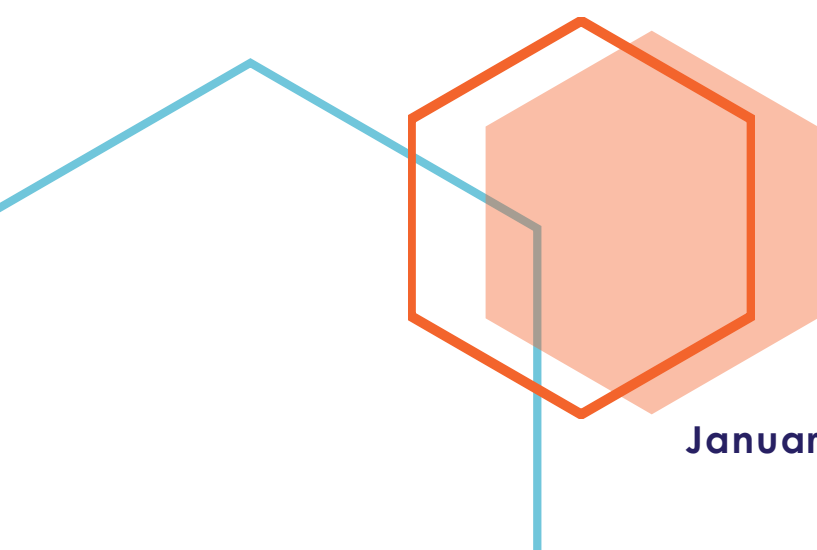




Specialist Health Visitors in Perinatal and Infant Mental Health



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Contents

Executive Summary 3

Background 6

Methods 9

Findings 10

 Qualifications 10

 Key Contributions of Specialist Health Visitor in PIMH 12

 Barriers to promoting PIMH 24

Discussion 27

Conclusions 28

Recommendations 28

References 30

Appendix 1 – Survey Questionnaire 32



Executive Summary

Background

Perinatal mental illnesses are common and can have a devastating impact on women and their families. They also have a high social cost in addition to a financial cost of £8.1 billion for each one-year cohort of births in the UK. Seventy-two percent of this cost relates to adverse impacts on the child. As such supporting maternal and family mental health is designated as one of six high-impact areas for the health visiting workforce. Specialist Health Visitors in Perinatal and Infant Mental Health (Sp HV PIMH) are local-level leaders who have post-registration training focused on family mental health and wellbeing, and promoting healthy caregiving relationships between parents and infants. However, Sp HV PIMH constitute just 0.8% of the health visiting workforce and this appears to reflect an ambivalence on the part of policy makers with regard to the development of specialist roles generally within health visiting, and a lack of clarity about the role and funding in terms of the commissioning of such posts more specifically. This study examines the training and qualifications of Sp HV PIMH and their role in terms of supporting health visitors within the wider workforce, and families at risk of or experiencing mental health problems during the perinatal period.

Methods

A mixed-methods study was conducted involving an online survey with 34 Sp HV PIMH and in-depth interviews with 7 Sp HV PIMH, and 3 Perinatal and Infant Mental Health Champions.

Results

The results show that around two-thirds of interviewees had completed a postgraduate certificate or a diploma in a relevant field (77%), with nearly a third of respondents having a Master's degree in community public health or psychological therapies (29%). In addition, 88% had completed the Institute of Health Visiting iHV Champions Training, 65% the Solihull Approach Training at NHS University Hospitals, and 12% had completed the ITSIEY training at the Anna Freud Centre. Respondents reported routinely updating their skills, with around half stating that they attend skills training every six months (51%), and most of the remainder attending skills training once a year (43%).

A clear distinction was drawn between the work of Sp HV PIMH and PIMH Champions. The role of the former was perceived to primarily involve providing strategic leadership including the development of training and governance, quality assurance, supervision of staff, service re-design and the development of policies and pathways, in addition to some clinical work. In contrast, PIMH Champions were described as carrying a full caseload, but also having some protected time in which to undertake a liaison role with specialist perinatal services, and in their wider communities. Around two-thirds of survey respondents reported having a small caseload of families with more complex mental health needs (69.6%). A majority of survey respondents reported their caseload to be under 100 families (74%), with the interviews indicating that caseloads typically consist of 15 to 20 families with complex problems. Casework was described as

Specialist Health Visitors in Perinatal and Infant Mental Health



focusing on areas such as parental antenatal depression, antenatal anxiety, general anxiety, birth trauma, postnatal depression and panic attacks, using a range of interventions including listening visits (96%), motivational interviewing (78%), self-guided meditation (61%), relaxation techniques (51%); mindfulness practices (48%), with around half providing interventions focusing on parent-infant relationships specifically (i.e. VIG) (44%). Other interventions included Solution Focused Therapy; CBT; NBAS/NBO and Promotional Interviews/Guides. However, many more respondents were trained in VIG than were able to deliver it as a result of the fact that it was not commissioned.

Survey respondents reported current barriers to the promotion of PIMH as being a lack of funding (82.3%) and lack of understanding among commissioners about PIMH (64.7%) and the role of HVs in PIMH (73.5%). An absence of and/or discontinuity in funding was cited as the biggest barrier to the promotion of perinatal and infant mental health, with the discontinuity in funding that has occurred over recent years being perceived to have led to a constant need to reinvent the wheel.

Conclusions

The findings of this report suggest that Sp HV PIMH have a unique role in addressing parent and infant mental health problems both strategically in terms of establishing and supporting integrated service delivery, and clinically in terms of supporting families experiencing mild to moderate problems using more specialist interventions including dyadic models of working such as VIG. The findings also suggest that these practitioners have significant experience and additional training to prepare them for this role and that formal commissioning of the role provides them with the necessary infrastructure to undertake the work.

Recommendations

- Sp HV PIMH should be commissioned by every Local Authority in England, every Health Board in Wales and Scotland and every Health and Social Care Trust in Northern Ireland. Such commissioning should include providing them with the necessary resources to enable them to work both strategically and clinically;
- Sp HV PIMH would appear to be best located within Universal Services where they play a significant role in supporting PIMH Champions and the wider health visiting workforce, in order to support parents and infants experiencing mild to moderate difficulties during the perinatal period;
- Sp HV PIMH should have expertise in assessing parent-infant interaction, using standardised observational tools such as the PIIOS, and delivering dyadic interventions such as VIG, to enable them to provide specialist support to parent-infant dyads experiencing interactional difficulties;
- Further work should be undertaken to explore specific guidance for use of VIG in health visiting services, including legal guidance regarding the status of such videos in the event of child protection issues;
- A national set of standards for health visiting and health visiting services are needed concerning Perinatal and Infant Mental Health. This could potentially build on current quality frameworks and service standards such as, the AiMH UK Infant Mental Health Competency Framework developed for

Specialist Health Visitors in Perinatal and Infant Mental Health



IMH practitioners (AiMH UK, 2021) and the Perinatal Mental Health Services Recommendations for the Provision of Services for Childbearing Women (Royal College of Psychiatrists, 2021).

- Sp HV PIMH demonstrate core capabilities of Advanced Clinical Practice described as the four pillars of clinical practice, leadership and management, education and research (NHS HHE, 2016) within universal services but beyond the level of practice of the registered Specialist Community Public Health Nurse (SCPHN) – health visiting. The role and contribution of this level of practice could be supported by the development of a credential for ACP – health visiting.



Background

It is estimated that up to 20 per cent of women in the UK develop a mental health problem during pregnancy or within a year of giving birth (Bauer *et al.*, 2019), and that perinatal mental health problems cost the welfare state about £8 billion each year, with 72 per cent of this cost being attributed to the adverse impact on the child (Bauer *et al.*, 2019). The latter reflects the fact that although many families experiencing perinatal mental health problems are able to continue to provide sensitive care, if left untreated, perinatal mental health problems such as depression can in some cases impact parental responsiveness to the baby's needs (Stein *et al.*, 2014; Beck, 1995). This is important because such disturbances in the parent-infant relationship can result in emotional, behavioural, eating, and sleeping disorders in the early years (Skovgaard *et al.*, 2010), in addition to insecure attachment (Zeegers *et al.*, 2017). Such early problems have a strong association with delays in motor, language, and cognitive development, and continuing parent-child relational problems (DeGangi *et al.*, 2000) and externalising disorders (Fearon *et al.*, 2010).

Health visiting is one of the key statutory services supporting pregnant and newly delivered women, and maternal mental health was one of six high impact areas for health visiting services that were drawn up by a partnership between the Department of Health, Public Health England, Local Government Association, NHS England, Early Intervention Foundation and Health Education England, as part of the transition to local authority commissioning of health visitors.¹ More recently newly revised guidance² and standards³ strengthens the accountability of the universal and specialist health visiting role in parental and infant mental health.

Health visitors are ideally placed to offer home-based early interventions that:

- can prevent mental illness occurring in the first place
- identify mental health and relationship problems early
- offer evidence based interventions
- ensure timely referral on for more specialist care when needed
- coordinate a package of care that is personalised to meet all of the families needs

Health visitors are the only health professional who routinely sees all families from pregnancy through to when the youngest child goes to school, giving them a unique opportunity to develop trusting relationships with families over time. Furthermore, as a recognised part of universal service provision, they are ideally placed

¹ <https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children/health-visiting-and-school-nursing-service-delivery-model>

² https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/960708/Commissioning_guide_2.pdf

³ <https://www.nmc.org.uk/globalassets/sitedocuments/post-registration/final-documents/standards-of-proficiency-for-specialist-community-public-health-nursing-.pdf>

Specialist Health Visitors in Perinatal and Infant Mental Health



to both identify and provide help in a way that is less stigmatizing, and are more likely to be successful due to the development of a positive long-term relationship with the family (Elmer *et al.*, 2019).

