not provide information on additional support, such as mental health and wellbeing support, participants felt they had no way of finding this information from another source.

Some participants felt that their limited understanding of the healthcare system and their rights, coupled with limited ability to express themselves in English, meant that they were more likely to have their concerns and questions dismissed or ignored. This further fed into their sense of vulnerability and helplessness.

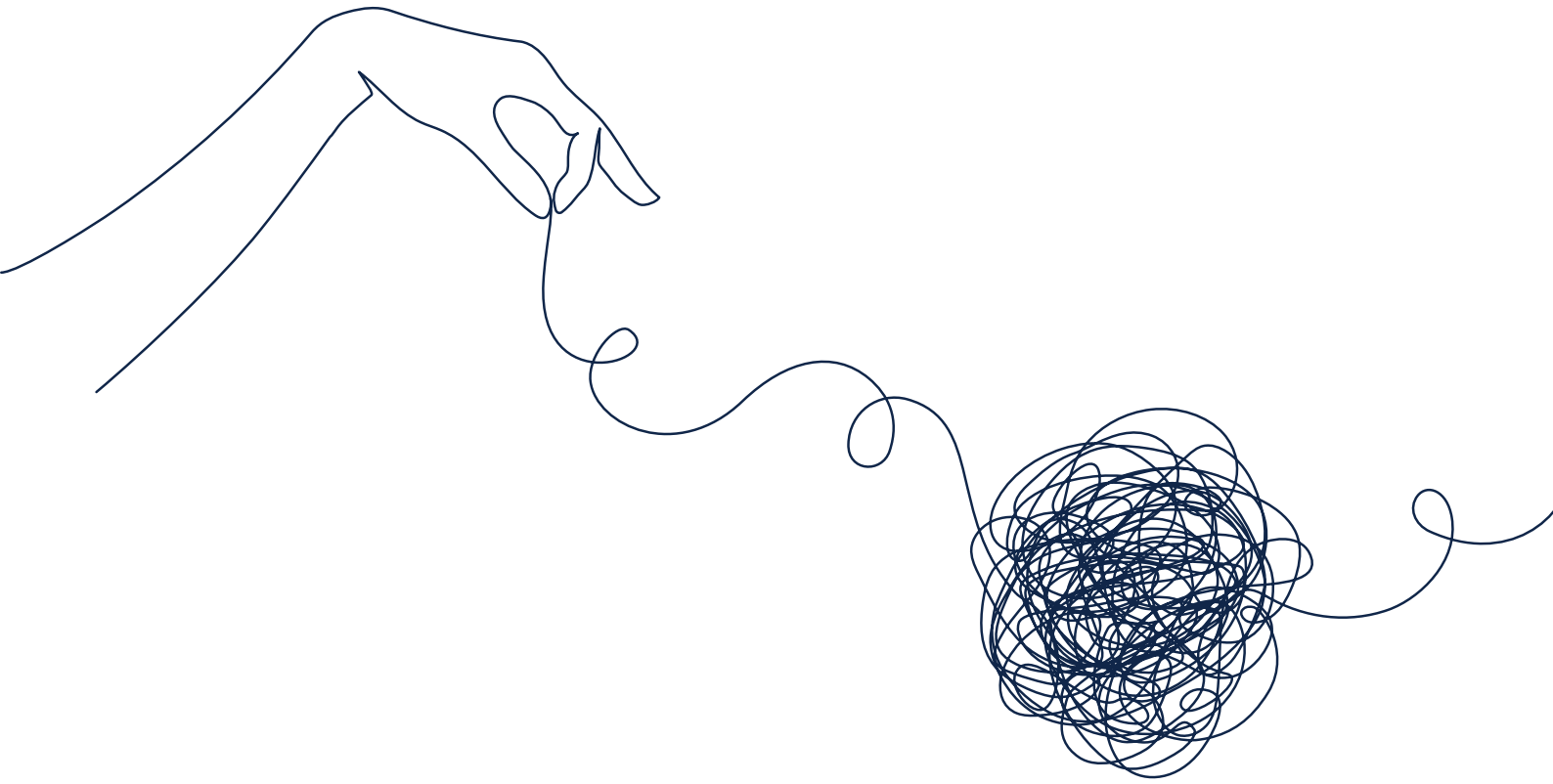
Interactions with maternity services.
Participants described a range of experiences when interacting with healthcare services during the perinatal period. Some felt that the care provided in the UK was better than what they would have experienced in their country of origin, namely, that there were more frequent checks of emerging issues with the pregnancy, or the baby. Others, however, explained that many migrant women who come to the UK expect the perinatal support and care provided to be of a very high standard. When this does not correspond to their experience, it can be challenging to adjust expectations to the reality of their new setting.

Discrimination
Some mothers reported experiencing racism when interacting with the healthcare system, for example, being treated differently from other women on the same wards. Others reported feeling discriminated against but were unsure if their poor experiences in interacting with the healthcare service were due to their ethnicity or immigration status.

- One mother, who had experienced post-natal depression, pointed out that, on several occasions in post-natal checks, she had been crying and visibly showed she was struggling with her emotional wellbeing. However, this was never picked up by those attending her. She felt they were cold and dismissive toward her and wonders whether some of this may have been due to her ethnicity or immigration status.

Mental health as a taboo
Several participants explained that mental health is not often talked about in their country of origin's culture. Many felt that many migrants do not have the vocabulary to describe mental health and wellbeing issues and, therefore, struggle to express what they are experiencing. Some also commented that people are afraid to be labelled as having mental health issues due to the stigma attached to this in their culture. While some migrant mothers are unable to recognise that they are struggling with mental health issues, others choose not to disclose it for fear of what others may think.

