Specialist Children's Services

NHS Greater Glasgow and Clyde

# Wee Minds Matter - NHSGGC Infant Mental Health Service Evaluation Report, May 2023 (Covering Oct 21 to Dec 2022)

*“It’s given me back my confidence and … improved my relationship with [my baby].”*
Parent feedback


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# 1 Background

'Infant mental health' describes the social, emotional and cognitive wellbeing and development of infants, expressed in the developing capacities to form close relationships; experience, regulate and express emotions; and explore the environment and learn (Zero to Three, 2017). As infants are dependent on caregivers to meet their needs, they adapt to their unique relational environment (National Scientific Council on the Developing Child, 2004). Where parents are adequately sensitive to their infant's cues, and predominantly match needs with an appropriate and nurturing response, stress is buffered, and infant mental health supported. By contrast, where parents cannot meet their infant's needs safely or consistently, psychological and neurodevelopmental adaptations will be made to prioritise survival (Hambrick et al, 2019).

Mental health problems can, and do, develop in infancy (National Scientific Council on the Developing Child, 2008/2012), and a range of health and social care research suggests that a significant proportion of infants are at risk (Hogg, 2020). Without intervention, early-life stress is likely to endure into the subsequent developmental period (Hambrick et al, 2019) and can have profound and lasting impacts across the lifespan. Given the fundamental importance of infant-caregiver relationships, a whole-system response to promote and support rewarding relationships for infants, and provide early intervention where difficulties arise, is indicated (Hogg, 2020).

The Rare Jewels report (Hogg, 2020) identified few specialist infant mental health teams across the United Kingdom, and very limited mental health provision overall for infants under 2 years old. In 2018, the Scottish Government pledged investment in perinatal and infant mental health services, and a Perinatal and Infant Mental Health (PIMH) Programme Board was established in 2019. Its remit included implementation and funding of a nationwide model of infant mental health provision, offering a valuable contribution to developing robust local systems and pathways for infants and caregivers. The Programme Board delivery plan (2019-20) detailed that the funding provides:

*"support for the development of infant mental health specialists within perinatal mental health teams and wider support for families experiencing significant adversity, including infant developmental difficulties, parental substance misuse, domestic abuse and trauma" (Scottish Government, 2019).*

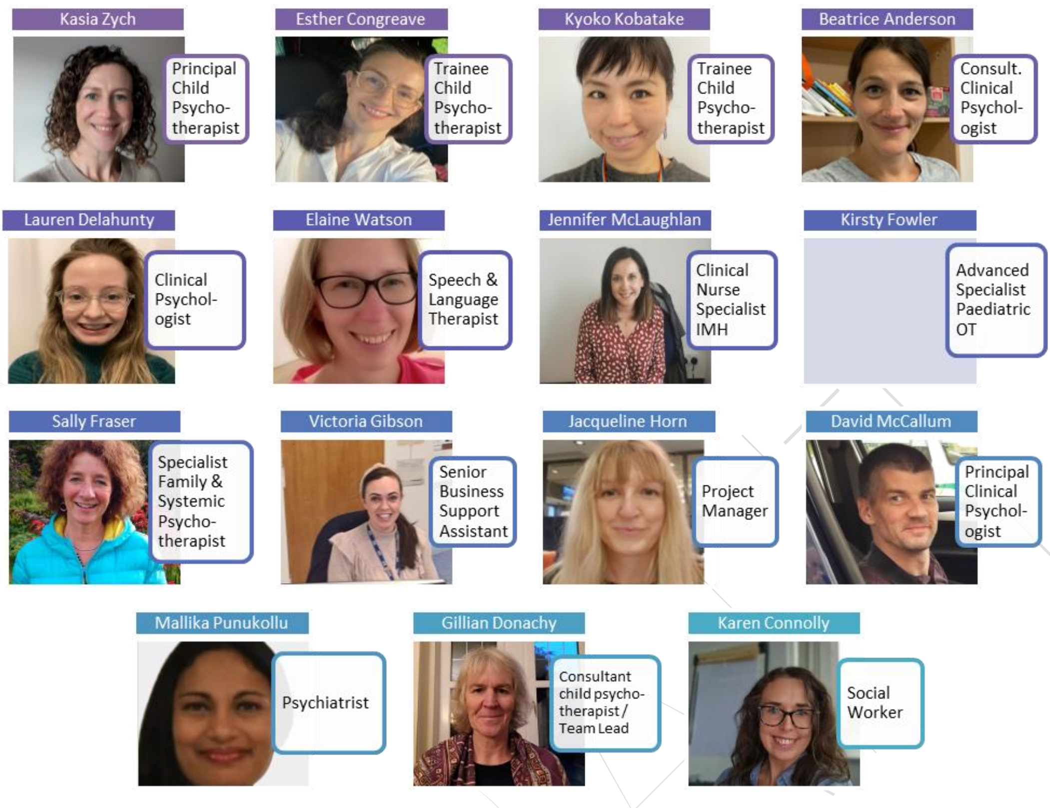
## 1.1 What is Wee Minds Matter - NHSGGC Infant Mental Health Service?

NHSGGC submitted a successful response to a funding call from the PIMH Programme Board in 2020. Development work to establish an Infant Mental Health Service began that year, with most of the initial team recruited by October 2021. In partnership with the first families, the name 'Wee Minds Matter' was chosen in 2022 to identify the NHSGGC specialist infant mental health service that works with infants and families from pregnancy to 3 years old. The service is multi-disciplinary by design and includes professionals from the following backgrounds: Child Psychotherapy, Psychiatry, Social Work, Nursing, Speech and Language Therapy, Occupational Therapy, Family and Systemic Psychotherapy, and Clinical Psychology. Wee Minds Matter aims to ensure that infants' experiences and needs are well understood, and that care is appropriately responsive to need at all tiers of service provision from universal to specialist.

The vision is to transform culture around infant mental health in Greater Glasgow and Clyde by raising awareness of infant mental health risks and resilience, supporting high quality practice by professionals working with infants and their families, and providing direct specialist support where required. It is anticipated the team will often be involved in supporting the work of other professionals directly engaged with babies and their families. The approach aims to keep a focus on relationship-based practice while delivering all aspects of the service activity. Service offers include a duty line; professional consultation; support with care planning, including during pregnancy; and joint working. The service offers education and training in infant mental health, and space for professionals to share, reflect on and develop their practice in work with infants and families. Wee Minds Matter also works directly with families where specialist assessment or intervention are needed. This involves relationship-based approaches with babies and caregivers together, in which babies are active participants in the work. It is thus led by infant needs but also considers families' preferences and goals. The team offers individual infant/parent work, and group work.

The current team are shown in Figure 1, with previous team members, including Jane Turner, having moved on to new roles. Additional people involved with securing funding, and developing and establishing the team include Andrea Blair, Lesley Boyd, and Andrew Dawson.

*Figure 1: Graphic showing the members of the Wee Minds Matter Team in April 2023*




## 1.2 The Infant Mental Health Pathway in NHSGGC

By design, WWM is part of a multi-agency network around each child referred and, unlike other health services, is never a stand-alone service. There is not one offer for all but rather a response based on the 5 key GIRFEC questions:

- What is getting in the way of this child's or young person's well-being?
- Do I have all the information I need to help this child and young person?
- What can I do now to help this child and young person?
- What can my agency do to help this child or young person?
- What additional help, if any, may be needed from others?

Infants and families should be offered an intervention that best fits their needs and the service strategy. This can range from support to the network via reflective practice or consultation, working alongside those already involved, or offering specific contributions to complement the work already being offered. Therefore, no infant should at any point be without a care plan and professionals actively involved. Consultations will be offered to fit in with existing care plan meetings, direct intervention will be offered on a soon basis, while groupwork will be on a scheduled basis, hence there may be some wait before a suitable group is available in an accessible venue.

### 1.2.1 The Infant Mental Health Pathway – Consultations and identifying risk

Within the original IMH Pathway proposal, one strand of work was framed as providing support to the system via Consultation with professionals, including Health Visitors (HV), Family Nurse Partnership practitioners (FNP) and Social Workers. This consultation work was intended to:

- Help to articulate infant mental health in the child's plan.
- Provide confidence that the plan is proportionate to infant's needs.
- Support Solihull as a starting point.
- Support reflective practice.
- Offer formulation and review of progress at touchpoints

Early experience of providing consultations tested out different approaches, but did not focus on the Solihull approach, as originally planned. Instead, from August 22 onwards the approach looked at the fundamentals of GIRFEC relating to the use of the resilience matrix and the risk quadrants to structure and organise discussion. This has been further enhanced by using the 4 Tiers of the framework for assessing and working with unintentionally harmful parent-child interactions looking in detail at the quality of carer-infant relationships (Glaser 2002, 2011), integrated with the GIRFEC National Practice Model. (Appendix I includes graphical overviews of the tools being used to assess risk, including the vulnerability and resilience matrix, and strengths and concerns risk quadrants from the GIRFEC National Practice Model.)