The rapid expansion of knowledge about the impact of parental mental health problems on development and health across the life course for the infant, in addition to evidence regarding the effectiveness of dyadic methods of working (i.e. as opposed to interventions that explicitly target the mother), has led to moves nationally to develop a set of practice competencies in relation to perinatal and infant mental health, and significant moves to upskill the health visiting service to enable them to both identify and treat parent and infant mental health problems. For example, a significant number of health visitors have also now undertaken the training being provided by the Institute of Health Visiting, to enable them to become Perinatal and Infant Mental Health Champions, as well as training in the Solihull Approach and specific interventions such as Video Interaction Guidance, Watch, Wait and Wonder, Mellow Parenting, Neonatal Behavioral Assessment Scale, and the Newborn Observation. In addition, assessment tools such as the PIIOS (Parent-Infant Interaction Observation Scale), were developed explicitly for use by Health Visitors as part of the Healthy Child Programme, to enable them to better identify problematic interactions, although the infrastructure is often not in place in practice to support this. Research shows that formal training in such assessment increases the ability of health visitors to accurately assess parent-infant interaction and identify appropriate interventions (Kristensen *et al.*, 2017; Svanberg, Barlow and Tigby, 2013; Wilson *et al.*, 2010).

However, a recent study by Condon *et al.* (2020), examining health visitors' experiences and views on promoting mental health, shows a clear demand for additional mental health training, with nine out of ten of health visitors requesting more training on how to work with parents (91%) and interdisciplinary working (94%). This study reiterates previous findings showing that health visitors often lack the confidence to intervene when there may be psychological or behavioural problems (Wilson *et al.*, 2012), do not have enough time to assess parent-child interaction (Pettit, 2008; Wilson *et al.*, 2008), lack confidence in the area of PIMH due to poor or insufficient training (Rowan, McCourt and Bick, 2010), and experience professional anxieties due to lack of resources and the availability of specialist support (Chew-Graham *et al.*, 2008).

Sp HV PIMH are health visitors with post-qualifying training and experience that equips them to fulfil specialist clinical, consultative, training, and strategic roles on behalf of health visiting service within the field of Perinatal and Infant Mental Health. Sp HV PIMH are generally seen as leaders in promoting perinatal and infant mental health across the universal services in their locality and are expected to have a higher level of post-registration specialist training focusing specifically on the promotion of healthy caregiving relationships between parents and infants. Specialist health visitors also provide training, consultation and support to health visitors and other professionals working with mothers with mental health difficulties, work clinically with families with higher levels of need, and represent specialist infant-parent services in conversations with commissioners and providers (NHS Health Education England, 2016). Given their potential contribution, many advocacy groups are calling on their local authorities to improve perinatal and infant mental health by having an identified Sp HV PIMH as part of the 0-5 public local health nursing services (see for example *Yorkshire & the Humber*, 2018).

However, although there is a broad agreement about the role of Sp HV PIMH as described above, there is great variability in the job description across the country, and they vary in professional status and come from different professional backgrounds. While, there is a growing number of health visiting services that have

Specialist Health Visitors in Perinatal and Infant Mental Health



Champions in PIMH who have completed additional training, only a small minority of health visiting services have formally commissioned Sp HV PIMH posts (NHS Health Education England, 2016); it is estimated that there are about 60 Sp HV PIMH across the UK although the true figure remains unknown. Furthermore, the recent survey carried out by the Institute of Health Visiting shows that while some local authorities are terminating the position, others are working hard to commission the role. This survey found that while some LAs perceived there to be no need for a Sp HV PIMH role because all health visitors are specialists to some extent in the area of PIMH, others felt that SP HV PIMH are crucial in ensuring that all health visitors are skilled and confident in addressing perinatal and infant mental health issues (Institute of Health Visiting, 2021).

The aim of the current study was to clarify the role and the unique contribution of Sp HV PIMH given the context of diverging opinions about the need to commission this position. The research set out to answer the following research questions:

1. What training and qualifications do Sp HV PIMH have that distinguish them from Champions in Infant Mental Health, and health visitors without any such specialist training in PIMH interventions?
2. What is the unique contribution of this group of specialist health visitors?



Methods

The research involved the use of a mixed-methods approach (Palinkas *et al.*, 2011; Padgett, 2014) with sequential quantitative and qualitative phases of data collection - the interviews in the second qualitative phase of the data collection were informed by the results of the stage one survey.

The first phase of the study consisted of an online survey exploring which training specialist health visitors have undergone, and what qualifications they have that distinguishes them from other health visitors, as well as their perspectives on their unique contribution to the promotion of PIMH. The survey was sent out via the Institute of Health Visiting, to known Sp HV PIMH. It should be noted, that because there is no current register of such practitioners, this sampling frame may not have been complete. Survey questions were drafted from knowledge of existing research about health visiting and then discussed for content and relevance with practicing health visitors. The survey questionnaire is attached in Appendix 1.

The second stage of data collection involved 10 semi-structured video or phone call interviews (7 with Specialists and 3 with Champions in PIMH). The topic guide for the interviews was based on the results of the survey analyses. A snowball sampling method was used to identify interviewees based on peer referral. Transcripts were anonymised, transcribed, and coded using the software NVivo. A thematic analysis was undertaken to facilitate cross-case comparison. The following sections provide an overview of the main themes that emerged from the interviews and the survey.



Demography	Online Survey Respondents	
Age		
30 to 39	5	14.7%
40 to 49	11	32.4%
50 to 59	17	50%
60 and above	1	2.9%
Region		
East England	4	12%
East Midlands	3	9%
Greater London	8	24%
North East	2	6%
North West	6	18%
Northern Ireland	1	3%
Scotland	1	3%
South East	4	12%
South West	1	3%
Wales	2	6%
West Midlands	2	6%
Years in role		
Less than 1 year	7	20.6%
1 to 5 years	28	52.9%
6 to 10 years	3	8.8%
More than 10 years	6	17.6%
Point in paygrade		
Band 6	5	14.7%
Band 7	27	79.4%
Band 8	2	5.9%

Findings

The online survey was completed by 34 health visiting professionals. The majority of survey respondents reported having an official job title of Specialist Parent and Infant Mental Health Visitor, Specialist Health Visitor for Parental Mental Health (22/34) or Health Visitor for Children and Families (5/34). Other titles included Perinatal Mental Health Practitioner (HV), Specialist HV, and Clinical Team Lead (6/34). Most of these posts were in either Universal Health Visiting Services (85.3%) or Perinatal Mental Health Services.

The majority of respondents (53%) have been in their role between one to five years and a quarter (26.4%) for more than six years, and about half of respondents work part-time while the rest work full-time. A majority (79%) were Band 7 with the remainder mostly being Grade 6 (15%) and or to a lesser extend Grade 8 (6%).

Qualifications

Based on the survey, in addition to having a nursing qualification, the majority of participants had a postgraduate certificate or a diploma in a relevant field (76.6%). Nearly a third of respondents reported having a Master's degree in community public health or psychological therapies (29.4%). In addition, 88.2% had completed the Institute of Health Visiting iHV Champions Training⁴, 64.7% Solihull Approach Training at NHS University Hospitals, and 12% had completed the ITSIEY training at

the Anne Freud Centre. Furthermore, respondents reported that they routinely attend skills training – half of the respondents reported attending skills training every six months (51%) while the other half attend skills training once a year (43%). Most would love to attend training more frequently as 64.7% said that the training available is below their needs.

However, some interviewee participants felt that having a graduate degree should not be a requirement for the role, and that expertise and experience were more essential:

I think that would be unfair when there are health visitors who are experienced and knowledgeable who don't have a Master's. Making it a requirement would mean that somebody who had far less experience would be more able to apply for such posts than somebody who has a lot of experience but not the Master's. (Interview 10)

⁴ The prevalence of this training might be exaggerated because the recruitment to the survey was conducted by the Institute of Health Visiting.

Specialist Health Visitors in Perinatal and Infant Mental Health



I did do a module at [...] University in maternal and infant mental health, but I have to say I don't know that I really learned anything more than I did already know, but it gave me the piece of paper. (Interview 2)

A preference for experience and passion for the job was also communicated strongly in all interview responses:

I don't think I'd be particularly looking at qualifications – I'd be looking at the person, the sort of person I'd want to do the role, and then look at what training I'd like them to go on, or what training they think they need to do, where their gaps [in service] are because I think it's more about the person in the role rather than the qualification as such. (Interview 5)

Several interviewees also pointed, however, to the benefit of specific additional professional training including, for example, an adult counseling qualification focusing on mental health:

She has an adult counseling qualification and she's a health visitor, so she's got a great combination of training to bring to the role. [...] So she's able to understand and work with parents who've got moderate to serious mental health problems. (Interview 6)

Some Sp HVs PIMH may work as part of a Mother and Baby Unit or be involved in step-up or step-down from specialist services. Additional qualifications were felt to be beneficial to the role of the Sp HV PIMH working with families who have mild to moderate mental problems (69.6%), and in addition for being the spokesperson for the development of mental health pathways (see below).