Some participants felt there was a need for more education on mental health and emotional wellbeing for women in the perinatal period. Some expressed that, had more information been given to them, they would have been more able to understand their experience, recognise their needs and ask for help. When asked whether she would have listened to her midwife or GP had they talked to her about mental health during her pregnancy, one participant answered very emphatically "No!". It was felt that community groups (such as Brushstrokes) were a more appropriate place to discuss this and learn from other mothers who shared similar experiences.



Discussion

The mental health, wellbeing and relationships established by parents and infants are foundational to the development of a healthy and resilient population. This report set out to explore and describe Sandwell's needs with regards to perinatal mental health and parent-infant relationships. It also sought to evaluate the help and support currently available and consider to what extent it is meeting the needs identified. Limited routinely collected and reliable measures of need in this area posed a challenge which was especially noticeable for parent-infant relationships. Therefore, this report relied primarily of proxy measures, use of national data to calculate local estimates, and the insights and perceptions of those involved in providing support, as well as those receiving it.

Sandwell has a predominantly urban and relatively young population. Despite declining fertility and maternity rates, as well as the proportion of the population composed by infants, these remain higher than those seen nationally. Sandwell's population is more ethnically diverse than England's. This diversity is higher among the parent and, in particular, infant population, and is increasing.

Sandwell's parent and infant population experience increased adversity. Several indicators associated with risk factors for antenatal and postnatal depression, and postnatal PTSD are more frequently seen in Sandwell, than nationally. Neonatal and infant death rates are markedly higher in Sandwell and the West Midlands when compared to England. Furthermore, high levels of deprivation are seen across the borough, with a high proportion of under 2s living in income deprived homes. Rates of teenage pregnancy, births outside marriage, domestic abuse and children living in households with substance misuse, emotional abuse and the "toxic trio" are all higher in Sandwell than in England. These prevalence of these indicators of adversity can be expected to increase the need for help and support with perinatal mental health and parent-infant relationship issues.

Analysis of limited local service data indicates that perinatal mental health needs may be increasing in Sandwell, or alternatively, are more frequently recognised. By contrast, referrals for infant mental health support, suggest these are under-identified, especially when compared with projected demands for parent-infant support services.

Service managers and practitioners involved in supporting parents and infants in Sandwell provided varied insights regarding strengths and limitations of the help and support provided across the system. While working in partnership was identified as foundational, barriers to this included poor information sharing and a fragmented system with weakened connections to primary care. Regular face-to-face update and networking meetings were felt to be an important way of overcoming these and health visitors were seen as vital in linking different groups. Most services faced considerable strain due to staffing issues, financial constraints, and increasing complexity of their caseload. Language, cultural barriers, and stigma further hindered access to support. Suggestions for improvement focused primarily on working closely with the community, facilitating peer support, investing in preventative work, and improving quality of support provided by training up staff and ensuring continuity of care. The overall sentiment emphasised the extent of unmet perinatal mental health and parent-infant relationship needs and the case for enhanced communication and stronger, well-resourced, and adequately specialised partnerships.

Consultation with parents and carers was restricted to two groups: those who had previously contacted the perinatal mental health services and migrant mothers. However, their insights added a personal perspective and further confirmed many of the assertions made by service representatives as well as indicator data. Parents and carers highlighted barriers to recognising and seeking support for mental health issues, including a lack of awareness, misconceptions, and stigma. This ignorance extended to their relatives, friends, and even some health professionals. Many felt ashamed and alienated, hesitating to seek help. Experiences varied in seeking support, with some disclosing struggles to family or healthcare providers, often facing dismissal. Positive experiences emerged with specialist teams, though follow-up support was felt to be lacking. Migrant women faced additional challenges due to language barriers, precarious living conditions, and limited support networks. Cultural taboos around mental health further hindered recognition and disclosure of their struggles. The consultation also did not include parents or carers that have experienced parent-infant relationship difficulties therefore it can be assumed that the voice of the baby has not been heard in this section.

Recommendations

1. Improve data collection and sharing

1.1. Considerations

- To some extent, there will necessarily continue to be a reliance on national and regional data as a means of estimating local need.
- Data collection will need to be informed by its intended purpose and the existence of systems to analyse it and action data-informed change.

1.2. How this can be achieved

- Raise awareness within local services interacting with families of the importance of data collection.
- Services to evaluate how their routinely collected data captures information on perinatal mental health and parent-infant relationship need and demand.
- Develop guidance on what data should be captured and how to go about this.
- Consider creating a joint resource, based on several services local data, providing a profile of mental health and wellbeing needs of parents and infants in Sandwell.

1.3. Next steps

- Create and share a summary of this report with relevant stakeholders and create opportunity for discussion around improvement of data systems.
- Ensure JSNA includes profiles on parental and infant mental health and wellbeing.

2. Improve coordination of and access to current services

2.1. Considerations

- Community-based services should be identified as an integral part of the care and support pathways for parents and infants.
- The frequent changes in system structure and pathways pose a substantial challenge in maintaining an up-to-date workforce that is informed of the local support offer.
- This report highlighted the importance of named individuals with previously established connections between services as a point of contact.
- When considering accessibility, special attention should be placed on groups that have been identified as more likely to be underrepresented (see Recommendation 6).

2.2. How this can be achieved

- Regular events (preferably with some face-to-face) to promote sharing of service knowledge, good practice and networking among services working in this area.
- Evaluate current directories to ensure that they map out support and referral pathways for perinatal mental health and parent infant relationship support. This should be considered for services as well as parents.
- Encourage services to evaluate accessibility of their service and whether certain groups are underrepresented.
- Incorporate the experience of parents and the perspective of the baby into any service provision planning and reconfiguration.