# 2 Evaluation methodology

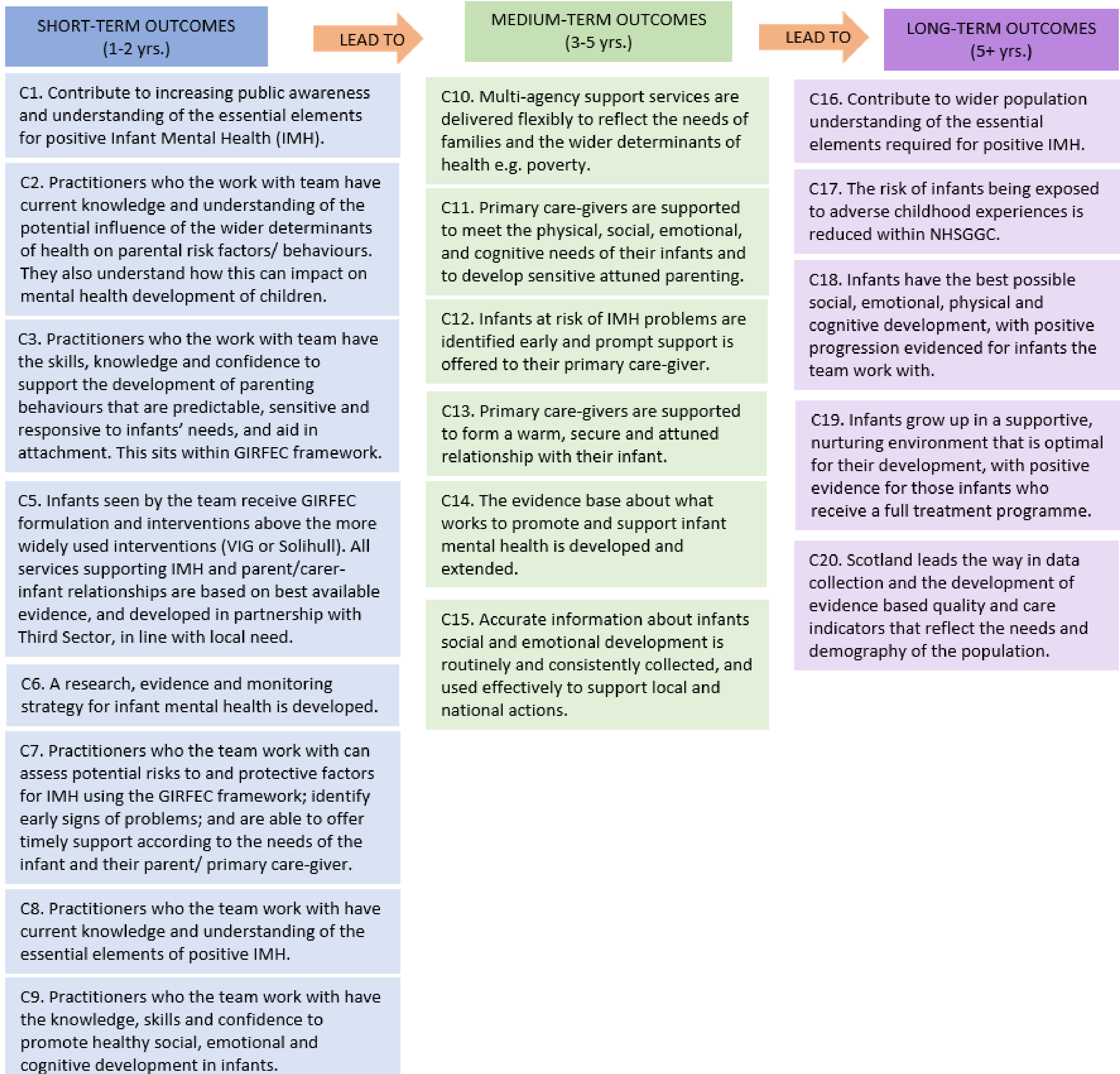
## 2.1 Adapting the national evaluability assessment and refining the Wee Minds Matter Programme Theory

The evaluation of Wee Minds Matter draws on the Evaluability Assessment of the Scotland-wide PIMH Programme (Wason et al., 2021) by adapting the proposed national Infant Mental Health Logic Model, and by adapting some of the suggested key evaluation questions. The questions from the Evaluability Assessment have been refined to place a stronger emphasis on identifying impact, see Section 2.2. For the purposes of this evaluation, Wee Minds Matter refers to the service provided by the IMH Team within NHSGGC. The broader IMH Pathway could also be seen to involve input from Health Visitors, Family Nurse Partnership Teams, Social Workers, and others.

A 'Data catalogue' was produced alongside the national Evaluability Assessment, this was reviewed to identify potential national data sources. The outcome of this is shown in Appendix II, which maps the key evaluation questions to potential methods and national data sources for the evaluation of Wee Minds Matter. Overall, there was little national data specifically concerning infant mental health, and this early review of data highlighted the need to focus on developing more local data sources.

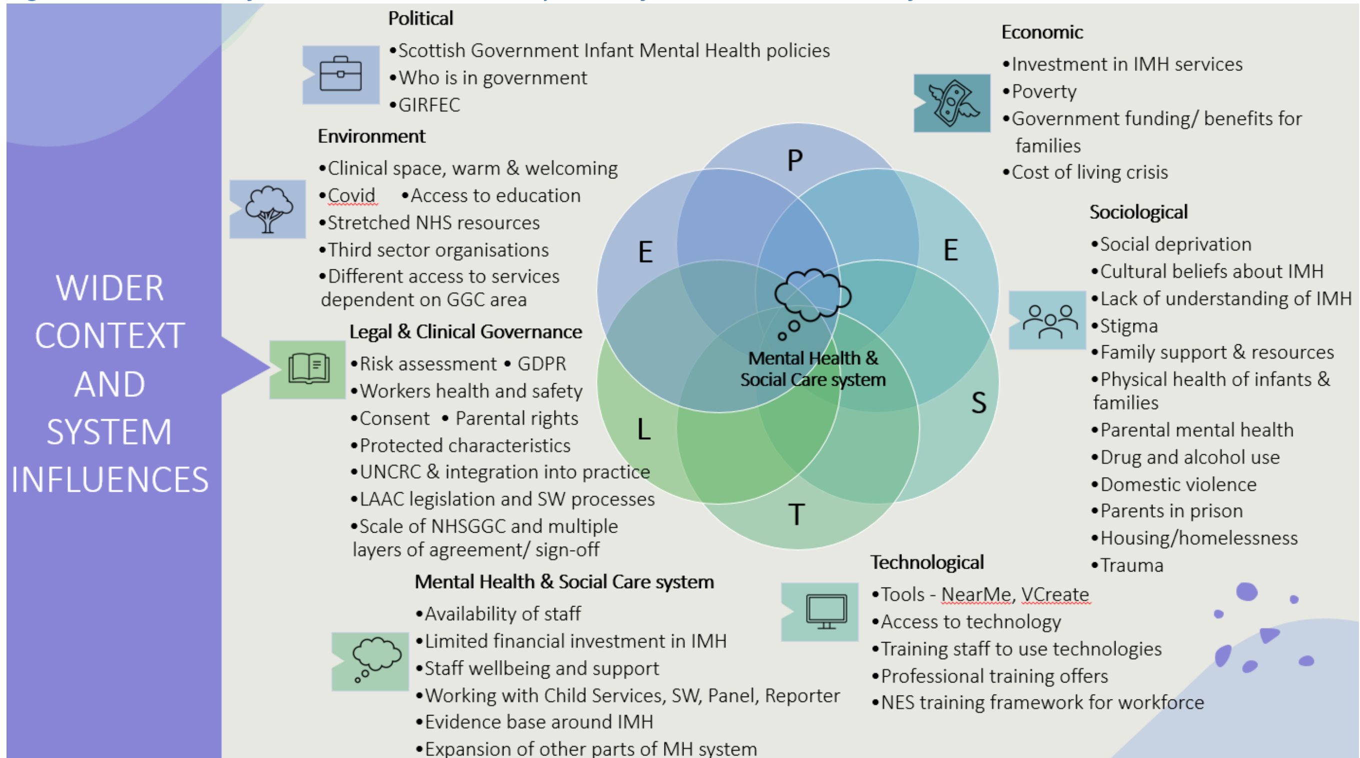
A more detailed schedule for evaluation data collection and analysis was also developed, in consultation with the IMH Team. Appendix III maps the key evaluation questions to the chosen methods and local data sources, and details timescales, along with who will administer the tools and to whom. Further detail on the range of validated tools and outcome measures are given in Appendix IV. The more bespoke qualitative data collection tools (interview schedules, focus group proforma, team reflections) will be developed on the basis of the updated programme theory and logic model, see Figure 2.