Being passionate about infant mental health was perceived to be an important requirement for the role because strategic planning requires the ability to inspire the workforce to upskill and to work effectively in terms of networking and advocating for infant mental health across the healthcare system:

Somebody who's very passionate about perinatal mental health [...] who's not afraid to stand up and be counted, as such; somebody who can lead and motivate others because, to me, that's part of the role, you know, motivating others, like my champions, to do the training. (Interview 5)

Passion means that you keep going when - for instance, the pandemic, through everything, we were able [to find] solutions to support families. I think that passion drives you to think about other options if you face challenges. (Interview 7)

Somebody with the tenacity [laughing] who wants a better service and doesn't give up! To me, it's having the passion and the enthusiasm when health visitors, managers, commissioners, have competing pressures for money, for services, etc. It's having that person that doesn't stop. there is something about just having that...that drive, I suppose, and not giving up. (Interview 2)

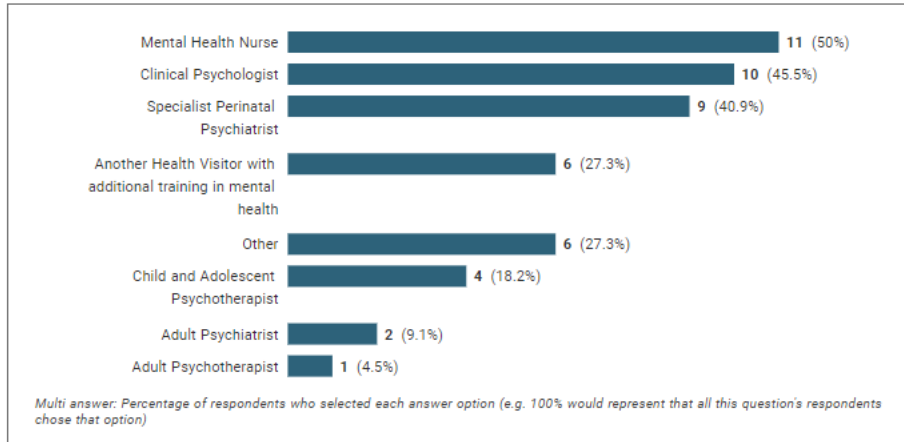
In terms of the support that they receive with regard to the PIMH role, 47% of survey respondents reported having supervision, and 66.7% as having access to supportive consultations. Out of those who have access to regular supervision regarding their PIMH work, 75% have access to clinical supervision, 56.3% to safeguarding, and 37.5% to informal peer group supervision. Supervision is provided by experienced health visitors with additional training in mental health (43.8%), clinical psychologists (31.3%), or child and adolescent psychotherapists (18.8%). Supervision was reported to be funded by the employer and in most cases, as taking

Specialist Health Visitors in Perinatal and Infant Mental Health



place every two to three months. Around a fifth (23%) reported having monthly supervision and 18% fortnightly supervision. With regards to consultations, specialists have access to a range of experts as shown in Table 2. Most Sp HV PIMH described being satisfied with their supervision or consultations.

Table 2 Which of the following can provide you with a consultation regarding PIMH aspects of your job?



Key Contributions of Specialist Health Visitor in PIMH

This section draws on both the survey and interview data to describe the contribution of Sp HV PIMH in terms of strategic planning for the parent-infant mental health pathway, supervision of health visitors, workforce training, and direct work with families.

Strategic Planning for the PIMH Pathway

Qualitative data showed that strategic planning for perinatal and infant mental health pathways was the most significant and irreplaceable contribution of Sp HV PIMH:

If you don't get the strategic bit right, then the rest of the service isn't going to be right, so that is a priority. (Interview 5)

Indeed, some of the Sp HV PIMH positions were described as having been created and advertised with the strategic responsibility in mind:

From some of the posts that I've seen advertised, it is more [of a] strategic [role], more looking at developing services (Interview 10).

Strategic planning in this context typically referred to the coordination of health services to ensure that there are clear pathways through which infants and parents can get support to meet their mental health needs. For example, some interviewees were involved in developing a PIMH pathway, including ensuring provision for the assessment of need, and the provision of care, including referral on to other services, and an evaluation of outcome:

We looked at the journey of a child and what we would do to provide support for that child in

Specialist Health Visitors in Perinatal and Infant Mental Health



terms of, firstly, assessing what the need was, so using the questionnaires that we would use to evaluate the need, and then what interventions we would put into place. So, we put together [a plan of] what we would provide for each child in terms of reflecting the need that they would have and the onward referral to other services [...] We also reflected the mental health needs of the parent, and that also helped to describe what care plan people would use, and suggest to be used, with the client. [The plan] would help them to remember to have clinical supervision if they had continuing concerns about the child, or safeguarding concerns, so safeguarding supervision, and then how to evaluate that intervention as well, and that's connected to a toolkit that we provide with a bit more detail about the evidence base to those interventions. (Interview 7)

Sp HV PIMH were perceived to be important at a strategic level in part because of their grassroots understanding of what practice should look like:

The commissioners decided that they'd employ somebody one day a fortnight to develop a perinatal mental health pathway. I got invited to some strategic meetings with commissioning. I was at this meeting with all these heads of services, trying to look at the development of a perinatal mental health pathway. But the role I did have at that meeting was that I was working at the grassroots level so I could say, "Yeah, that's supposed to happen, but that's not really what happens – this is what happens..." (Interview 2)

The successful planning and implementation of a pathway were perceived to be dependent on networking and maintaining personal relationships with professionals in other services:

The real impact of a Specialist is being able to do that networking with your local perinatal team, with your local children's centres, with the voluntary organisations that are going on, really, really being able to advocate and being very accessible for staff. I am available, but I'm spread across a big county, and across three localities, and so, even in a full-time role, it's quite difficult to be as connected and accessible as I would like to be. (Interview 1)

Survey findings also indicated that all Sp HV PIMH liaise with a wide range of services including perinatal mental health services, infant mental health services, maternity services, midwifery services, adult mental health services, GP surgeries, social work, children's centers, and thirds sector voluntary organisations. One interviewee highlighted how the relationships that Sp HV PIMH rely on typically take a long time to establish:

It's probably taken 11 years of building those relationships with commissioners, with the local authority, with health, that I think we're getting somewhere. (Interview 3)

Sp HV PIMH were also perceived to be experts in identifying the gaps in service provision and pulling together available resources to close those gaps and meet the needs of vulnerable families and infants:

The problem is that, if we come across a relationship issue between a mother and a child when they are over two, we have no services we can send them to and get support for because CAMHS will only take children when they're five and over. So, there's that gap in the service

Specialist Health Visitors in Perinatal and Infant Mental Health



there, and as a specialist health visitor, I am bringing [this] to the managers'/commissioners' attention, to the Institute of Health Visiting attention, you know, because, actually, I think everywhere has got that gap in the service. (Interview 5)

The trouble is that services still work in silos, and what you lose if you do that is the contact with primary care, and this is – primary care. And so there is this element of building capacity, at least within the health visiting profession, within the wider early years workforce, including GPs and others working in primary care. (Interview 6)

The networking is really important, you know, where are the gaps, who's doing what, how have other services been adapting (Interview 1).

Several interviewees noted that Sp HV PIMH repeatedly remind others about the importance of infant mental health:

It's that constant chip, chip, chip away really, sharing some of the work the Parent-Infant Foundation have done, their Rare Jewels report is really helpful, but you do feel like a broken record sometimes, where you're constantly having to explain the importance of those periods of development for children (Interview 3).

I am constantly highlighting the need to focus on the infants' mental health (Interview 10).

Sp HVs were also perceived to typically be the practitioner who raises awareness amongst other services of the types of interventions that health visitors and specialist services can provide, including the provision of dyadic methods such as Video Interaction Guidance (VIG):

I've been working around video interaction guidance, so I've been setting up the video interaction guidance service and training my colleagues in that – so I'm now training as a supervisor – and so, again, raising awareness of that, around the Trust. (Interview 10)

Interviewees argued that without the ongoing advocacy from Sp HV PIMH, the wider services might not take into account infant mental health or appreciate the contribution of health visitors:

I think we feel very fortunate in this area to have a specialist to be shouting out for our area, and I think, in years where we didn't have one, it was very hard to know that people were listening. So, it does feel very safe to have that extra voice for us. (Interview 4)

It is having somebody there who's always sort of looking on the mental health side of it for our clients and making sure it's not forgotten in whatever it is we're doing. (Interview 5)

Furthermore, without a Sp HV PIMH, some interviewees felt that the focus on PIMH might be lost due to the competing priorities with other high-impact areas on which health visitors and other professionals have to focus:

Specialist Health Visitors in Perinatal and Infant Mental Health



We need to make sure that somebody is leading it [PIMH] and focusing on what's important for the mental health needs of mothers and children because there's only so much people are able to absorb in terms of information. So, I think, leading means making [PIMH] uppermost in people's minds. If you didn't have somebody leading it, the emphasis might be lost because of the demand there is for our services in other high-impact areas. (Interview 7)

Sp HV PIMH were perceived to be an important link between health visitors who interact with families and other services, whether it is specialist parent-infant partnerships (PIPs), Child and Adolescent Mental Health (CAHMS), or adult mental health:

[I] offer something that's in between the generic health visitor role and specialist mental health services, adult mental health service, CAHMS, or child mental health services. Kind of bridging primary care and mental health if that makes sense. (Interview 6)

Such oversight and linkage between the services were felt to promote a more seamless transition from one service to another for families who might otherwise feel that they were just being endlessly passed on from one service to another:

I work quite a lot in creating pathways to ensure we understand how we link with other services and how will we ensure families know what that pathway looks like because, often, parents will say to us they feel like they're passed from one place to another, and trying to make things more seamless. I do think that's a really important part of the role. It's understanding how we work together, and having that leadership, trying to create that type of pathway to make it easier for people to navigate. (Interview 7)

One interviewee felt that establishing an effective multiagency collaboration was the most valuable contribution she had made in her role:

I think is the most valuable thing we've achieved is a weekly multiagency liaison meeting for maternal mental health. We have a discussion every week where we can talk about women who the agencies are concerned about. So if there's a client that I've spoken to and I think that their mental health is very poor and I'm really worried about them, so they might be showing some signs of psychosis or they've talked about some suicidal intent or having difficult thoughts about their baby, but haven't had any contact with – well, even if they have had some contact with the Perinatal team [...] At that meeting, there's us, there's the Health Visiting Service, the Perinatal team, the local IAPT provider, and two of the voluntary agencies that support postnatal mental health [...], and then we've got a mother and baby unit, so someone comes from there. We have also invited the maternal mental health specialists within the two hospital midwifery services. (Interview 8)

During the Covid pandemic, Sp HV PIMH again played an important role in maintaining a focus on babies, and redesigning the PIMH pathway to be digital:

Specialist Health Visitors in Perinatal and Infant Mental Health



When we went into lockdown it was really interesting because I was able to really flag up to colleagues in Maternity and Social Care and the Education sector about the need to prioritise and highlight the unborn baby and the under-ones. (Interview 10)

We are re-defining our infant mental health pathway to be a bit more responsive, particularly during the pandemic. So, for example, the video interaction work that we were doing, we were asked to stop that and not to be offering that face-to-face, but we re-designed a virtual pathway so, although we're not using video, we're using a lot of the same principles. (Interview 1)

When the pandemic started, we had to make a decision about what services we were going to provide as a health visiting service. And I raised it as a concern that we weren't doing a lot within perinatal mental health. It then sort of went on the risk register that, actually, at the moment, we're not identifying mental health issues because, at that time, they weren't only doing 6-8 week reviews [...] And we brought back listening visits, and I was asked what I thought when they brought back even more staff. (Interview 5)

Supervision of PIMH Champions and Workforce Training

A third of survey respondents reported that in addition to their strategic role, their responsibilities included supervision and training (32.4%) of PIMH Champions:

What I do in my role. I have the IHV trained Perinatal Champions that I lead, so I have about 14 Champions across [the location]. We meet every couple of months and I look at our mental health data that we have on our health visiting pathways and we look at how we're doing as a Trust. (Interview 10)

I have more of a strategic role in leading a group of Champions – so these are PIMH Champions in the organisation. (Interview 7)

So the role is probably more supervision, support of practitioners and training. (Interview 8)

Survey data showed that Sp HV PIMH deliver training focused on PIMH to the following practitioners: health visitors (84.8%), student health visitors (69.7%), nursery nurses (75.8%), pre-registration nurses (30.3%), school nurses (24.2%), social workers (24.2%), community nurses (27.3%).

The Sp HV PIMH and PIMH Champions were perceived to have very different roles with the former being focused on strategy and supervision, and the latter being primarily practice-based:

We use the title "Champion" for health visitors who are holding a generic caseload but have a special interest and maybe have undergone...have a little bit of protected time, maybe two or three hours a week, to be a touchpoint for their local teams, to have additional knowledge, to be a sounding board in practice, to co-facilitate training with me in my specialist role. My whole role is dedicated to perinatal and infant mental health, as a specialist, but with more of a strategic focus. My role is primarily strategic, developing training, looking at governance,

Specialist Health Visitors in Perinatal and Infant Mental Health



quality improvement, a lot of supervision of staff, and influencing service re-design and policies and pathways; whereas, our Champions are in practice. They will have a liaison role with the specialist perinatal services and, in their own communities, doing that networking, but they have a very limited protected time to do that. (Interview 1)

Health visitors who have a particular interest in perinatal mental health are the Champions within the teams. So, it may be that they like working with people with mental health issues, and they might take a lead within their areas or within their teams for perinatal mental health, but my role is overseeing those Champions that I have [...] I take a bit more of a sort of strategic sort of leadership role within my position than perhaps those health visitors with an interest do. (Interview 5)

This was also perceived to be the case by health visitors who were PIMH Champions, as opposed to Sp HV PIMH

I have taken the responsibility of being the PIMH Champion for this team. So, we sit on a workstream with our specialist health visitor, who's in the role to cover the entire of the county. (Interview 4)

The specialist is a Band 7 and Champions are Band 6s, basically, so she is responsible for overseeing the service and doing a lot of the service delivery, our support and supervision, and she would be the one that would be actively seeking out new research and looking for how we can implement that into practice. Whereas we are Champions, so we've completed additional training to be able to disseminate knowledge to our locality teams (Interview 4).

Somebody who is a generic health visitor might be asked to become the Champion for their borough, and they go off and do a two-day training and they become the Champion. They're probably doing it or being asked to do it because they've got an interest (Interview 6).

In locations where there is a lack of funding for a Sp HV PIMH role, Champions described feeling compelled to take on the strategic and pathway planning responsibilities that specialist health visitors would normally undertake but without the necessary time or resources:

Due to service changes and funding cuts basically, there was not enough capacity in the Health Visiting Service to have a specialist role or the time for the health visitors to do a specialist role, but yet there is definitely a need for that within communities. So, I do training, I deliver training [as a Champion]. We've developed a model and a resource within our service, and I am rolling that out, but it is...it is a very compromised position because it's not sustainable for just me to be doing that. (Interview 9)

Champions argued that there is a lot of value in having Sp HV PIMH who are knowledge leads because health visitors do not have enough time to keep up with the latest research publications whilst also carrying a large

Specialist Health Visitors in Perinatal and Infant Mental Health



caseload of families:

Having that person whose ultimate job is just to find out that correct information and that correct research on that one subject matter gives you that wealth and that dearth of information and correct processes, which, actually, for the majority of us, who have to deal with a universal caseload, it's really difficult to retain all that information about such different areas and such different specialties. (Interview 4)

Why do we still need a specialist health visitor? Because I think you still need someone to keep the service is up-to-date in terms of its evidence base about parental and infant mental health. (Interview 8)

Sp HV PIMH were as such perceived to be the person to send updates about the most recent research in the form of fortnight, monthly, or bi-monthly emails:

Every couple of months, I do an update for my Champions to share with their colleagues – so, for example, the update this month was about dads' mental health, about being inclusive of dads. It was about staff wellbeing, in the current circumstances, and practitioner wellbeing, and, again, encouraging colleagues to use the assessment tools and the pathways so that we can evidence our work. (Interview 10)

I send out quite a regular newsletter, you know, with updates in the service or anything new I've found or any new research. Especially during the pandemic [it is a way] to let them know what other services are doing and offering (Interview 5)

Through their supervisory roles, Sp HV PIMH were described as having responsibility for setting the threshold for care for health visitors with a specialist interest in PIMH. Setting the threshold for care meant that in some cases, specialists would encourage health visitors to feel more confident in providing interventions, and in others, they would encourage health visitors to refer their client to a different service because the needs of the client were felt to be beyond health visitor's expertise:

I get a lot of phone calls from health visitors saying, "I've got this person and I don't know what to do with them, because this service won't have them, this service won't have them – have I done the right thing? Is there another service I can refer them to?" So, I am sort of in like a supervision role, and I take that on board and provide that support for them. (Interview 5)

Well, we can be offering intervention at a mild to moderate level, but, actually, often what we need to be doing in the perinatal and infant health world is also signposting or referring on to agencies who are able to offer more of a specialist intervention. So, there is a little bit of a tension around offering specialist intervention [and] training up the workforce to have a better understanding to inform the assessments. (Interview 1)

As such, Sp HV PIMH felt that their key contribution was in recognising the boundaries in relation to the provision of support by health visitors, to families with complex problems:

Specialist Health Visitors in Perinatal and Infant Mental Health



The most important thing is to know where our boundaries are as a service and what we can provide. So, we provide support for women with mild to moderate symptoms of depression and anxiety, and, as a health visitor, we are trained to do that, and we have that expertise to do that, and that's very much how other services see us – you know, that's our expertise, in identification of maternal mood and needs [...]. The role of the specialist health visitor, I think that's what I do quite a bit of, is helping health visitors understand where those boundaries are – what we do that's really important and valuable and vital to really identify where people need more support and where the risks are, but it's also then being very clear when it is a referral to somewhere else. That's where I often do get asked for some supervision about clients where a health visitor might come to me because they want to discuss a client that they're concerned about and they're not quite sure whether it fits the threshold for that service or that service. (Interview 7)

If we cannot recognise what's going on, we cannot then make the right assessments and refer them on to the right services. So, for example, a health visitor the other day rang me to ask me what was her role around assessing attachment, and she shared with me concerns about a child, a two-year-old child, and how they'd presented. I obviously advised her it's not our job as health visitors to be diagnosing attachment disorders – that is absolutely not our role. However, it is appropriate that we recognise behaviours that might raise possible concerns about attachment and then refer on to the right professionals. (Interview 10)

PIMH Champions also identified this as being the role of the Sp HV PIMH:

I've certainly said to one colleague in the last sort of six months, "I don't think you should hold onto this woman anymore - she needs some specialist support, you know, she sounds very sick to me." And that's where that specialist supervision would come in. (Interview 8, Champion)

If we feel that this client is a bit too complex, we will then give our specialist a call to see what her feeling is about the referral process or how the situation should be handled, which is a role that we haven't always had. It is very useful, if we're caring for a complex family, to have that sort of part of the structure to enable us to make the right decisions alongside the family, rather than feeling a bit uncertain about what would be the most effective referral process. I find, even as a Champion, I find sometimes I'm a bit uncertain if they need to go to the Perinatal [all] service or whether they would be better just for a referral to a PIP or whether the client should be just managed by the GP. (Interview 4, Champion)

Joint visits were perceived to be a key part of this role:

You may have people in generic health visiting roles who are very competent to do some kind of basic level of parent-infant work. Some of them are. But, it needs to be teased out, you know, do you need to be taking this case on directly, or could a first step be to do a joint visit, for instance, with the allocated health visitor? So, it's a kind of stepped process. (Interview 6)