2.3. Next steps

- Agree on stakeholder group, format and frequency of meetings. Ensure adequate representation from the voluntary and community sector.
- Collate information on current support and identify available resources to work on updating support directories.
- Consider consultation and co-production with parents and vulnerable groups (see Recommendations 3 and 6)
- Create a whole-system pathway for parent-infant relationship support.
- Create a parent/carer friendly version of this report to share with families.

3. Strengthen identification and assessment of parent-infant difficulties

3.1. Considerations

- It is important to ensure that parents are listened to throughout all stages of the perinatal period.
- It is important that the emotional and physical needs of babies and their parent-infant relationships are considered by all practitioners during the perinatal period, including in pregnancy.
- To ensure that difficulties are picked up, all workforce involved in assessing children and families should receive training in identifying and assessing risk of perinatal mental health and parent-infant relationship issues.
- Improved identification of perinatal mental health and parent-infant relationship issues can cause a strain on specialist services.

3.2. How this can be achieved

- Consultation with families and facilitation of peer-support systems.

- Ensure coordination and consistency across agencies regarding assessment of need by identifying and supporting the use of shared assessment identification tools.
- Ensure local service workforce training and development plans adequately cover assessment of risk and signposting to support for anyone who assesses families as part of their job.

3.3. Next steps

- Identify current peer-support groups and areas where these can be created or strengthened.
- Collate perinatal mental health and parent-infant relationship assessment tools used locally and assess for consistency across services.
- Identify Sandwell staff who assess families as part of their job.
- Roll out of level 1 training in parent infant emotional wellbeing across the Sandwell workforce.

4. Continue developing universal services.

4.1. Considerations

- It is vital to raise the profile of perinatal mental health and parent-infant relationship within universal services currently supporting families.
- It is necessary to ensure everything possible is being done to provide support for all those who could benefit from it.

4.2. How this can be achieved

- Ensure routine checks and visits are reaching everyone in a timely manner by continuing efforts to increase workforce and streamline and coordinate patient encounters.
- Ensure parent-facing literature is consistent, up-to-date and sensitively discusses perinatal mental health and parent-infant relationships.

4.3. Next steps

- Create a summary and share insights from this report with appropriate services and create opportunity for discussion.
- Encourage services to evaluate support offered for perinatal mental health and parent-infant relationships within their current offer.
- Collate current parent-facing materials used in Sandwell and assess its appropriateness.

5. Consider developing a specialised parent-infant relationship team

5.1. Considerations

- This specialised team would have the purpose of offering direct interventions to families with complex parent-infant relationship needs and consultation, supervision, collaborative working, and training to build connection and capacity across the system.
- The team should ideally include representation from the local authority, healthcare services, voluntary sector, and parents.

5.2. How this can be achieved

- Ensure the team is embedded within the overarching system (including universal, targeted and specialist services), working closely with perinatal mental health teams, and integrating with national and local plans.
- Funding for the delivery of this service provision should be identified in order to build a business case.

5.3. Next steps

- Establish inter-agency conversations regarding opportunity of developing this specialised service.
- Consultation with the Parent-Infant Foundation, and familiarisation with their development and implementation toolkit.

6. Advocate for vulnerable groups

6.1. Considerations

- This report has identified certain population groups as having particular unmet needs or facing greater barriers in accessing support, namely, migrant parents, certain cultural and ethnic groups (e.g. Asian, African and Traveller communities), and fathers or male carers.
- Infants in themselves can be considered an under-represented group, given that several mental health and emotional wellbeing issues seem only to be recognised at a later point.
- While support should seek to access all, particular focus should be placed on ensuring these groups are not left out.

6.2. How this can be achieved

- Gaining better understanding of these groups' experiences and needs.
- Ensuring the voices of these groups are included in parent co-production of services and support materials.
- Ensure perinatal mental health and parent infant relationships are embedded within other mental health and wellbeing strategies (e.g. Sandwell's Better Mental Health Strategy)

6.3. Next steps

- Identify existing forums with these groups and coordinate consultation and co-production work.
- Encourage local services to assess representation of these groups in their caseload.

7. Raise public awareness of the importance of perinatal mental health and parent-infant relationships.

7.1. Considerations

- There are ethical issues regarding raising the public's awareness to a need which cannot be supported with current service capacity. Therefore, this should be considered with caution and, ideally, enacted once service capacity has been strengthened.
- All communications should seek to address the stigma surrounding mental health, particularly during the postnatal period. Emphasis should be placed on using culturally appropriate language, particularly targeting communities where seeking support for mental health is seen as taboo.

7.2. How this can be achieved

- Together with parent/carer and service representatives, co-produce an information campaign communicating key messages on how to identify and access support for perinatal mental health and parent-infant relationship needs.
- Encourage local services to evaluate their communications with parents and support them in how to communicate in a reassuring, non-judgmental way, using appropriate language.

7.3. Next steps

- Identify key groups to be involved in co-producing information campaign.
- Consider further consultation with representatives from Asian, African and Traveller communities to identify appropriate language with which to address mental health issues.
- Develop guidance for local services on the use on appropriate, de-stigmatising language when communicating directly with parents, as well as through written, digital and social media.

Throughout this project, several contextual factors were repeatedly identified as compounders of mental health and wellbeing needs. These included relationship breakdown, isolation, and limited support networks, as well as financial constraints. While certain groups were thought to have increased needs or higher risk of not accessing support (e.g. migrants, certain ethnic/cultural communities), there was a lot of uncertainty as to who these might be. This further points toward weak systems of capturing and monitoring data on perinatal mental health and parent-infant relationship needs. However, fathers and male carers were frequently mentioned as having unmet needs, albeit with recent years seeing some improvement in how these are recognised and addressed.