*Figure 2: Original NHSGGC Infant Mental Health logic model.*




The wider programme theory and logic model underpinning the work of Wee Minds Matter has been reviewed in collaboration with the IMH Team. This involved desk-based research, along with a 'Programme theory workshop' in which the WMM team contributed to a stakeholder analysis, review of wider context and system influences (shown in Figure 3), and identification of interventions and underlying mechanisms of change. This was delivered remotely, and data captured using an online whiteboard. Findings were synthesised and revisited at a follow-on workshop.

*Figure 3: Overview of the wider context and system influences on the work of the Wee Minds Matter IMH Team.*




## 2.2 Aims and key evaluation questions

This evaluation is intended to review the implementation and impact of Wee Minds Matter, the NHSGGC Infant Mental Health Service within Specialist Children's Services, NHSGGC.

**Aim I: Infants at risk of mental health problems are identified early and support offered to them in the context of their primary caregiving relationships**

*Understanding of IMH - risks*

1) What impact has Wee Minds Matter had on professionals' understanding of risk and resilience factors relevant to infant mental health?
2) What impact has Wee Minds Matter had on women and families' understanding of risk and resilience factors relevant to infant metal health?

*Equality of access*

3) What impact does social circumstance have on equality of access and timeliness of access for infants at risk of poor mental health?

*Service Delivery – reach, timeliness, & effectiveness*

4) What proportion of infants at risk of poor mental health are referred for support?
   i) What proportions across the levels of service provision?
   ii) And, how timely is this?
5) What proportion of infants at risk of poor mental health are offered and receive appropriate support?
   i) And, how timely is this?
6) What evidence is used to confirm Wee Minds Matter is appropriate for responding to poor mental health? [How well is Wee Minds Matter used to respond to poor mental health?]
   i) Evidence collected by clinicians – evidence of appropriate use of tools/adherence to pathway component delivered by NHSGGC IMH Team.
   ii) Short-term impact on child – evidence of progression.
7) How well is Wee Minds Matter perceived by families?

*Child outcomes*

8) What is the impact of support (i.e. services and/or intervention) in response to poor infant mental health on the long-term outcomes for the child?

**Aim II: Primary care givers and their families are supported to meet the needs of their child/children, and to form and maintain a healthy relationship with their child/children.**

*Understanding of IMH – healthy relationships*

9) What impact has Wee Minds Matter had on professionals' understanding, knowledge and skills regarding healthy relationships between infants and care givers?
   i) Including assessment
10) What impact has Wee Minds Matter had on women and families' understanding of what constitutes a healthy relationship with their infant?

*Service Delivery – reach, timeliness, access*

11) What support has Wee Minds Matter provided to parents to encourage a healthy relationship between them and their child?
   i) And, how timely is this?
   ii) What reach does this have across the population?
   iii) What are the enablers and barriers to awareness of /access to support?

*Understanding of IMH – support available*

12) What impact has Wee Minds Matter had on professionals' awareness of what support is available both nationally and locally?

**Aim III. To implement a well-functioning, high quality and sustainable IMH service that engages in ongoing service improvement to meet the needs of infants and families in NHSGGC.**

The formative evaluation process will focus on identifying potential enablers and barriers to accessing IMH support, and timeliness of access; and will capture areas of success or excellence, as well as areas of challenge in service development and delivery. Evidence of how Wee Minds Matter responds to identified enablers and barriers will be captured. The process of involving stakeholders in the design of Wee Minds Matter will also be reviewed, and evidence collected on how valuable this process is. Evidence of the quality of the service will be drawn from across the evaluation but will also involve reviewing to how complex cases proceed, and how aspects of this change as the IMH team develops, settles in and matures.

# 3 Findings

## 3.1 Aim I: Infants at risk of mental health problems are identified early and support offered to them in the context of their primary caregiving relationships

### 3.1.1 Understanding of IMH - risks

The first evaluation question asks **"What impact has Wee Minds Matter had on professionals' understanding of risk and resilience factors relevant to infant mental health?"** Within Greater Glasgow and Clyde, evidence of inputs in relation to this include team activity to raise professional awareness of IMH services and supports. Some of this outreach activity is recorded as part of a log of duty calls and actions. Additional service information sessions delivered by the team are detailed in Section 4.3.

Duty calls were offered and undertaken by the team to support professional awareness. From January to mid-December 2022, approximately 150 calls were received from numerous professionals including health visitors (61), family nurse practitioners (9), psychologists (13), and midwives (8).

The general themes of calls were recorded. There were 123 queries concerning potential referrals, which were either completed during the call, brought forward at a referral management meeting, submitted on EMIS or re-directed to

the appropriate department. In total, seven duty calls were later converted into EMIS referral submissions. The remaining calls to the team concerned Newborn Behavioural Observations (NBO) requests, information requests from social workers, consultation requests, and advice and support. Duty calls have thus supported professionals to interpret their cases in relation to infant mental wellbeing and proceed with this in mind. The team were able to support professional awareness during duty calls through offering clarity on who WMM are, the service they offer, and the factors impacting risk and resilience to infant mental health.

Members of the team also delivered an evening Film Event to colleagues across Greater Glasgow and Clyde who were currently working with under 5's and wanted to know more about Infant Mental Health. Sixteen professionals attended from a variety of backgrounds including NHS, Bluebell Perinatal Service, Early Years Scotland, Children's 1st and Social work colleagues. Attendees gave feedback on the potential impact of the session on their practice:

> *"Makes me more curious re: parents' experiences of being parented, be more observant to difficulties between parents and children."*
>
> *"Interested to find out more about the funding and resources available for support services."*

This feedback indicates the impact of WMM on widening awareness of risk and resilience factors and drawing attention to the services available to families.

At a national level in Scotland, the team are supporting professionals' understanding by contributing to an Infant Voice Short Life Working Group, led by the PIMH Programme Board. The team are also working on the latest update of the NES Matrix of Psychological Therapies. Contributions by the team to the Infant Voice Short Life Working Group has led to development of Best Practice Guidelines for Supporting Infant Voice, an 'Infant Pledge' and an Infant Rights Statement (Scottish Government, 2023). To raise understanding outside of Scotland, conference abstracts have been submitted by the evaluation team and WMM team (see Section 4.2).

The evaluation also considers families' understanding, and asks **"What impact has Wee Minds Matter had on women and families' understanding of risk and resilience factors relevant to infant mental health?"**

All team members have now received accreditation in Newborn Behavioural Observation (NBO). The NBO is a strengths-based approach aiming to improve the parent-infant relationship. In the intervention, practitioners share observations with parents of new-born babies to help them understand their babies' communication behaviour, movements and responses, and their babies' likes and dislikes. The team have been offering NBO by identifying babies needs early on in pregnancy or post-delivery.

The team have attended training in Circle of security parenting (COS-P). COS-P is a parental support program that informs parents of the basic emotional needs of infants up to 6 years old. The aim of the program is to support parents in meeting their infants' needs and promote secure attachment. The service has been innovative by working with Third Sector organisations to secure venues in which they can run groups, as there are childcare facilities. The first COS-P group began in November 2022 in a nursery in Paisley. The team plan to continue to work with nurseries in Paisley and elsewhere, and hope that staff from nurseries / early years centres will decide to fund training for their staff (from COS International). This approach to working alongside other professionals is an example of extending the reach of the team via partnership working. Future evaluation reports will involve more detailed evaluation activity around COS-P and will likely include a dedicated COS-P case study.

The IMH Experience of Service Questionnaire (ESQ) will be used to capture any feedback from families regarding the service provided by WMM, including feedback on understanding of risk and resilience. The latter has not been mentioned in the initial responses to the ESQ.

### 3.1.2 Equality of access

Ensuring equality of access to health services means understanding the social determinants of health; considering the impact social determinants and protected characteristics may have on mental health, and on access to mental health support, when designing or delivering services; and attending to equality data to monitor any inequalities of

access or service delivery. The evaluation therefore also asks **"What impact does social circumstance have on equality of access and timeliness of access for infants at risk of poor mental health?"**

Presented below are the available demographic and other protected characteristics information for parents and infants who have received support from the WMM team. Table 1 shows the majority of parents/caregivers were female, while there was an even balance of infants in terms of gender.

*Table 1. Gender of parents and infants in contact with WMM.*

| Gender | Parent | Infant | Total |
|---|---|---|---|
| Female | 17 | 48 | 65 |
| Male | 1 | 47 | 48 |
| **Total** | **18** | **95** | **113** |

Table 2 provides an overview of ethnicity, with the majority of infants seen being white Scottish. Monitoring this relative to expected ethnicity profiles across the NHSGGC area would be useful and may suggest areas for the team to target, such as specific ethnic groups. A high portion of parents (n=12 of 18) have no ethnicity recorded, and this could be an action for the team to improve on in future.