Direct Work with Families

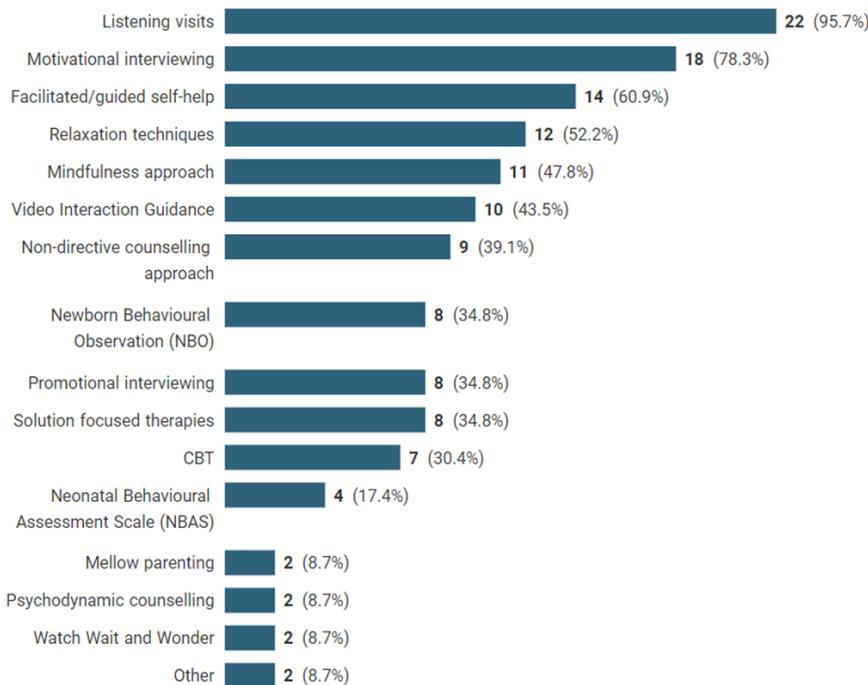
The survey showed that 23/35 Sp HV PIMH were conducting direct work with families focusing predominantly on addressing parental antenatal depression, antenatal anxiety, general anxiety, birth trauma, depression, panic attacks, postnatal depression. having a small caseload of families with greater mental health needs (69.6%). While the majority of survey respondents reported their caseload to be under 100 families (73.9%), the interviews suggested that specialist health visitors caseloads typically consist of 15 to 20 families at most:

I've got a very small sort of specialist caseload, so I only have about 20 families that I'm directly working with, because that's not really part of my job description to hold a caseload, but every time there's a staff shortage [laughing], those of us in specialist roles get sent off to help out, and then you accumulate families. (Interview 1)

I work with maybe 10 to 15 families at any one time. But aside from that then, a lot of my role is staff development (Interview 3)

Sp HV PIMH reported using a range of methods to work with families including listening visits, motivational interviewing, self-guided meditation, and relaxation techniques, with around half providing dyadic interventions focusing specifically on parent-infant relationships (e.g Video Interaction Guidance).

Table 1 Interventions offered by Specialist Health Visitors in PIMH



The interview data suggested that these techniques were used flexibly depending on the needs of the family:

Specialist Health Visitors in Perinatal and Infant Mental Health



We are trying to think creatively with them about what would work best for them, so kind of normalising, containing, exploring with them their relationship with their infant or child, how they're feeling about them, talking to them about things like grounding techniques if there's a lot of anxiety or sort of panicky feelings, strategies for managing low mood. It's been more, yeah, listening, containing, reflecting. (Interview 8)

While the survey revealed that 70% of Sp HV PIMH are qualified VIG practitioners, only 44% reported using VIG in their practice. The reasons behind the infrequent use of dyadic interventions, such as video-interactive guidance (VIG), were explored further in the interviews. Respondents explained that dyadic interventions are rarely commissioned, or that there is no supervision available to enable them to provide it:

We are commissioned to offer interventions that enhance the parent-infant relationship, but VIG is not specified. It's a very long training. We bid for some of the transformation funding sort of 2016, and 12 of our health visitors began the video training, but it took a long time to get buy-in from information governance around consent and storing film on our laptops and that sort of thing. There's quite a clash over the time that it takes to train and then to actually offer it as an intervention. (Interview 1)

I did some VIG training, probably two years ago now, but unfortunately, I was never funded for any supervision, so I wasn't able to ever deliver that package of...technique, which would have been really good, really interesting, and very beneficial. (Interview 4)

There were lots of issues around capacity to be able to dedicate health visitors to the training – it is a robust training and it requires dedicated time really – and so we learned a lot through that experience, and only two of us actually went on to qualify in VIG. (Interview 10)

One of the interviewees reported that the management in their location was opposed to health visitors using VIG because of the potential to re-traumatise parents as a result of recording their parenting techniques:

[Some] are quite sceptical about the VIG because obviously they see very traumatised women and she feels that we need to be really careful not to re-traumatise them. People are very concerned that if we film somebody and there's the evidence of them, if you like, not doing a good job as a mum, that that would be quite devastating for people and that would be traumatic in itself. (Interview 2)

A number of interviewees expressed enthusiasm for providing dyadic interventions such as VIG and wished there was capacity for it:

If we were to provide something like VIG, I'd really like to be able to provide that as part of my role. (Interview 7)

Instead of just going in and feeling like you're just maybe monitoring or you're really not achieving anything, and you're just trying to contain them, which is really important, but not ever getting anywhere, I [wish I] was able to offer them interventions, and I was able to say "I can offer you this or this – what do you feel would help you at the moment?" (Interview 10)

Specialist Health Visitors in Perinatal and Infant Mental Health



While dyadic interventions of this sort may be provided by other services in the area, including specialist perinatal mental health teams, specialist parent-infant partnerships (PIPs), children's centres, and charitable organisations, the availability of such offers varies greatly across locations:

Here I've got Babies First, I've also got our IPPS team, who are the Infant & Perinatal Parent Specialists, so I can send them there as well – you know, so I've got a lot. But in [previous location], if you came across a problem with parent and infant interaction, there was nowhere that you could send them – no services. (Interview 5)

Some interviewees expressed concern about an increasing trend to push generalist health visitors to provide specialist interventions:

In some areas, health visitors are expected to deliver highly specialised parent-infant interventions. Now, that is madness because they don't have any mental health training necessarily. Some of them will have, but only because they've kind of sorted it out for themselves, but you're not required, as a nursery nurse, to have mental health training. So, that is very worrying. That is really like trying to get parent-infant psychotherapy on the very cheap [laughs], and probably people will be out of their depth in no time at all, and they could even be doing harm. (Interview 6)

In the survey 12/35 Sp HV PIMH reported not working directly with families, and many interviewees who were non-case-carrying explained that this allowed them to focus entirely on their strategic and supervisory responsibilities:

I have more of a strategic role. I don't carry a caseload of clients myself. (Interview 7)

I think it is useful to have it as a separate role. I would really like to see families [but] I have been incredibly busy and it's been very hard – I've worked really hard to do the things that I've done over the last year. I do think that it's helpful to have somebody dedicated to just doing this role [...] I certainly wouldn't be able to work with 10 families and do what I'm doing now. (Interview 10)

While these Sp HV PIMH had no direct work with families they were playing a key role in supporting individual practitioners:

I can still take referrals for parents and families that they are concerned about, but I won't be doing any of that direct work anymore. I'll be supporting the individual practitioners in the work that they're doing, almost like child protection supervision I guess but on a much more...what's the word...probably more sort of short-term, intense basis with the practitioners. (Interview 8)

I spend half my week doing clinical work, or really supporting health visitors to support the women, because obviously, I can't support all the women in [my location], and the other half is doing the training, sitting on these other networks and things that I sit on, and developing things (Interview 2)

Specialist Health Visitors in Perinatal and Infant Mental Health



Some non-case carrying Sp HV PIMH were, however, offering group-based provision:

I don't carry a caseload of clients myself. I have run some of the [...] groups myself, and I have followed up with mothers who've attended those groups where there's been a need to do so. (Interview 7)

We do have a complex needs service for clients who have, say, personality disorder, but there is a long, long wait – you know, it seems to be anything from eight to 18 months. These clients are just sort of left, because they're too complex for our talking space, for our Talking Therapies, Adult Mental Health won't touch them because they're complex needs and they need to go to the Complex Needs Service, but there's such a long wait. I am looking at putting on a group for our complex needs mums with a volunteer organisation, because, quite often, they miss having somebody they trust they can talk to, and they find it hard to make friends, so we're sort of thinking, well, could we do a virtual group for them (Interview 5).

Most specialists taking part in the survey reported making an official record of whether the intervention provided had been successful and whether parents were satisfied with the support they received (82%). They reported using observation, informal discussion, and parental self-report tools to do this, the three most commonly used such tools being the GAD-7 (Generalized Anxiety and Depression Scale; 57% of respondents), EPDS (Edinburg Postnatal Depression Scale; 46%), PHQ-9 (Patient Health Questionnaire; 37%). The remaining assessment tools listed, including the Parent-Infant Interaction Observation Scale, Neonatal Behavioural Assessment Scale, Karitane Parenting Confidence Scale (see survey Question 30), were used by five or fewer survey respondents. Three respondents mentioned using Whooley questions as a formal assessment tool, and one interviewee described using Ages & Stages Questionnaire (ASQ) or ASQ-SE questionnaire, in cases where it is apparent that an infant's needs are not being met:

We look at questionnaires to assess how confident they feel as a parent – so we do that pre-intervention and post-intervention. And then the same with children: we assess how they're developing with their overall development skills, but also looking at their social and emotional needs. It's not used for every visit, but if we identified a need, then we would use those questionnaires as an opportunity to review progress for the development of the child. So, it's a tool that we can use in practice if we've identified a need. (Interview 7)

The finding that limited parent-infant assessment tools are being used currently by many of this specialist group of practitioners was unexpected:

I've noticed that, on the specialist health visitor emails, people are talking about using tools, and we are not using any tools to assess the mother-infant relationship at present. We do assess the mothers' mental health, but not really that interaction – you know, we observe the interaction. (Interview 2)

We've been trying to use those also as a measure at the end of our time of contacting them, just to try and get some kind of outcome data, but we haven't been very rigorous on that. (Interview 8)



Some interviewees reported that they found qualitative evidence and family case studies most useful for both capturing the outcomes as well as for advocating for funding from commissioners:

We collect case studies that we share with our commissioners, and I think – I mean, I think there's growing recognition that that is a very valuable way to share outcomes. I think we need to move away from just wanting to report on numbers and scores and different things, but that requires staff then setting aside the time to write case studies. (Interview 1)

Commissioners like hearing the patient's story, and I think it makes a lot of sense to them, so they do encourage us to do that. (Interview 2)

In addition to being better at capturing the nuance of the work, the inflexible and complex nature of the recording systems was also felt to reinforce a preference for qualitative data:

I think our actual recording systems are so [sighs heavily], oh, they're just so big and complex and, you know, you can't easily say, oh, I've identified a new tool that would be really good. There's such a lot of red tape to go through to have anything approved and then set up for us to be able to use it in an easy way (Interview 1).