Limitations

This report is by no means an exhaustive assessment of perinatal mental health and parent-infant relationship needs in Sandwell. Several limitations have been identified and described throughout the report. These can be grouped in the following areas:

Challenges in accessing reliable measures of need.

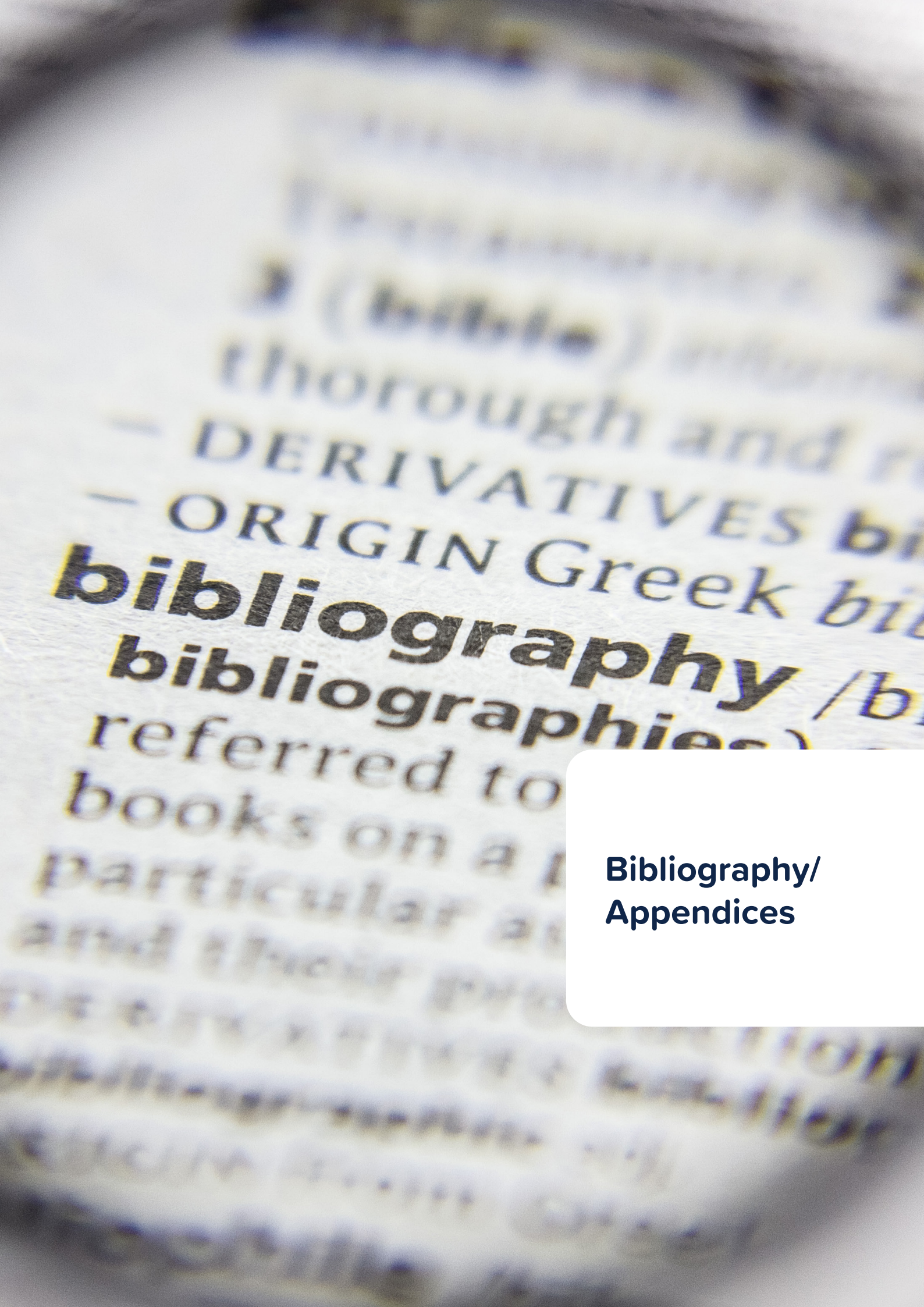
- In view of limited routinely collected measures of perinatal mental health and, in particular, parent-infant relationship needs, this report has relied on several proxy measures as well as local estimates derived from national data. These are, therefore, subject to error, as they do not always consider underlying mechanisms, confounders and the impact of contextual factors (such as Sandwell's cultural and socioeconomic context).

- Local service data made available for this assessment was limited and, in several cases was made up of very small numbers. Consequently, it provides a fragmented picture of which limited conclusions can be made. However, it does also indicate possible gaps in recognition of certain needs.

Consultations' sample size and representativeness

- This project was limited by time and capacity constraints and, therefore, was not able to offer a more comprehensive consultation. Notable gaps in service representatives include primary care and CAHMS. Despite several attempts to engage with multiple parent and carer forums, only two groups took part in this project. Therefore, this report explores the views of a fraction of those involved in providing and receiving support in this area and cannot be considered representative of the whole population.

- As previously mentioned, interview data is subject to the influences of the context in which it was elicited and the biases of those interpreting it. In this case, it is possible that those who were willing to take part in the consultation had a special interest in this topic, previous personal experiences, or were seeking particular outcomes. It may, therefore, present a one-sided view on this topic and must be interpreted with a critical mindset.