*Table 2. Ethnicity of parents and infants in contact with WMM.*

| Ethnicity | Infant | Parent | Total |
|---|---|---|---|
| White: Scottish - Scotland ethnic category 2011 census | 71 | 0 | 71 |
| White: Polish - Scotland ethnic category 2011 census | 2 | 0 | 2 |
| White: other British - Scotland ethnic category 2011 census | 2 | 0 | 2 |
| White: any other White ethnic group - Scotland ethnic category 2011 census | 1 | 0 | 1 |
| Other White background - ethnic category 2001 census | 0 | 2 | 2 |
| British or mixed British - ethnic category 2001 census | 0 | 2 | 2 |
| Scottish - ethnic category 2001 census | 0 | 1 | 1 |
| Asian or Asian Scottish or Asian British: Indian, Indian Scottish or Indian British - Scotland ethnic category 2011 census | 3 | 0 | 3 |
| African: African, African Scottish or African British - Scotland 2011 census category | 4 | 0 | 4 |
| Chinese - ethnic category 2001 census | 0 | 1 | 1 |
| Mixed or multiple ethnic groups - Scotland ethnic category 2011 census | 6 | 0 | 6 |
| Other ethnic group: Arab, Arab Scottish or Arab British - Scotland 2011 census | 2 | 0 | 2 |
| Ethnic category - 2011 census Scotland (legacy category within EMIS) | 2 | 0 | 2 |
| Not completed | 2 | 12 | 14 |
| **Total** | **95** | **18** | **113** |

Table 3 shows Scottish Index of Multiple Deprivation (SIMD) categories for parents and infants who have been in contact with WMM. Monitoring this relative to expected SIMD profiles across the NHSGGC area would be valuable, and some targeting of some specific SIMD areas may be useful to consider.

*Table 3. Scottish Index of Multiple Deprivation (SIMD) categories for parents and infants in contact with WMM.*

| SIMD Quintile (Health Board 2019 defined) (n=133) | Count | Percent (%) |
|---|---|---|
| 1 – Most deprived | 41 | 30.8 |
| 2 | 25 | 18.8 |
| 3 | 26 | 19.6 |
| 4 | 6 | 4.5 |
| 5 – Least deprived | 8 | 6.0 |
| Post Code not recorded on SIMD | 27 | 20.3 |

### 3.1.3 Service Delivery – reach, timeliness, & effectiveness

To consider reach of the IMH service, the evaluation asks, "**What proportion of infants at risk of poor mental health are referred for support?"** As this is the first year of the WMM team being operational, the evaluation simply reports on referral numbers. Future reports will review these in relation to the infant population within the NHSGGC area, the demographic profile of patients seen, and findings from needs analyses undertaken elsewhere. An analysis of the need for an Infant Mental Health Service was published in NHS Lanarkshire in 2022. This describes a wide range of factors that may impact on infant mental health, including maternal poverty and deprivation, young motherhood, substance and alcohol use in pregnancy, maternal mental health difficulties, homelessness, developmental concerns in infancy, unintentional injuries, abuse and neglect, and infants who are on the child protection register or in the care system (Galloway et al, 2021). While local data is presented for many of these, the report highlights how it is difficult to present the overall complexity for "individual infants who are subject to multiple factors" and thus difficult to estimate population level need. It does, however, note "most indicators have a social or deprivation 'gradient' and are associated with experiencing poverty".

From when the service started receiving referrals to December 2022, a total of 130 referrals had been received and 16 had been rejected (12.3% rejections). The month-by-month profile of accepted and rejected, or redirected, referrals is shown in Figure 4. Reasons recorded for rejection or redirection are displayed in Table 4. This shows the team's acceptance rate for appropriate referrals is very high.

*Figure 4: Referrals to the WMM Infant Mental Health Service, showing those accepted and rejected or redirected.*

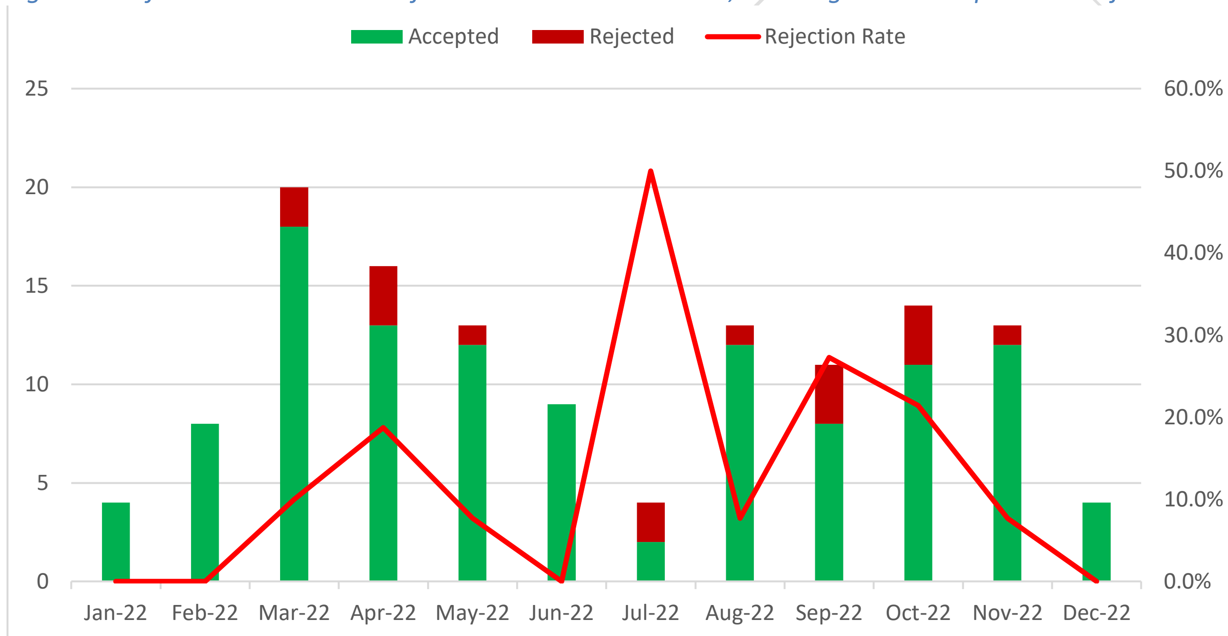
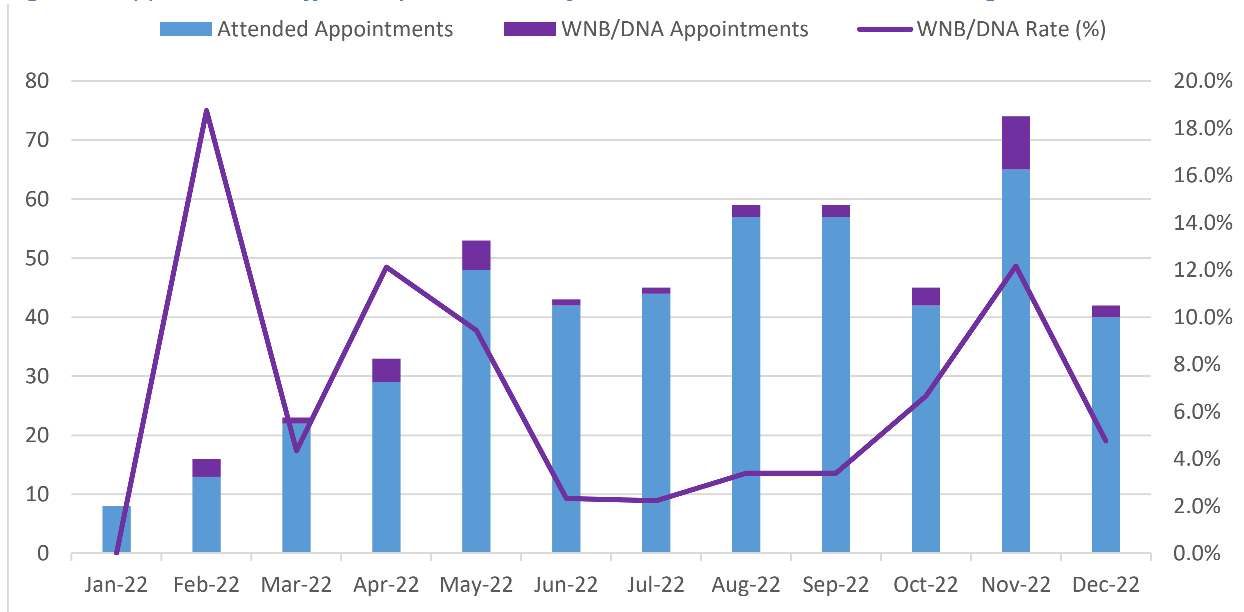



*Table 4. Reasons referrals to WMM were not accepted.*

| Reason for Referral Rejection | Count | Percent (%) |
|---|---|---|
| *Advice \ Information given* | 1 | 6.7 |
| *Inappropriate referral: Advice/info/signposting provided* | 6 | 40 |
| *Patient out-with the area* | 1 | 6.7 |
| *Referral Added in Error* | 4 | 26.7 |
| *Referred to another Service within the Organisation* | 3 | 20 |
| ***Total*** | **15** | **100** |