In addition, narrative style reporting was perceived to require practitioners to have a more in-depth understanding of what they are writing about compared to quantitative measures:

A tick-list of mutual gaze, reciprocal interaction, attunement, those sort of things can be ticked without someone really understanding what they are seeing or not seeing. If it's in a much more narrative form, it's more likely to enable the practitioner to really show that they're understanding and recording what they're seeing or what they're not seeing, and that is much more like the voice of the child. (Interview 9)

Barriers to promoting PIMH

In the survey, practitioners reported that the key barriers to the promotion of PIMH are absence or withdrawal of funding (82.3%), lack of understanding among commissioners about PIMH (64.7%), or the role of HVs in PIMH (73.5%). Of these, discontinuity of funding was cited as being the biggest barrier to the promotion of parent and infant mental health. Discontinuity in funding in recent years was perceived to have led to repeated efforts to roll out similar projects and interventions and to a constant re-inventing of the wheel:

Funding comes and funding goes. So, certain projects, like SureStart, were so helpful, and then that changes to something new, and then you almost are re-inventing the wheel again, and really you think sometimes, well, we did this 10 or 12 years ago, you know? [...] Funding changes and direction changes, but it's hard because you almost feel some of this needs to be so embedded that it doesn't change, you know? (Interview 3)

Some interviewees felt that the lack of funding was demotivating given that the core purpose of their role was to develop services. Without funding, they perceived themselves to be unable to do what they had been employed to do:

Specialist Health Visitors in Perinatal and Infant Mental Health



When I started my post a year ago, I had all my vision of what I wanted to achieve and that I wanted to set up the VIG service and various other initiatives [but] I was told there's no money and there's no capacity for these things. So, I was very frustrated, and I felt like resigning, to be honest [laughing], because I just couldn't see why I'd taken the job on if there was no money to actually achieve what was in the job description. (Interview 10)

Lack of funding was perceived to be a greater barrier compared with the lack of understanding about PIMH among commissioners. Participants reported that the commissioners with whom they are in contact, generally do have a good understanding of the importance of early years, but that there is just not enough funding for commissioners to prioritise this high-impact area:

I don't think the money is there for it all, but I do feel there is an understanding of the importance of the perinatal period and infant mental health. (Interview 5)

As a result, the need to identify and bid for funding was felt to left at the door of the individuals such as Sp HV PIMH:

The funding is down to bare bones. So, it's just down to individuals, like myself, who really see the need and really have to work hard to find funding somewhere. It doesn't seem to be in the statutory commission, from what I know, yeah. (Interview 9)

One favorable development that was frequently referred to by participants with regards to funding infant mental health pathways was the recent increase in funding allocated to perinatal mental health pathways, which was in some cases perceived to have legitimised and strengthened infant mental health pathways:

I was dealing with heads of services with no budget, and I was trying to persuade them to employ staff with no budget, and I had no budget. But then, obviously, NHS England came up with the money for developing perinatal mental health services, so I had, by that time, designed the pathway that was – you know, it looks fine but obviously it wasn't very well populated with staff [laughing]! So, the NHS England money just completely revolutionised that, so that was fantastic (Interview 2).

In addition to the above barriers, interviewees identified a lack of national standards and central guidance for infant mental health as also being a barrier to PIMH provision. Having clear central standards and guidance was felt to be necessary to establish specialist PIMH roles and teams.

I think what's interesting is the work that the Perinatal Network have done, like I said, we need to evidence almost a similar process for infant mental health, and then almost a national framework for that work is needed, and from that then would stem specialist teams and specialist roles. (Interview 3)

I think, for a lot of us, we've been making the role up as we've gone along. [We] have a specialist because we know that area is important, but, actually, there's very little direction and understanding. I wonder whether we're all slightly making it up as we go along. (Interview 1)

Specialist Health Visitors in Perinatal and Infant Mental Health



Practitioners reported leveraging national reports when lobbying for the commissioning and development of Sp HV PIMH role:

So, NHS England brought out a document about why each Trust should have a perinatal mental health midwife and health visitor, and, even after that, it still probably took a couple of years before the [specialist] post was sort of agreed (Interview 2).

We've used the PIP toolkits and reports that they've done. So, all of that has been massively helpful. But it takes time, I think, and time to look and find everything because not everything is always waving itself at you, as such, to some extent [laughing]. (Interview 3)

Some Sp HV PIMH reported relying on the directives of supranational organisations such as UNICEF to make the case for commissioning champions at their location:

UNICEF has a programme called the Baby-Friendly Initiative, which health visiting services and hospital trusts can sign up to, and you have to work really hard to get your standards to a really high standard to then receive accreditation from UNICEF. One of the three principles [is] to promote close and loving parent-infant relationships [...] I've really emphasised that we cannot remain to be accredited with UNICEF if I don't have the champions' support. We need that support. And if the Trust wants to remain accredited with UNICEF, it's an important benchmark to have, so therefore, because of that, I've able to have my champions. (Interview 9)

Given how common infant-parent relational disturbances are and how well health visitors are positioned to address these difficulties, some interviewees argued that the central government should issue a directive for commissioning Sp HVs in PIMH across the UK:

I think it's mostly more prevalent than people think it is, that a mother feels that she's not engaging with her child, and she's not feeling that bond and attachment with her child [...] I think that the only way that you will get those Trusts, at the moment, doing it, is if they're told by the Government that they have to do it [...] It has to come in writing from the Government. You know, it's a bit like you have to do your core visits, you have to do your new birth visits, you have to do this and you have to do that. It needs to be written down that actually they need to have a specialist health visitor in Perinatal Mental Health, and they need to be offering listening visits. (Interview 5)



Discussion

The findings of this survey and set of interviews suggest that SP HV PIMH are a highly qualified group of practitioners who are employed to provide a strategic leadership role in terms of the development of community-based perinatal and infant mental health services. Their responsibilities include fostering and maintaining relationships between health visiting and other services to maintain clear and effective integrated PIMH pathways, designing and delivering PIMH-specific training to health visitors and others, lobbying for funding for PIMH training and the commissioning of PIMH interventions, and providing significant support to Champions who work with families experiencing mental health difficulties. They appear to play a key role in ensuring that perinatal and infant mental health is kept on the commissioning agenda.

The findings also suggest that a key part of their role is supervision and training, especially of PIMH Champions, and also of the wider health visiting workforce, and a key part of that role involves ensuring that practitioners have access to the most up-to-date knowledge and evidence. They also appear to play an important role in establishing thresholds for service provision in terms of having the expertise to advise both PIMH Champions and health visitors more widely, about when parents and their babies should be referred on for additional support.

Although only two-thirds of Sp HV PIMH were delivering services directly to women, almost all were providing clinical input in the form of joint clinical visits or specialist groups. Sp HV PIMH with a caseload were providing a range of specialist interventions to women experiencing mental health problems and also using standardised measures to assess the outcome of such input. However, while 70% of the survey respondents reported being trained in a dyadic method of working with mothers and babies (mostly VIG), only 45% were delivering this service either because it hadn't been commissioned or because there was no adequate supervision available to them. Furthermore, most of the standardised tools being used were self-report measures of maternal mental health, and few of the available observational measures of parent-infant interaction were being utilised.

Lack of funding or the availability of only short-term funding was identified as being one of the key barriers to effective working, with much time and resource being spent 'reinventing the wheel' to address gaps in service provision, and Sp HV PIMH spending significant time trying to identify future potential sources of funding. A lack of knowledge on the part of commissioners with regard to perinatal and infant mental health and the role of SP HV PIMH, was also identified as being a barrier to effective working. These problems were perceived to be increased by the absence of national standards with regard to infant mental health (i.e. similar to those for Perinatal Mental Health), and the absence of any requirement for the employment of Sp HV PIMH across the UK.



Conclusions

The findings of this report suggest that Sp HV PIMH have a unique role in addressing parent and infant mental health problems both strategically in terms of establishing and supporting service delivery, and clinically in terms of supporting families experiencing mild to moderate problems using more specialist interventions including dyadic models of working such as VIG. As well as providing specialist clinical care themselves, they have significant roles in brokering research based knowledge to support practice, service delivery, care pathway development and commissioning. Some have direct involvement in research programmes. They have a clinical and strategic leadership function across service boundaries and at commissioning level; and they support workforce development and quality through their educational role directly or through PIMH Champions. The findings also suggest that these practitioners have significant experience and additional training to prepare them for this role and that formal commissioning of the role provides them with the necessary infrastructure to undertake the work.



Recommendations

- Sp HV PIMH should be commissioned by every Local Authority in England, every Health Board in Wales and Scotland and every Health and Social Care Trust in Northern Ireland. Such commissioning should include providing them with the necessary resources to enable them to work both strategically and clinically;
- Sp HV PIMH would appear to be best located within Universal Services where they play a significant role in supporting PIMH Champions and the wider health visiting workforce, in order to support parents and infants experiencing mild to moderate difficulties during the perinatal period;
- Sp HV PIMH should have expertise in identifying and assessing parental and infant mental health and parent-infant interaction using observational tools such as the PIIOS, and delivering dyadic interventions such as VIG, to enable them to provide specialist support to parent-infant dyads experiencing interactional difficulties;
- Further work should be undertaken to explore specific guidance for use of VIG in health visiting services, including legal guidance regarding the status of such videos in the event of child protection issues;
- A national set of standards for health visiting and health visiting services are needed concerning Perinatal and Infant Mental Health. This could potentially build on current quality frameworks and service standards such as, the AiMH UK Infant Mental Health Competency Framework developed for IMH practitioners (AiMH UK, 2021) and the Perinatal Mental Health Services Recommendations for the Provision of Services for Childbearing Women (Royal College of Psychiatry, 2021).
- Sp HV PIMH demonstrate core capabilities of Advanced Clinical Practice described as the four pillars of clinical practice, leadership and management, education and research (NHS HHE, 2016) within universal services but beyond the level of practice of the registered Specialist Community Public Health Nurse (SCPHN) – health visiting. The role and contribution of this level of practice could be supported by the development of a credential for ACP – health visiting.