Bibliography/ Appendices

Bibliography

1. Antoniou E, Stamoulou P, Tzanoulinou MD, Orovou E. Perinatal Mental Health; The Role and the Effect of the Partner: A Systematic Review. Healthcare (Basel). 2021 Nov 18;9(11):1572. doi: 10.3390/healthcare9111572.
2. Dekel S., Stuebe C., Dishy G. Childbirth Induced Posttraumatic Stress Syndrome: A Systematic Review of Prevalence and Risk Factors. Front. Psychol. 2017;8:560. doi: 10.3389/fpsyg.2017.00560.
3. NICE. [CG192] Antenatal and postnatal mental health: clinical management and service guidance. https://www.nice.org.uk/guidance/cg192 (2020).
4. Howard LM, Molyneaux E, Dennis CL, Rochat T, Stein A, Milgrom J. Non-psychotic mental disorders in the perinatal period. Lancet. 2014 Nov 15;384(9956):1775-88. doi: 10.1016/S0140-6736(14)61276-9. Epub 2014 Nov 14. PMID: 25455248.
5. Paulson J.F., Bazemore S.D. Prenatal and Postpartum Depression in Fathers and Its Association with Maternal Depression: A Meta-Analysis. JAMA. 2010;303:1961–1969. doi: 10.1001/jama.2010.605.
6. Rao WW, Zhu XM, Zong QQ, et al.. Prevalence of prenatal and postpartum depression in fathers: a comprehensive meta-analysis of observational surveys. J Affect Disord. 2020;263:491-499. doi: 10.1016/j.jad.2019.10.030
7. Royal College of General Practitioners. Position statement about Perinatal Mental Health. https://www.rcgp.org.uk/policy/rcgp-policy-areas/perinatal-mental-health (2016).
8. Hogg, S. and Moody, J. (2023). Understanding and supporting mental health in infancy and early childhood - a toolkit to support local action in the UK. UNICEF UK.
9. Darling RP, Storebø OJ, Løkkeholt T, et al. Attachment as a Core Feature of Resilience: A Systematic Review and Meta-Analysis. Psychological Reports. 2019;122(4):1259-1296. doi:10.1177/0033294118785577
10. Department of Health & Social Care, "Reflecting on parent-infant relationships: a practitioner's guide to starting conversations," March 2024. [Online]. Available: https://www.gov.uk/government/publications/parent-infant-relationships-starting-conversations-practitioner-guide/reflecting-on-parent-infant-relationships-a-practitioners-guide-to-starting-conversations#about-this-guidance. [Accessed 24 July 2024].
11. National Scientific Council on the Developing Child (2015). Supportive Relationships and Active Skill-Building Strengthen the Foundations of Resilience: Working Paper No.13
12. Perry BD. Childhood experience and the expression of genetic potential: what childhood neglect tells us about nature and nurture. Brain and mind. 2002;3:79–100
13. National Scientific Council on the Developing Child (2010). Early Experiences Can Alter Gene Expression and Affect Long-Term Development: Working Paper No. 10. http://www.developingchild.net, p7
14. Centre for Mental Health & London School of Economics Personal Social Services Research Unit. The costs of perinatal mental health problems. https://www.centreformentalhealth.org.uk/publications/costs-perinatal-mental-health-problems (2014).
15. Yan H, Wu Y, Li H. Effect of mindfulness-based interventions on mental health of perinatal women with or without current mental health issues: A systematic review and meta-analysis of randomized controlled trials. J Affect Disord. 2022 May 15;305:102-114.
16. Smith CG, Jones EJH, Wass SV, Jacobs D, Fitzpatrick C, Charman T. The effect of perinatal interventions on parent anxiety, infant socio-emotional development and parent-infant relationship outcomes: A systematic review. JCPP Adv. 2022 Nov 19;2(4):e12116.
17. Verbeke E, Bogaerts A, Nuyts T, Crombag N, Luyten J. Cost-effectiveness of mental health interventions during and after pregnancy: A systematic review. Birth. 2022 Sep;49(3):364-402. doi: 10.1111/birt.12623.
18. National Scientific Council on the Developing Child. (2004). Young children develop in an environment of relationships. Working Paper No. 1. Retrieved from http://www.developingchild.net
19. Feinstein, L. (2003). Inequality in the early cognitive development of British children in the 1970 cohort. Economica, 70(277), 73-97.
20. Center of the Developing Child, "Brain Architecture," Harvard University, [Online]. Available: https://developingchild.harvard.edu/science/key-concepts/brain-architecture/. [Accessed 24 July 2024].
21. Geddes, H. (2006) Attachment in the Classroom: the links between children's early experience, emotional wellbeing and performance in school. London: Worth Publishing"
22. Bergin, C. and Bergin, D. (2009) Attachment in the Classroom. Educational Psychology Review, 21, 141-170
23. Siegel, D. (2012) The Developing Mind: How relationships and the brain interact to shape who we are. New York: Guildford Press
24. O'Donnell, K., Glover, V., Barker, E. D. & O'Connor, T. G. (2013). The persisting effect of maternal mood in pregnancy on childhood psychopathology. Development and Psychopathology
25. Straatmann, V. S., Lai, E., Lange, T., Campbell, M. C., Wickham, S., Andersen, A. M. N., & Taylor-Robinson, D. (2019). How do early-life factors explain social inequalities in adolescent mental health? Findings from the UK Millennium Cohort Study. J Epid
26. Hambrick, EP., Crawner, TW. & Perry, BD. (2019). Timing of Early-Life Stress and the Development of Brain-Related Capacities. Front. Behav. Neurosci., 13:183. doi: 10.3389/ fnbeh.2019.00183. https://www.frontiersin.org/articles/10.3389/fnbeh.2019.00183/f"
27. Sitnick, SL., Galàn, CA., & Shaw, DS (2018). Early childhood predictors of boys' antisocial and violent behavior in early adulthood. Infant Mental Health Journal, 40(1): 67-83. https://onlinelibrary.wiley.com/doi/full/10.1002/imhj.21754
28. UNICEF, [Online]. Available: https://www.unicef.org.uk/campaign-with-us/early-moments-matter/. [Accessed 24 July 2024].
29. Fraiberg, S., Adelson, E., & Shapiro, V. (2003). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant-mother relationships. Parent-infant psychodynamics: Wild things, mirrors and ghosts, 87, 117
30. Nelson (2003), Charles A. "Neural development and lifelong plasticity." Handbook of Applied Developmental Science: Promoting Positive Child, Adolescent, and Family Development Through Research, Policies, and Programs 1 (2003): 31
31. Fox, S. E., Levitt, P., & Nelson, C. A., 3rd (2010). How the timing and quality of early experiences influence the development of brain architecture. Child development, 81(1), 28–40. https://doi.org/10.1111/j.1467-8624.2009.01380
32. First 1001 days (2021), Evidence Brief 6, Investing in Babies; The Economic Case for Action https://parentinfantfoundation.org.uk/1001-days/resources/evidence-briefs/
33. Heckman, "The Heckman Curve," 2023. [Online]. Available: https://heckmanequation.org/resource/the-heckman-curve/. [Accessed 24 July 2024]
34. Sandwell Metropolitan Borough Council, "Joint Strategic Needs Assessment for Sandwell," Sandwell Trends, [Online]. Available: https://www.sandwelltrends.info/jsna-2/. [Accessed 24 July 2024].
35. Ministry of Housing, Communities & Local Government, "The English Indices of Deprivation 2019 - Statistical release," London, 2019.
36. Marmot, M. Fair society, healthy lives: the Marmot Review: strategic review of health inequalities in England post-2010. (2010) ISBN 9780956487001
37. Children's Commissioner for England, "Trends in childhood - Vulnerability technical report 1," Children's Commissioner's Office, London, 2019.