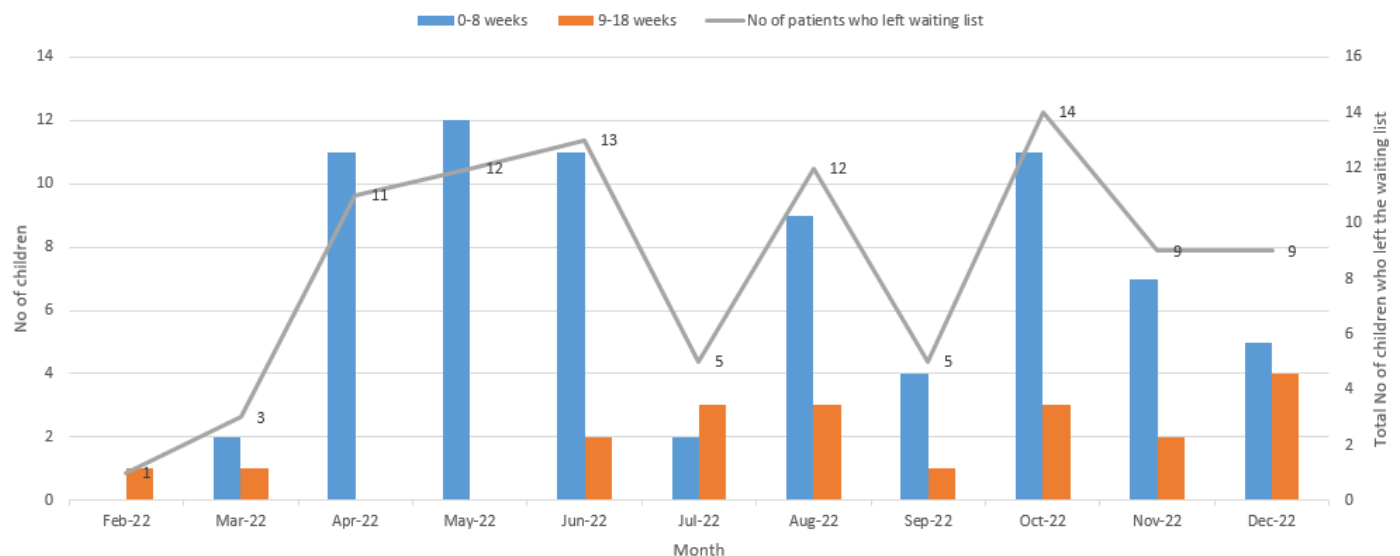
Figure 5 provides an overview of the appointments offered by the team across 2022, along with Was not brought (WMB) or Did not attend (DNA) rate. As this is a new service, the 'normal' profile of appointments is yet to be established. In November, the high level of appointments (both attended and not-attended) relates to the delivery of COS-P groups.

*Figure 5: Appointments offered by the WMM Infant Mental Health Service, showing attended and not attended.*




To further consider reach, as well as the timeliness of the IMH service, the evaluation also asks, "**What proportion of infants at risk of poor mental health are offered and receive appropriate support?"** As this is the first year of the WMM team being operational, the evaluation simply reports on waiting times, as shown in Figure 6. This demonstrates that most patients referred for specialist input from the team are seen within 0-8 weeks. It is useful here to reiterate that the WWM team are part of a multi-agency network around each child referred. No infant should thus be without a care plan at any point, and professionals will be actively involved. Direct interventions with the WMM team will be offered on a soon basis, and groupwork on a scheduled basis. There may thus be a wait before a suitable group is available in an accessible venue. It is important to consider this when looking at waiting times for direct intervention.

*Figure 6: Experienced wait for referrals to the WMM Infant Mental Health Service.*




In relation to identifying infants at risk, the team have also developed their plans for using the GIRFEC National Practice Framework for assessing risk, including the strengths and concerns grid shown in Appendix I, and described in more detail in Section 1.2.1.

In relation to service delivery effectiveness, the evaluation asks, **"What evidence is used to confirm Wee Minds Matter is appropriate for responding to poor mental health?"** At this stage, evidence is drawn from the team's CPD and reflections on practice.

As part of monitoring the team's progress, achievements and identified barriers, a reflective practice session is undertaken on a 3-monthly basis. These began in December 2021. The templates completed during these sessions demonstrate the WMM team's views on their ability to respond to poor mental health. From understanding the varied practices needed to successfully respond to a family's needs: *"Think [we have] a good balance of seeing families, education and reflection".* To recognising the multi-disciplinary experience and knowledge offered by the team: *"Everyone brings something different to the team […] not experienced that before".*

Some achievements noted in the reflective templates indicate the range of relevant training undertaken:

*"People starting to use COS-P training (Circle of security parenting (COS –P))."*
*"Completed lots of relevant CPD (FASD, formulation, child protection, neurodevelopmental pathway)."*
*"All being trained in NBO and finding ways to apply it."*
*"Getting training – e.g. COSP, Health Visiting conference, Talking Mats training".*

Other comments represent the adherence of the team to the pathway, and to developing relationships with other teams and services to best respond to poor mental health:

*"Supporting development of coherent and communicable perinatal pathway with perinatal/MNPI/GIFT colleagues."*
*"Links with 3rd sector, e.g. Homestart and Art at the Start."*
*"Establishing a duty line".*

Future evaluation activity to address this question on effectiveness of service delivery, will include auditing adherence to the IMH pathway (with key criteria to be developed in collaboration with the WMM team*)* and identifying any evidence of how tools, treatments, or programmes are being used and having impact. Any evidence of short-term impact or evidence of progression of infants or children seen by the team will also be reviewed. This could include any change in developmental or infant/caregiver relational indices, as recorded via standardised measures such as the ASQ, PAI, PBQ, or Karitane.

In terms of "**How well is Wee Minds Matter perceived by families?"** the responses to the IMH Family ESQ indicate a high level of satisfaction. See Section 3.2.1 for further detail.

In future, additional evidence will be collected from records of Goal-Based Outcomes and/or EMIS Care Plans, and potentially a Parent-infant questionnaire on progress towards own identified goals. This would also be a useful Trainee inquiry around presence of the infant voice in case notes, or infant experience and impact.

### 3.1.4 Long-term child outcomes

As the WMM team is still a new service, it is not yet feasible to review long-term impact. However, a future sub-project or Trainee research project will investigate the "**impact of support (i.e. services and/or intervention) in response to poor infant mental health on long-term outcomes for children**".

## 3.2 Aim II: Primary care givers and their families are supported to meet the needs of their child/children, and to form and maintain a healthy relationship with their child/children

### 3.2.1 Understanding of IMH – healthy relationships

Consultation work has the clear potential to impact on professionals' understanding of IMH. Evidence is being collected by the WMM team to demonstrate **"What impact Wee Minds Matter has had on professionals' understanding, knowledge and skills regarding healthy relationships between infants and care givers?"** To support collation of evidence a 3-tiered approach is being introduced, and this will involve sharing the Professional's ESQ with QR code and web link - in the MS teams invite, and the MS teams chat, and included in any follow up letters. This will maximise opportunities for feedback about this strand of the WMM service delivery. This is in addition to the education and support activity described in Section 3.1.1.

From the Consultation Feedback log, one FNP noted that it had been helpful to reflect on goals for infants, and the consultation had "*Provided reflection on current progress and identified aims*".

Also from the feedback log, a HV provided detailed feedback that gives real insights into how Consultations can help professionals develop their understanding of infant and caregiver relationships in a range of contexts. This included "*... fleshing out aspects of the mother and child relationship, what is the mothering role, the positivity for [infant] in the care of 2 women who love and show affection for her*". The HV reflected on the emotions felt by the mum, the family's circumstances, and what was needed to support the infant caregiver relationship.

> *"Mum was reassured her friend provided best care for [infant] ... realised she needs to spend more quality time, be more emotionally available to her daughter. To do this mum has been to her MP's office for support for her visa application ... considering her right to benefits for family life."*

The HV felt that working with the WMM team had contributed to the infant's "*development, confidence, assertiveness and peer relationships [and helped the HV] to understand that [infant's] needs were in the main met ...* ***It changed the way I understood and responded to [infant's] needs***".

As well as considering the impact on professionals, the evaluation also asks, "**What impact has Wee Minds Matter had on women and families' understanding of what constitutes a healthy relationship with their infant?**"

The Karitane Parenting Confidence Scale is used to assess perceived parental self-efficacy in terms of caring for their infant. The tool is a screening measure to assess confidence ranging from non-clinical to severe clinical, which indicates a need for further intervention. The scale has been completed by eight parents/ carers; including one father, six mothers, and one caregiver where the child relationship is not reported. The scale was completed pre- and post-intervention on three occasions: two parents scored in the non-clinical range at the start and end of intervention; one parent scored moderate clinical at the start and increased confidence over the intervention to mild clinical. Of the remaining families, one scored non-clinical, one mild clinical, one moderate clinical and two severe clinical.