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Appendix 1 – Survey Questionnaire

Survey information

This is a survey of **specialist health visitors (SHV)** aimed at developing a national picture of Specialist Health Visitors' **contributions to parent and infant mental health**. This study has been commissioned by the Institute for Health Visiting and is being conducted by Professor Jane Barlow and Dr Olha Homonchuk at the University of Oxford, Department of Social Policy and Intervention. You have been invited to take part because you fall into the professional group of specialist health visitor with expertise in PIMH.

The study has two parts:

Phase 1: An online survey distributed to health visitors specialising in PIMH.

Phase 2: Phone interviews carried out with SHV in PIMH. You are being invited to take part in the online survey. You can opt in to take part in phone interviews at the end of the survey.

We appreciate your interest in participating in this online survey. Please read through these terms before agreeing to participate by ticking the 'yes' box below.

Do I have to take part?

Participation is completely voluntary. We would be grateful if, once you have started the survey, you complete it fully, but of course you may withdraw at any point during the questionnaire for any reason, before submitting your answers, by closing the browser. We have included a 'Prefer not to say' option for each set of questions if you prefer not to answer a particular question. Once you have submitted the completed survey it is not possible to withdraw your individual responses.

How will your data be used?

The findings of the study will be fed back to the Institute of Health Visiting and disseminated to the existing network of researchers and practitioners in the fields of health visiting as well as parent and infant mental health. The results will also be published as a journal article.

Who will have access to your data?

Your information will be accessed by two lead researchers: Professor Jane Barlow and Olha Homonchuk. Your data will be stored in a password-protected file. Your IP address will not be stored. Research data will be stored for a minimum of three years after publication or public release.



Who has reviewed the study?

This project has been reviewed by, and received ethics clearance through, the University of Oxford Central University Research Ethics Committee (CUREC) Number: SPICUREC1a__20_014

If you have concerns about any aspect of this project, please email the lead researcher: jane.barlow@spi.ox.ac.uk. If you remain unhappy or wish to make a formal complaint, please contact the relevant Chair of the Research Ethics Committee at the University of Oxford: ethics@socsci.ox.ac.uk

If you have read the information above and agree to participate with the understanding that the data (including any personal data) you submit will be processed accordingly, please select yes below to get started.

Are you a health visitor with advance expertise (or specialising) in parent and infant mental health?

Yes

No

Are you willing to take part? *Required

Yes, I agree to take part

Part 1: General Information

1. What is your job title?

- Specialist Parent and Infant (Mental) Health Visitor
- Health Visitor for Children and Families
- Flying Start Health Visitor
- Other

Please specify

2. How long have you been working in your current role?

- Less than 1 year
- 1 to 5 years
- 6 to 10 years
- Over 10 years
- Prefer not to say

3. What is your age

- 20-29



- 30-39
- 40-49
- 50-59
- 60+
- Prefer not to say

4. Approximately what point are you at in terms of your professional pay grade?

- Band 4
- Band 5
- Band 6
- Band 7
- Band 8
- Band 9
- My position is outside NHS
 - Top of pay grade
 - Middle of pay grade
 - Bottom of pay grade
- Prefer not to say

5. Is your current post:

Formally commissioned

Informal (you are known within your organisation as informal lead for PIMH)

Other

6. Is your current post:

Part time

Full time

Temporary Contract

Permanent Contract

Other

7. Please list the first three characters of your work post code

8. Please select what type of service/team you work in:

- Not applicable
- CAMHS

Specialist Health Visitors in Perinatal and Infant Mental Health



- Adult Mental Health Services
- Universal Health Visiting Service
- Perinatal Mental Health Service
- Parent-Infant Mental Health Service
- Maternity Services
- Local Authority
- Flying Start (Wales)
- Third Sector (Voluntary) Organisation
Please specify _____
- Other
Please specify _____

9. Which other professionals are part of your work team (tick all that apply)?

- Child Psychotherapist
- Community Nurse
- Couples or Family Therapist
- Family Support Worker
- GP
- Infant Mental Health Practitioner
- Midwife
- Nurse
- Occupational Therapist
- Perinatal Mental Health Practitioner
- Psychiatrist
- Psychologist
- School Nurse
- Social worker
- Other
Please specify _____

10. Do you liaise with other services (teams) on a regular basis?

- Yes
- No

If Yes: Which of the following services do you liaison with on a regular basis?

- CAMHS
- Drug and Alcohol Services

Specialist Health Visitors in Perinatal and Infant Mental Health



DVA Services
Social Work
Maternity Services
GP Surgery
Paediatricians
AMHS
Perinatal Mental Health Service
Adult Mental Health Service
Neonatal Units
Parent-Infant Mental Health Teams
Midwifery Services
Children's Centres
Foster Care Services
Family Courts
Third Sector (Voluntary) Organisations

Please specify _____

Other

Please specify _____

11. Which of the following trainings have you had an opportunity to complete? Please tick all that apply:

Institute of Health Visiting iHV Champions Training

Infant Mental Health

Perinatal Mental Health (multi-agency)

Perinatal mental Health (uni-professional Health Visitor)

Fathers and Perinatal Mental Health

Perinatal and Infant Mental Health (multi-agency)

Perinatal and infant mental health (uni-professional- HV)

International Training School for Infancy and Early Years (ITSIEY) through Anne Freud Centre

An introduction to perinatal and infant mental health

Mentalizing in practice; working with parents and babies

Early Intervention Skills to Enhance Parent Infant Relationships

Neuroscience: its relevance to work with parents, infants and young children

Reflective supervision in infant mental health (0 - 24 months): Holding the supervisee, child and family in mind

Parental mental illness

Recognising Risk to Infants

Other; Please Specify _____

Solihull Approach Training (NHS University Hospitals Birmingham)

Specialist Health Visitors in Perinatal and Infant Mental Health



Two Day Foundation Training

- Generic
- Antenatal
- Fostering, Adoption, and Social Work
- Adult ('Keeping Trauma in Mind')
- Foundation Training for Managers

Early Years Foundation Stage Training

Group Facilitator Training

- Parenting Group Facilitator
- Antenatal Parenting Group Facilitator
- Foster Carer Course Facilitator
- Postnatal Parenting
- Postnatal Plus Parenting

Combined Foundation and Group Facilitator Training

- Antenatal Foundation and Parenting Group Facilitator
- Foster Care Foundation and Foster Carer Course Facilitator

Train the Trainer

- Parenting Train the Trainer
- Antenatal parenting group Train the Trainer

- Foster carer course Train the Trainer
- Postnatal group Train the Trainer
- Postnatal Plus group Train the Trainer

Solihull Approach Plus Seminars

- Brain Development
- Attachment
- Refresher Day
- Understanding Trauma
- Advanced Training 'The Solihull Approach to Management'
- Solihull Approach Reflective Supervision training

Online Course

- Clinical workshop through the UK Association for Infant Mental Health
- Training in father-inclusive practice through the Fatherhood Institute
- Multi-disciplinary training in Perinatal Mental Health through Perinatal Mental Health Network
- Brain Story Certification (Alberta Wellness Initiative)
- None of the above

12. How often are you able to attend trainings supporting your continuing professional development:

- Never
- Every six months
- Once a year

Specialist Health Visitors in Perinatal and Infant Mental Health



Every two years

Every three years

13. How would you characterise the availability of **financial resources** to pursue continuing professional development?

- 1 far below the level of my needs
- 2 moderately below the level of my needs
- 3 reflective of the level of my needs
- 4 moderately above the level of my needs
- 5 far above the level of my needs

14. How would you characterise the availability of **time** to pursue continuing professional development?

- 1 far below the level of my needs
- 2 moderately below the level of my needs
- 3 reflective of the level of my needs
- 4 moderately above the level of my needs
- 5 far above the level of my needs

15. Have you undertaken any **specialist placements** to support your current role?

Yes

No

Not Applicable

16. Have you undertaken any specialist placements to support your current role?

Yes

No

Not Applicable

If yes, please elaborate _____

17. Was mentoring by a specialist one of qualifications/prerequisites for your current role?

Yes

No

Not Applicable

18. Do you currently have access to regular **supervisions regarding PIMH aspect** of health visiting?

Yes

No

Prefer not to say

19a) What type of supervision do you have access to?

Clinical

Managerial

Specialist Health Visitors in Perinatal and Infant Mental Health



- Safeguarding
- Restorative
- Reflective
- Informal Peer Group
- Formal Peer Group
- None

19b) Who provides the supervision?

- Another health visitor with additional training in mental health
- Clinical Psychologist
- Child and Adolescent Psychotherapist
- Adult Psychiatrist
- Adult Psychotherapist
- Specialist Perinatal Psychiatrist
- Mental Health Nurse
- Other (please specify)

19c) Are supervisions self-funded or funded by the employer?

- Self-funded
- Funded by the employer

19d) How frequently do you have supervision?

- Fortnightly
- Once a month
- Every two to three months
- Every six months
- Once a year

19e) How satisfied or dissatisfied are you with the supervision regarding PIMH?