38. R. Strachan, S. Zahid, K. Chapman, M. Manoli, L. Hucks, L. Aston and E. Doyle, "A service evaluation to establish if the perinatal service meets the needs of the Black Country birthing population," West Midlands, 2024.
39. K. Bateson, M. Sercombe and W. Hamilton, "Securing Healthy Lives - An extended summary of research about parent-infant relationship help and support across Cwm Taf Morgannwg," Parent Infant Foundation, 2021.
40. C. Nuttall, C. Osborne, A. Meades and C. McCloskey, "Nurturing our future: holding young minds in mind - A needs assessment of parent-infant relationship help and support in Birmingham," Birmingham Women's and Children's NHS Foundation Trust, Birmingham, 2022.
41. van IJzendoorn, M. H., & Kroonenberg, P. M. (1988). Cross-Cultural Patterns of Attachment: A Meta-Analysis of the Strange Situation. Child Development, 59(1), 147–156. https://doi.org/10.2307/1130396
42. Cyr, C., Euser, E. M., Bakermans-Kranenburg, M. & Van IJzendoorn, M. (2010) Attachment security and disorganization in maltreating and high-risk families: A series of meta-analyses. Development and Psychopathology. 22 (1), 87-108
43. National Institute for Health and Care Excellence. Children's attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care," no. https://www.nice.org.uk/guidance/ng26/documents/childrens-attachment-final-scope2.
44. R. H. S. M. e. a. Miranda Wolpert, "THRIVE Framework for," CAMHS Press, London, 2019.
45. Evans D, Eatwell D, Hodson-Walker S, Pearce S, Reynolds V, Smith S, Whitehouse L, Butterworth R. Collaborative Recognition of Wellbeing Needs: A Novel Approach to Universal Psychosocial Screening on the Neonatal Unit. J Clin Psychol Med Settings. 2024 Apr 29. doi: 10.1007/s10880-024-10016-6.
46. Braun V, Clarke V. "Using thematic analysis in psychology," Qualitative Research in Psychology, vol. 3, no. 2, pp. 77-101, 2006.
47. Stein A, Pearson RM, Goodman SH, Rapa E, Rahman A, McCallum M, Howard LM, Pariante CM. Effects of perinatal mental disorders on the fetus and child. Lancet. 2014 Nov 15;384(9956):1800-19. doi:

Appendices

Appendix 1 – Topic guide for service representative interviews

Section 1. Interviewee details

1. What is your job title and role within your organisation/group?

Section 2. Description of interviewee's service/support

2. Could you describe your role of working in the area of PMH/PIR?
   - PMH, PIR or both?
   - Could you give examples of what this might look like on a regular day/week/month?
3. Thinking about your service/support in particular:
   - **What kind of issues do you deal with?**
     - Who do you see/support?
     - What is offered to them?
     - Who is involved in this?
   - **How do you feel about the support you are able to provide?**
     - What do your patients/service users say about the support you provide?
     - Would you like to be able to do more?
     - What stops you from doing that?
     - Are there issues with staffing?
     - Are there issues with funding?
     - How could it be improved?
   - **How well do referrals into your service work?**
     - Are those who need to refer into it aware of your service?
     - Are they aware of how to refer into your service?
     - Are referrals appropriate?
     - What is the waiting time?
   - **Do you feel your service is reaching everyone it needs to?**
     - Who is being missed out?
     - How could this be changed?

Section 3. Needs of Sandwell

4. How would you describe the mental health and wellbeing of parents/infants in Sandwell and why?
   - What do you see as being the greatest mental health and wellbeing needs of parents in Sandwell?
   - What mental health issues have you come across in your work?
   - What about wider context factors (e.g. finances, housing, community, relationships)?
   - What about alcohol/drugs, physical mental health?
   - What aspects of Sandwell might make it more challenging to be a parent/infant?
5. Which groups of parents/infants in Sandwell who you think have greater MH and WB needs?
   - Certain ethnic, religious, social groups (e.g. people seeking asylum, Traveller communities, etc)
   - What about fathers and partners?
   - What are those specific needs?
   - Why do you think that is?
6. What do you think of the current services and support available to parents/infants with their mental health in Sandwell?
   - What services/support are you aware of?
   - Would you say they adequately meet the needs of the population?
   - Are there any gaps in what is provided?
7. What would you say stops people who need these services/support from accessing it?
   - Are there any groups who face particular barriers in accessing it?
   - Is there anything that makes it easier for people to access it?