Completion of the scale pre- and post-intervention is low, mainly as interventions are ongoing or due to disengagement. Interpretation of these results must therefore be taken with caution. However, the WMM team's use of the Karitane Confidence Scale allows an insight into the parent/ carers understanding and confidence in their ability to engage in a healthy relationship with the infant. It will be useful for the WMM team to focus on improving completion and reflecting on the potential of this scale in future.

Evidence of impact on families can also be drawn from the IMH Experience of Service Questionnaire (ESQ). The digital ESQ was established in August 2022, and three respondents to the Family ESQ have been entered so far. All respondents stated 100% 'certainly true' for all clinical and service-related questions. Further, these qualitative responses from the ESQ demonstrate the impact the team has had on families' understanding of what constitutes a healthy relationship with their infant.

> *"We were offered really good support and learned more about our sons special needs."*
> *"It's given me back my confidence and therefore improved my relationship with [my baby]."*
> *"I think [my baby] would say they have a happier more relaxed mum."*

#### 3.2.2 Service Delivery – access

Some of the impact the WMM team have had on individual parents and caregivers has been described in previous sections. With early data provided on service reach and timeliness. Thus, to address the question "**What support has Wee Minds Matter provided to parents to encourage a healthy relationship between them and their child?**" this section will focus on the enablers and barriers to becoming aware of and gaining access to support amongst parents and caregivers (and enablers and barriers to providers seeking to reach these parents).

As this is a new service it has been necessary to develop:

- A professional network, to enable joint working and referrals to the team (described elsewhere).
- Awareness raising with families, by producing service information leaflets and posters, and this WMM team overview video.
- Staff, by providing high quality training and CPD opportunities and ensure they are well supported to provide a specialist service (described elsewhere).
- Processes for gathering feedback from service users in a formative way, to ensure quality improvement from the start (see Infant Voice and ESQ responses).

As noted, the SCS Professional Lead Child Psychotherapist was involved in the early setup of WMM, and continues to act as critical friend to the team. From his perspective, **enabling factors** for the above have been:

- Taking a broad and inclusive process to designing the service,
- Working closely with partners in health and social care,
- Committing to a multi-disciplinary team that could network into health and social care,
- Embracing the GIRFEC National Practice Model and using a common language for the work, as well as
- Using the governance, management and networks available across Specialist Children's Services.

Partnerships with other services are also enabling more families to get support in a way that suits their needs and circumstances. For example, Home Start work to provide direct care in the home, and reflective practice with them has enabled a wider reach for the service and enhanced existing support; while working with Art at the Start has enabled a service to be offered in a non-stigmatising venue, and using creativity.

**Barriers to providing support** have also been identified. While there has been great progress in raising awareness of the service, this will require continued attention due to the size of the health board and turnover of staff in the sector. WWM has a relatively small number of individual staff and can only provide a specialist service by working alongside the wider workforce. Awareness raising, working alongside others, and additional training for professional networks will continue to be required to optimise the chances of all children who would benefit from the service, actually accessing it. Finally, WMM could make use of video recording and playback with some families, via Video-Interactive Guidance (VIG) and other therapies. This has not yet been possible due to storage, governance and jurisdiction issues around the recording and storing of video.

### 3.2.3 Understanding of IMH – support available

It is crucial that professionals understand the support available, and the final evaluation question asks, "**What impact has Wee Minds Matter had on professionals' awareness of what support is available both nationally and locally?**"

Early evidence for this is drawn from the Professional ESQ, which was launched in August 2022. Two responses were submitted by end of December 2022, and they stated 100% 'certainly true' for all clinical and service-related questions. Demonstration of raising awareness of support available was indicated when a professional commented:

> *"Easy to contact and expert feedback in relation to my concerns and what support was available. Family referred onto a more appropriate service by IMHT [Wee Minds Matter] and I and the family kept up to date. Good we can see shared record on EMIS."*

One Health Visitor commented "*I feel more confident that there is specialist service and clear pathway for IMHS for families and that promotion and use of the service is becoming embedded in practice*".

In addition, the WMM team have undertaken continuous outreach activity in the form of service presentations to other services and professionals, and information sessions, which give an overview of what WMM offers and are open to up to 80 participants. These presentations have been delivered to localities across GGC and the wider network, and attended by health visitor, CAMHS, and nursing teams, and early learning leads and managers.

Over 250 people have been involved in these sessions, of these 123 completed a follow-up survey. The majority were based in Glasgow HSCP (n=63) although all GGC HSCPs were represented. The most common profession were

health visitors (59.5%) followed by nursing (19%). Overall, 99.2% respondents felt the session met their expectations. Around 76 professionals found the session to give an overview of the service and provide clear referral criteria and guidance. With comments including:

> *"Understanding more about the team's role and now knowing how to make contact with them directly. It was certainly very thought provoking and shows great opportunities for joint working in the future."*
> *"I have called since and found the team very approachable and helpful."*

Survey responses have suggested that the WMM team are providing a better understanding of who the team are, what service they provide. Aims to widen the reach of these sessions show consideration for how multiple services may work together to offer more efficient and effective services for families.

## 3.3 Aim III: To implement a well-functioning, high quality and sustainable IMH service that engages in service improvement to meet the needs of infants and families in NHSGGC

The WWM service was designed to create a cultural change in the field of infant mental health by working into the multi-agency networks supporting families. Over time the team would increase awareness and understanding of infant mental health, as well as providing interventions that meet the needs of infants, particularly those who are most disadvantaged, in families affected by trauma, addiction, and poor mental health. WMM is a trauma specialist service and therefore the team culture needs to create a strong sense of belonging in the team and confidence in observing, describing and working with trauma and maltreatment, some aspect of which may be active rather than historical. There also needs to be a service wide sensitivity to the emotional experience of the work to avoid compassion fatigue, burnout, secondary trauma and moral injury. Therefore supervision, team reflective practice, team development days, a research agenda, a commitment to a learning culture and relationship-based practice are core to the service. These qualities and ways of working can then be shared with the wider network over time.

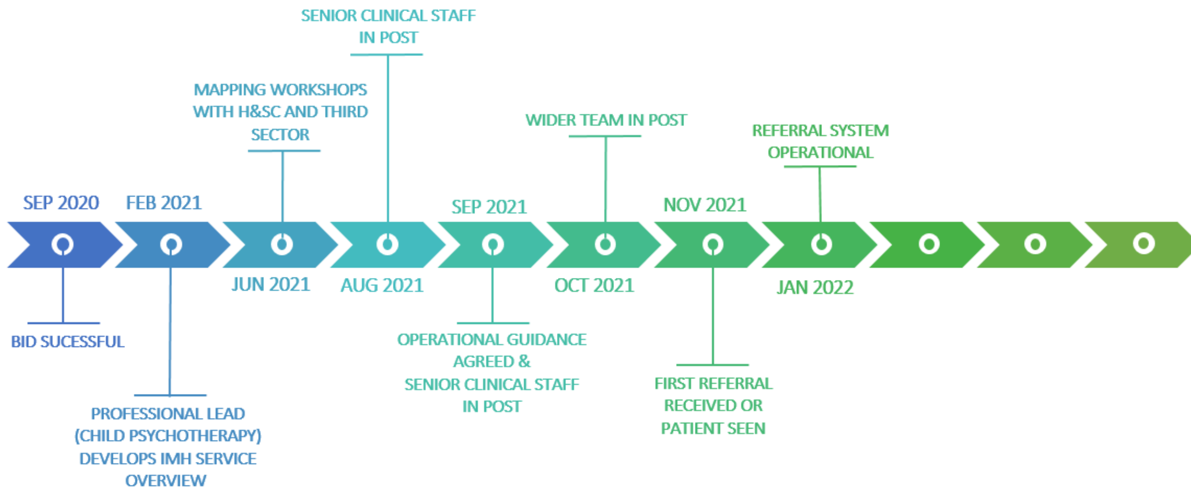
### 3.3.1 Sustainability of the IMH service

In the first year of practice, the team has undergone several changes in that staff have left and replacements recruited for the following posts: Social Worker, Consultant Child Psychotherapist (IMH Lead), and Systemic Family Therapist. The team's Consultant Psychologist started maternity leave in December 2022, with her post being backfilled for four sessions per week from March 2023. This has meant the team has had to function on less than a full complement, with only 3.2 WTE at times. While the team have had dedicated Project Management to support the setup and embedding of this new service, and ongoing Business Support, a reduced complement and turnover of staff is an obvious barrier to the service offering the full range of IMH support. Reasons for leaving posts have ranged from geographical distance from work, personal reasons, or feeling unsuited to the work in practice. The service has remained functioning throughout this period and the feedback from exit interviews has provided insights into the unique demands of the work and prompted reflection on the supports that are in place. It has also taken many months to create and protect sessions for the psychiatry post, which is now resolved. In January 2023, all clinical posts had been recruited and the team have 5.2 WTE (excluding trainees and business support).