Very satisfied/satisfied/neither satisfied nor dissatisfied/dissatisfied/very dissatisfied

19. Do you currently have access **to consultation from other professionals** regarding PIMH aspects of health visiting?

- Yes
- No
- Prefer to not answer

20a) Which of the following can provide you with a consultation regarding PIMH aspects of your job?

- Another health visitor with additional training in mental health
- Clinical Psychologist
- Child and Adolescent Psychotherapist
- Adult Psychiatrist

Specialist Health Visitors in Perinatal and Infant Mental Health



Adult Psychotherapist
Specialist Perinatal Psychiatrist
Mental Health Nurse

20b) How frequently do you have consultations?

Fortnightly
Once a month
Every two to three months
Every six months
Once a year

21e) How satisfied or dissatisfied are you with the supervision regarding PIMH?

Very satisfied/satisfied/neither satisfied nor dissatisfied/dissatisfied/very dissatisfied

20. Have you received **support in your role** of Specialist Health Visitors (PIMH)**from** any of the following **groups and organisations**? (Answer Options: No, I have not needed support so far; No, I did not know that was an option; Yes, but only once; Yes, regularly)

Locally provided Perinatal or Infant Mental Health Network
Institute of Health Visiting including iHV Champion Forums
The Association for Infant Mental Health
Parent Infant Foundation
Early Intervention Foundation
Other (Please Specify)

21. Are there other experiences that have equipped you for the specialist role in PIMH not mentioned above?

No
Yes
Please specify _____

22. If you would you like to make any comments about your experiences related to training for the role of SHV in PIMH, please give details in the text box below:

Part 3: Work with the families

23. In your current post as a specialist health visitor, do you work directly with families who experience individual and/or relational (dyadic/triadic/family) mental health difficulties?

Yes, I work directly with families experiencing mental health difficulties

Specialist Health Visitors in Perinatal and Infant Mental Health



No, my responsibilities are mostly supervisory and training

*IF no directed to Part 4 of the survey

24. How large is your case load?

- Less than 100 children
- 101-200 children
- 201-300 children
- 301-400 children
- 401-500 children
- 501-600 children
- 601-700 children
- 701-800 children
- 801-1000 children

25. Does your family caseload consist primarily of families with higher levels of mental health needs?

- Yes, caseload consists primarily of families with higher levels of mental health needs
- No, a regular caseload within which I encounter families with mental health needs

26. Which of the following mental health problems (based on clinical assessment) have been experienced by mothers and/or their partners who have received support from you?

	Yes	No	Don't know
Tokophobia			
Antenatal depression			
Antenatal anxiety			
Birth Trauma			
Postnatal depression			
Postnatal anxiety			
Depression			
Anxiety			
Social anxiety (social phobia)			
Panic attacks			
Panic disorder			
Psychosis			
Puerperal psychosis			

Specialist Health Visitors in Perinatal and Infant Mental Health



Personality Disorder			
Complex trauma			
Schizophrenia			
Bipolar affective disorder			
Schizoaffective disorder			
Obsessive-compulsive disorder			
PTSD			
ADHD			
Eating disorder			
Autistic spectrum disorders			
Alcohol use disorder			
Substance use disorder			
Suicidal thoughts			
Self-harm			

27. How do you assess the potential impact of parental mental ill-health on the parent-infant relationship?

28. Which of the following difficulties presented by infants and their parents you, as a SHV in PIMH, have given support to?

- Bonding/attachment problems
- Couple relationship problems
- Excessive crying
- Feeding difficulties
- Parental reflective functioning
- Sibling rivalry
- Sleeping difficulties
- Speech and language development delay/disorder
- Other (please describe)

	Yes	No	Don't know
Excessive crying			
Feeding difficulties			
Sleeping difficulties			
Bonding/attachment problems			
Parental reflective functioning			
Couple relationship problems			

Specialist Health Visitors in Perinatal and Infant Mental Health



Sibling rivalry			
Speech and language development delay/disorder			
Other (please describe)			

29. How do you identify family mental health needs? For example: What are the processes and factors you consider important when assessing family needs?

30. Do you use any of the following tools to assess parental and infant mental health and the quality of the parent-infant relationship? (Please tick all that apply)

	Used with the mother	Used with the father/partner
GAD-7 (Generalized Anxiety and Depression Scale)		
EPDS (Edinburg Postnatal Depression Scale)		
PHQ-9 (Patient Health Questionnaire)		
HADS (Hospital Anxiety and Depression Scale)		
PIIOS (Parent-Infant Interaction Observation Scale)		
NBAS (Neonatal Behavioural Assessment Scale)		
KPCS (Karitane Parenting Confidence Scale)		
MORS (Mother's/Child Object Relations Scale)		
CARO (Child and Adult Relationship Observation; a streamlined version of the Mellow Parenting Observation System)		

31. If you use any other formal assessment tool or criteria, please provide details below:



32. Which of the following models of interventions are you qualified to provide (tick all that apply):-- MERGE WITH QUESTION 32

- CBT
- Facilitated/guided self-help
- Listening visits
- Mellow parenting
- Mindfulness approach
- Motivational interviewing
- Neonatal Behavioural Assessment Scale (NBAS)
- Newborn Behavioural Observation (NBO)
- Non-directive counselling approach
- Promotional interviewing
- Psychodynamic counselling
- Psychotherapy
- Relaxation techniques
- Solution focused therapies
- Video Interaction Guidance
- Watch Wait and Wonder

(VIG) ((a) I have completed a two-day VIG Introductory Course b) I am a qualified VIG practitioner)

Which of the following interventions do you use to support mental health of the parents?

	Yes	No	Don't know
Psychodynamic counselling			
Psychotherapy			
CBT			
Facilitated/guided self-help			
Mindfulness approach			
Motivational interviewing			
Non-directive counselling approach			
Promotional interviewing			
Relaxation techniques			
Solution focused therapies			
Listening visits			
Other (please describe)			

Specialist Health Visitors in Perinatal and Infant Mental Health



33. How do you determine that the intervention has been successful? _____

34. Where and how do you record the content, process, and outcome of any intervention that you have offered? _____

35. Is parental satisfaction being assessed and recorded?

Yes

No

37a) Please specify how you assess and record parental satisfaction _____

36. Prior to COVID-19 pandemic, how did you deliver packages of support to families?

--Frequency scale (never/rarely/sometimes/often/always) ----

Phone

Video Calls

Home Visits

Meeting family outside the home (e.g. clinic)

Groups

37. How do you currently deliver packages of support to families?

--Frequency scale (never/rarely/sometimes/often/always) ----

Phone

Video Calls

Home Visits

Meeting family outside the home (e.g. clinic)

Group Workshops

38. If not already specified, what other strategies, techniques, and resources do you use to promote parent-infant relationships and infant well-being when working with families?

Part 4: Additional Responsibilities

39. As a SVH in PIMH, I have **delivered training focused on PIMH** to the following practitioners (please tick all that apply):

Children Centre Practitioners

Specialist Health Visitors in Perinatal and Infant Mental Health



Community Midwives
Community Nurses
Emergency services (eg paramedics)
Family Courts Staff
Foster Care Workers
GPs
HVs
Infant mental health professionals
Mental health professionals (adult services)
Mental health professionals (CAMHS)
Midwives
Nursery Nurses
Obstetricians
Occupational therapists
Parents
Pre-registration Nurses
Private sector
School Nurses
Social Workers
Specialist Perinatal mental health professionals
Specialist Teenage Midwives
Student Health Visitors
Third sector
Other (Please specify)

40. As a SVH in PIMH, my responsibilities currently also include (please tick all that apply):

Advising and providing content for pre-registration HV training
Co-working with HVs (visiting families together to provide reflective supervision)
Developing and leading PIMH groups for families
Service audit and evaluation of PIMH
Providing clinical supervision
Offering shadowing opportunities for practitioners
Developing protocols and policy
Supporting the development of community initiatives promoting PIMH
Establishing and/or participating in a local PIMH network
Advocating for commissioning of P and IMH specialist services
Attending and contributing to multi-disciplinary/specialist clinical team meetings
Attending and contributing to service operational meetings
Attending and contributing to regional meetings such as local maternity systems, primary care networks

Specialist Health Visitors in Perinatal and Infant Mental Health



41. What are the most important ways in which specialist health visitors promote parental and infant mental health? (Number in the order of importance with 1 – most important, 4 least important)

By offering a targeted service when families have more complex mental health needs

By providing ongoing support and supervision to other health visitors

By advocating for PIMH across the healthcare system

Providing training to universal workforce staff who work with children under the age of 5

42. What are the barriers in promoting PIMH have you personally encountered in the role of specialist health visitor?

43. There are some comments that health visitors have made about obstacles to development of the Specialist Health Visitors (PIMH) roles across the UK. Please indicate the extent to which you agree or disagree with these statements.

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
There are no obstacles to development of Specialist Health Visitors (PIMH)					
There is not enough funding to commission SHV in PIMH					
There is lack of understanding among commissioners about the importance of supporting parent-infant mental health and relationships					
There is lack of understanding among commissioners about the role of health visitors in promoting PIMH					
Commissioners overestimate the confidence and competency of non-specialised health visitors in handling PIMH difficulties					
It is difficult to recruit for the position of SHV in PIMH					
The retention rates for SVH in PIMH are very low					
Health Visitors generally do not feel confident in helping families with PIMH difficulties					

44. Do you know of any areas that you consider to be delivering excellence or innovating in PIMH provision?

Specialist Health Visitors in Perinatal and Infant Mental Health



Yes

No

44a) Could you please specify which location (CCG)?

44b) What makes this area exemplary or innovative?

45. Are you aware of any locations in the UK where there has been a specialist PIMH health visiting post that has been lost? (Yes/No)

45a) Where was this post located?

45b) What was the rationale for termination of the position?

46. Thank you for making the time to complete this survey. Would you be willing to take part in an interview to further discuss your experience as a specialist health visitor in parent and infant mental health?

Yes

No

Could you please provide us with an email and/or phone number at which we can reach you?