How could the support given to parents/infants in Sandwell for their mental health and wellbeing be improved?

- Are you aware of anything that has been done to improve it?
- What needs changing?
- What is needed for that change to happen?
- Who needs to make the change happen?
- What would the effect of having that change be?

Section 4. Final thoughts

Is there anything else you would like to add?

Final questions

Do you have any data around caseload/referrals you would be willing to share?
Do you collect any feedback/qualitative data from patients/service users?
Have you conducted any evaluation/audit you would be willing to share?

Appendix 2 – Topic guide for parent and carer focus groups

1. When thinking about the perinatal period, what were the greatest challenges you faced in terms of mental health and wellbeing?
- Anxiety, depression, worry
- Feeling lonely, stressed
- Uncertain future, lack of support, financial constraints

2. What things had the biggest impact on your mental health and wellbeing?
- **Prompts:**
- Needs around relationships and wider social network support (Do parents feel lonely? Do they have a strong network of people around them? Are families supportive?)
- Needs around people's wider context (Are there issues around unemployment or financial security? Is housing an issue? Do parents feel safe where they live?)

3. What things do you think had the biggest impact on the wellbeing of your baby?

Relationship with parents
Stability in the household (emotional, relationships, financial)

4. What kind of support would you like to receive (for yourself or your baby)?
- How to interact with/care for baby?
- Breastfeeding
- Managing own emotions and wellbeing
- Interacting with others
- Finances
- Who should be providing that support?
- Which services/groups do you know of?
- **What are your thoughts on how well those groups are working?**

5. What would you like that support to look like?
- Meeting other parents/group sessions
- Meeting at home
- Cost
- When (antenatal, straight after pregnancy, long after)
- Informal/befriending support
- More bespoke (not one size fits all)

6. What things keep you from reaching out for help with your mental health and wellbeing?
- **Prompts:**
- Are you aware of what support is available?
- Are you worried that asking for support may impact how they are seen by others?
- Are you worried about how it will make you feel?

7. What things keep you from receiving that support?
- **Prompts:**
- Are your needs misunderstood?
- Is there no support available?
- Are there language or cultural barriers?
- Are people reluctant to support you?
- Lack of time
- Difficulty getting to places
- Having other children/responsibilities

8. What has been your experience of receiving support for mental health in the perinatal period?
- **Prompts**
- Where did you look for support? Family, GP, midwife, health visitor, community groups, etc...
- Was it easy to find help?
- What were the things that you found helpful?/What worked well?
- What did you find difficult?
- What could have been better?

- How would you describe the support you received?
- How helpful was it? Would you have liked more support?
- Did it take long?

9. What could be done to improve the mental health support for parents/carers and their children?
- **Prompts:**
- Do you need more information on where to find help? Or more information on how to help yourself?
- Is the information given easy to understand and useful?
- Do you need more contact with people to support you?
- Are there areas where more support is needed (e.g. financial advice, how to manage stress/anxiety, etc)?

10. What things about living in Sandwell do you think have a particular effect on your mental health and well-being?
- **What do you think are the specific needs of fathers/partners?**
- Is support available for them?

Changing childhoods. Changing lives.

Appendix 3 – Report on Perinatal mental health and parent infant relationship consultation June – July 2024

The Health, Well-being and Engagement Team within Sandwell Family Hubs was asked to undertake a consultation between June and July 2024 with parents with a child under two years of age around perinatal mental health and parent infant relationship.

We targeted the consultation at baby clubs and baby massage groups taking place in Family Hubs and spokes across Sandwell and invited parents to participate. In addition, Family Hub Workers also consulted with parents they were supporting on a 1:1 basis. We invited 33 parents to participate, and 26 parents agreed to take part. Three parents were aged between 20-24, fifteen parents were aged 25-34 and eight parents aged 35-44. 100% of participants had a child aged 0-2.

The table below provides a brief overview of participants.

Date of Consultation	Number of parents /carers in session	Number of parents/carers willing to participate	Age band of parent/carer	Ethnicity	Ages of children	Number of parents in household
Town: Oldbury						
20/06/2024	3	1	25-34	Mixed Indian/ British	0-2, 5-11	2
25/06/2024	4	1	35-44	White British	0-2	2
Town: Smethwick						
26/06/2024	5	3	20-24 25-34 25-34	Indian - Indian	0-2, 5-11 0-2 0-2	2 2 5
Town: Rowley Regis						
24/06/2024	4	4	25-34 25-34 25-35 25-34	White British White British Black Caribbean White British	0-2 0-2 0-2 0-2	2 2 2 2
Town: Tipton						
20/06/2024	4	4	25-34 35-44 25-34 25-34	British Indian Indian White British Indian	0-2, 2-5, 5-11 0-2 0-2, 5-11 0-2	2 2 1 4
21/06/2024	6	6	35-44 20-24 35-44 35-44 35-44 25-34	British Indian White British African Mixed Caribbean White British British	0-2 0-2 0-2, 2-5, 5-11 0-2, 2-5, 5-11 0-2, 5-11 0-2,2-5, 5-11	3 2 1 2 2 1
26/06/2024	2	2	25-34 20-24	British British	0-2 0-2	1 3
27/06/2024	2	2	25-34 25-34	British British Indian	0-2, 2-5 0-2	2 2
Town: West Bromwich						
June 2024	1	1	25-34	Indian	0-2	4
Town: Wednesbury						
June 2024	2	2	35-44 35-44	Whitie British White British	0-2 (pregnant) 0-2 (pregnant)	2 2
TOTALS	**33**	**26**	**20-24 x 3** **25-34 x 15** **35-34 x 8**		**0-2 x 26** **2-5 x 5** **5-11 x 8**	

Parents were asked the same set of questions regarding perinatal mental health and parent infant relationship: -

- What do you see as the being your greatest mental health and well-being needs?
- What are the main barriers that stop you from receiving the mental health support you need?
- What can be done to improve mental health support for parents/carers and their children?