### 3.3.2 Implementing a high quality IMH service

Wee Minds Matter has engaged in a range of activities to ensure the quality of the service and to identify enablers and address barriers to accessing infant services. This has included: co-creation and planning workshops with the third sector, MNPI and Perinatal Services, and a wider range of other services who are in contact with infants and families; evaluation planning workshops; contributions to research and the wider policy conversation on infant mental health; Learning From Excellence Awards; pro-active outreach clinical work; a comprehensive training programme for the new staff team and ongoing reflective practice and development sessions. (Additional details, aside from those already included within the main body of the report, are provided in Appendix V.) The overall timeline showing key points in the development of the service are shown in Figure 7.

*Figure 7: Timeline showing development of the WMM Infant Mental Health Service.*




# 4 Outputs from the Evaluation and WMM Team

## 4.1 Evaluation Outputs

A range of outputs have been produced by the Evaluation Team to support the evaluation process. These include:

- An initial Evaluation Plan containing key aims and evaluation questions, a review of the National data catalogue and other potential data sources or methods, mapped to those evaluation questions.
- A Schedule for data collection and analysis, mapped to key evaluation questions.
- A revised logic model, adapted from the national model and initial Wee Minds Matter Programme Theory.
- An overview of Validated Tools and Outcome measures to be used by the WMM team.
- Digital versions of the CHI Experience of Service Questionnaire, and Feedback questionnaires for professionals tailored to the work of the WMM team.

## 4.2 Dissemination

A poster ‘’How should we evaluate ‘Wee Minds Matter’? Through coproduction and applying the new MRC Complex Interventions Evaluation Framework’, was presented at the NHS Research Scotland Mental Health Network Annual Scientific Meeting 2022 (Harris et al, 2022). The poster focused on a ‘Programme theory workshop’. The workshop was developed by the evaluation team to gain an insight into the underpinning theory of the service, how it will work, for whom, and in what context. Results were discussed within the context of the MRC framework for evaluating complex interventions (Skivington, 2021).

Further poster abstracts, and oral presentations have been accepted for the World Association of Infant Mental Health (WAIMH) Congress 2023. Presentations and posters include:

- Birth story: reflections on the creation of an infant mental health service (Lauren Delahunty; Jen McLauchlan & Bea Anderson).
- Occupational Therapy within Infant Mental Health Services in Scotland (Kirsty Fowler in collaboration with Rhona McAlpine, Occupational Therapist, Lothian).
- Holding the baby in mind throughout family support provided by a voluntary sector network (Alex Corgier & Hannah Guzinska, Home-start UK; and Kasia Zych).
- What has been investigated and understood about the impact of the maternal experience of perinatal loss on the developing relationship between the mother and the subsequent child? (Kyoko Kobatake).
- Care-experienced and expecting? Exploring lived experience of pregnancy and supportive interventions across the perinatal period (Esther Congreave).
- Evaluating the implementation and impact of Wee Minds Matter - NHSGGC Infant Mental Health Service (Andrew Dawson, Rachel Harris, Bea Anderson, Alice McFarlane).

- How we co-produced a programme theory to support the development of Wee Minds Matter (Rachel Harris, Bea Anderson, Andrew Dawson, Alice McFarlane).

# 5 Conclusions and Next steps

## 5.1 Achievements in relation to the evaluation aims

***Aim I: Infants at risk of mental health problems are identified early and support offered to them in the context of their primary caregiving relationships***

- Professional awareness raising

The team were able to support professional awareness of IMH risk during duty calls through offering clarity on who WMM are, the service they offer, and the factors impacting risk and resilience to infant mental health. Duty calls have thus been an effective means of supporting professionals to interpret their cases in relation to infant mental wellbeing and proceed with this in mind.

The team have also contributed to the national Infant Voice Short Life Working Group, which has developed Best Practice Guidelines for Supporting Infant Voice, an 'Infant Pledge' and an Infant Rights Statement. UK-wide and International awareness raising is underway in the form of presentations at conferences.

- Equality of access

Given the stage of this new service, with just a year of referrals to review, it is difficult to fully comment on this. The team have noticed that referrals increase following awareness raising events. While the service has been well advertised and promoted in the first year, the size and scale of the health board, and the multiple potential referrers, suggest it may be some time before all relevant referrers are fully aware of what the team can offer. A rolling programme of awareness raising and promoting the pathway is thus recommended.

A focus on addressing health inequality and outreach is one of the service's main workstreams. The team have thus taken a strategic stance to support other workers in the sector, and in that way make a contribution to the care of infants who may not otherwise have access to the service. This includes reflective practice with Specialist Health Visitors supporting asylum seeking families, the feedback from which indicates this has been a valued intervention. Another example is the reflective practice offered to Home Start workers, which again increases the reach of the service to support the work with multiply disadvantaged families. Activity in these areas is mainly on interventions with staff, therefore the demographics and number of families helped is not recorded.

The service also worked in partnership with MNPI and multiple Social Work groups supporting families through pregnancy. The team have invested in NBO training and are exploring how to make best use of this by identifying families in need of support at the earliest stage. While this is certainly the right direction of travel for early identification and intervention, the numbers remain small and it is still unclear if this can be scaled-up to make an impact proportionate to the needs of families across GGC.

- Longer term outcomes

It is too early in the evaluation process to comment on this.

***Aim II: Primary care givers and their families are supported to meet the needs of their child/children, and to form and maintain a healthy relationship with their child/children***

The team have provided a staged contribution to families, by supporting the network around them, providing access to groups, and working with individual families. Again, we are looking at a small number of cases at this stage, and primarily using feedback from families to guide the evaluation. From the feedback it is clear that getting a better understanding of the infant and the parent-child relationship has been the focus of the work. This has been found to be valuable and produced meaningful changes for the families involved.

***Aim III: To implement a well-functioning, high quality and sustainable IMH service that engages in ongoing service improvement to meet the needs of infants and families in NHS GGC.***

The service was developed and set up at a time when Covid restrictions were in place. Nonetheless, the service is now staffed to the full clinical complement of 5.2 WTE (excluding trainees and business support), even though there have been times when staffing has been low.

The service made a major investment in the initial induction and training package to ensure that existing competencies were enhanced and WMM was truly a specialist MDT. This included whole team training in NBO, Warwick IMH, and Circle of Security Parenting (COS-P) training. In addition, there were team workshops and regular development days.

There is clear evidence that this was a very successful launch of a new service that is relevant, needed and, provides a resource that was not previously available. There is also clear evidence that WMM is using reflective practice, team planning, and quality improvement techniques to set up and continue to develop this new service. This should mean providing a strategic response to their brief, and that referral and reporting processes are in place and functioning well.

One concern is that in time, when new staff are appointed, it will not be possible to deliver these whole team trainings or to provide new staff with the same CPD in such an intense manner. Future induction processes should therefore be developed and a proportionate budget for training new staff as well as maintaining CPD for existing staff may need to be planned for.

The learning culture in the team is clear, and this has been shared across the network in GGC and at national fora relating to IMH. The breadth of work that has been accepted as part of the WAIM conference is evidence of this. As the team members develop their expertise over time, it is important that their practice is shared through case studies, academic work and teaching. The WMM research and evaluation work should therefore liaise closely with the NHS GGC SCS CAMHS Research and Evaluation Planning Group, to ensure that this work can be supported and has strategic relevance.

## 5.2 Key points of learning

WMM was designed with an ambitious long term strategy to use relationships and partnerships to change the culture around infant mental health. Essentially to hold co-production at the core. Further, WMM would support all services to identify and address IMH, and to work with the most vulnerable infants. This would be achieved via four workstreams:

- outreach to address inequalities and access,
- pre-birth help and anticipatory care planning,
- consultative support to the system, and
- direct therapeutic interventions as part of a GIRFEC care plan.

The WMM team have made impressive strides forward in each of these challenging areas. The key to the successes we have described has been the quality of the relationships that have been established with the voluntary sector, within health, with services supporting families through pregnancy, and with referrers. The findings provide clear evidence of impact on the professional network, at the same time as highlighting the scale of the network. The findings also highlight the need to continue to raise the profile of WMM, while also working to increase understanding around infant mental health and healthy parent-child relationships.

There are several examples of how the WMM team were able to build relationships and create some new infrastructure:

- Circle of Security Parenting has been delivered in partnership with early years providers who have been able to identify appropriate families and to support them as they attend groups WMM clinicians were running;
- Support and reflective practice to home start has helped WMM to reach a wider range of infants and families who need intensive support;

- Consultation and reflective practice for health visitors supporting excluded vulnerable groups has shown that the WMM's trauma specialist support has been a profound support to staff at times of crisis.

In these ways, and others, the partnership working has been a real success in increasing the impact of the service, creating capacity beyond the numbers of staff in the service, raising awareness and confidence in partners and reaching groups that may otherwise not have been aware of or made use of the service.