Summary of answers provided: -

What do you see as the being your greatest mental health and well-being needs?

Feeling isolated and alone, having first baby and it has been a whole lifestyle change- thrown in at the deep end.

Four parents stated they had no mental health needs

One parent said she had sought support from her GP for her mental health and is currently taking medication to help with this. She commented that coming to Baby Club helps parents to cope with changes that parenthood brings.

One parent said she would like support when she needs it. Sometimes she has felt overwhelmed by all the changes in the recommendations from professionals compared to when she had her older child six years ago. "Talking to parents in sessions reminds you that you are not alone."

One parent said they were diagnosed a few years ago with anxiety and depression and was supported by family and attending therapy. This parent told us that joining a local gym and enrolling on a fashion course had also helped her.

One parent mentioned they had suffered with anxiety and depression before having her children. She found it worrying and stressful whilst pregnant when she missed appointments that had been booked on the Bager Notes App. Her husband missed the birth of their third child because fathers are asked to leave the hospital at 9pm and the hospital failed to call him back. This caused both parents to feel let down by the hospital and upset by the whole experience. The couple felt "we were just left to get on with it when we got home with our new baby."

Three parents shared it is important to have time to themselves – me time.

One parent mentioned sleep deprivation affects their coping mechanisms.

One parent said that not feeling like yourself physically after you have had a baby can affect your emotions.

One parent felt they have the right kind of support and are not judged when they ask for help. One 1 parent told us it is good for their mental health to set themselves a goal to focus on.

One parent said managing more than one child can affect how you feel.

One parent said, "accepting the way I look."

One parent receiving 1:1 support has recently been through a termination and felt this put a lot of pressure on her mental health and well-being. She has had no formal diagnosis around her mental health issues and no medication has ever been taken. This parent said that workload can be a lot and sometimes it can be stressful when she is called out of work. She said her manager was very understanding particularly about the termination. She told us some of her coping strategies include taking a shower, family friends, husband and even her baby when she is feeling stressed. She also listens to religious prayers.

One parent receiving 1:1 support has been diagnosed with depression and her partner told us that he has struggled being out of work as he feels like a failure not being able to support the family. He believes this is having an impact on his mental health. Both parents said the lack of finances has had a negative impact on their mental health and well-being.

What are the main barriers that stop you from receiving the mental health support you need?

Four parents said not knowing what is available and having to research information.

Four parents said they felt they know where to find help if they needed it.

"Feeling nervous about going on my own."

"Classes at the Hubs are not advertised clearly and I can only attend one in a term."

Session restrictions, for example, "I had just started to feel confident when attending Baby Sensory sessions, I have been going on my own with my baby and getting to know other parents. I have been told I am not allowed to go again for 12 months and by this time my baby will be too old."

Two parents said waiting lists.

A parent reflected that her own pride sometimes got in the way of her accessing support "... not wanting to admit I may need help with my baby and thinking I can do it on my own."

Three parents said there were no barriers.

Four parents shared they felt having the confidence to seek support, as it can still be a taboo subject that people do not want to admit to. One of these mums went on to say she has not been feeling herself recently and recognised she needs to ask for help from family members.

One parent said the change in lifestyle after having a baby can be a barrier.

Two parents said that midwives and health visitor had not told them about Family Hubs.

One parent mentioned the difficulty in getting a GP appointment.

One parent found it hard to find someone to listen to her. She had no home visit from her health visitor – just telephone contact. This parent said she attends a self-weigh clinic at a Hub but worries if she is doing it correctly.

Even when a parent can have a good support system around them including family and friends, sometimes not wanting to talk to anyone when you are going through a difficult time, for example, a termination can be difficult.

A dad said he worries about to speaking to someone and opening up about his feelings.

What can be done to improve mental health support for parents/carers and their children?

Parents asked for more support from hospitals before you leave with your newborn.

Being discharged from hospital too soon is unhelpful. There should be more after care support.

New mums should feel listened to by their midwife.

More support for new parents "So you don't feel alone.'"

One parent said more support should be offered by midwives and health visitors – and parents should not be "fobbed off with meaningless replies to concerns raised."

Another parent said having a supportive health visitor who offered sound advice and support.

It should be easier to get an appointment with a health visitor.

More home visits by health visitors as a parent could have post-natal depression and this is not easily diagnosed during a telephone contact.

One parent said health visitors should recommend services and parents need more information about mental health services available in their community.

More regular visits from midwives during pregnancy.

Knowing what is available from the outset of pregnancy was suggested by one parent.

"The 12 month restriction rule to be removed, allowing more parents to continue to attend more baby sessions."

Three parents said there was nothing that could be done to improve mental health support. Others felt there is a lot of support available.

Parents said coming along to Baby Clubs is a good support as parents discuss their experiences and ask questions about their baby.

Organisations should ask parents about individual needs as everyone is unique.
There should be more places offering support in a timely way as not all parents have support from their families.

One parent suggested having information about accessing training courses.

Sandwell
Family Hubs
Helping Families Thrive

For more info contact us on 0121 522 5210
www.sandwellfamilyhubs.com