## 5.3 Recommendations

For the WMM team

1. Continue to provide a rolling programme of awareness raising to parents, caregivers, and families.
2. Continue to promote the pathway to professionals in health, social care, early years and the voluntary sector.
3. Continue to work in partnership with the third sector.
4. Consider 'best' cohorts to target. This will require careful data collection around Inequalities/demographic data. This will likely be influenced by policy drivers, whereby there may be an emphasis on considering the needs of those affected by poverty, alcohol and substance misuse, homelessness, and poor parental mental health.
5. Ensure the process for collecting Outcome Measures is embedded and used.
6. To review the strategy for use of, and requirements for, Brazelton Newborn Behavioural Observations (NBO) as part of the IMH pathway in NHSGGC.
7. To continue to review emerging research and learning to support adaptation of service delivery models and methods.
8. Future induction processes should make use of SCS and Board wide induction programmes, while the team should support the development of team specific induction, and plan for maintaining CPD for existing staff.
9. WMM could make use of video recording and playback with some families (e.g. VIG), however, it is proving difficult to resolve storage, governance and jurisdiction issues. (This is not unique to WMM.) The WMM team should investigate whether other teams have resolved this (SLT and Prof Lead for Systemic Psychotherapy are also working with video). Should barriers remain, Senior Management Team to be approached to support resolution.

For Service Managers (and the WMM team)

10. The team have identified difficulty in accessing consistent space for clinical work in community settings and in NHS venues across NHSGGC. For some of the team's work with partners, it has brought added benefits where crèche facilities were available. The team (with Service Manager support) need to look at how other services facilitate work with families, as the NHS does not supply crèche facilities due to procurement limitations and child protection considerations. It could also be useful to explore with partner agencies venues and funding streams to support crèche options.
11. Encourage the team to share their practice through case studies, academic work and teaching.

For SCS Senior Management Team

12. Senior Management Team to be alert to issues regarding video and access to clinical space, and support where required.
13. The WMM research and evaluation work should continue to liaise closely with the NHSGGC SCS CAMHS Research and Evaluation Planning Group and SCS Quality Improvement Team, to ensure that this work can be supported and has strategic relevance.
14. Continue to resource the research and evaluation work, including research assistant time, as part of the agreed setup period to 2024.
15. Options appraisal is underway for a Centre for Excellence for Infant Mental Health, which likely will be located in Glasgow. SCS Senior Management Team to support the involvement of NHSGGC staff in the options appraisal process.

For National Agencies

16. Recognising that this is a new service in a developing field, ensure national networking continues to support comparison of services and exchange of good practice. National networking could be via the NSS PMHN Infant Mental Health Forum and the Parent Infant Foundation Forum.
17. Continue to develop the relationship with NES, in regard to training for IMH teams, and for training across the sector.

## 5.4 Next steps for the evaluation

Following the production of this report, which has addressed the range of evaluation aims and questions, the evaluation team will review the evaluation plan and identify key themes or 'deep dives' for the next 12 months. Areas that are likely to be covered include:

- Enhancing the evidence gathered from parents, caregivers and families, with consideration of how well the IMH service performs in relation to Arnstein's ladder of engagement. (It may also be useful to consider the recently published Quality Framework for Community Engagement & Participation.) This could also include evidence from families in the form of against goals and as identified in EMIS Care Plans.
- Investigating the impact of the team in relation to 'Infant Voice'.
- Taking an appreciative inquiry approach to the specific contribution of the different professions within the MDT.
- Auditing adherence to the IMH pathway and identifying any evidence of how tools, treatments, or programmes are being used and having impact, e.g. a concentrated investigation around CoS-P.
- Review the use and efficacy of the WMM's approach to risk assessment.

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# Appendix I – Tools for assessing risk aligned to GIRFEC National Practice Model

*Figure 8: Resilience – Vulnerability Matrix from the GIRFEC National Practice model.*

**The Resilience - Vulnerability Matrix** – Based on Daniel and Wassell, (2002).

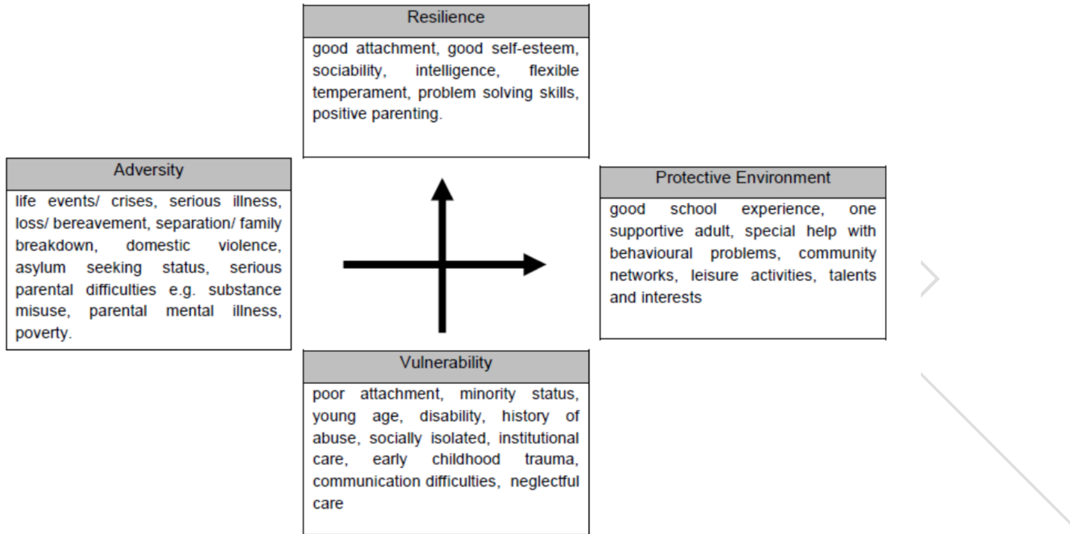
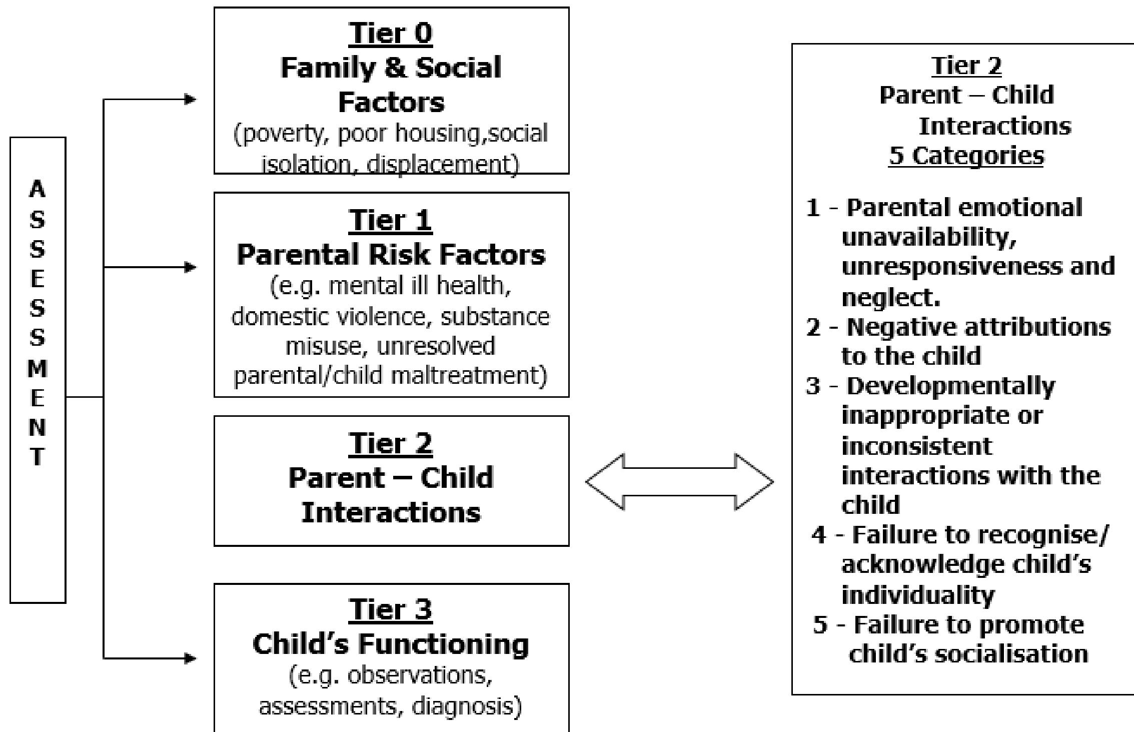



*Figure 9: GIRFEC - strengths and concerns risk quadrants.*

| **Low strength/ high concern**<br><br>Parents are likely to be at the pre-contemplative stage and unlikely to move from this position. Families assessed to be in this category are the most worrying. Parents may display avoidant behavior or disguised compliance. The children are likely to need to be looked after, probably long term. The length of time in care will be dependent on the parent's ability to change, however their own upbringing may have left them too damaged to change. The risk is significant. | **High concern/ high strength**<br><br>Parents may be more willing to change at this level. There will be parents at different stages of change. There could be worries about children living in these families and alternative placement may be an option however this depends on the parent's ability to change. There is more scope for working with families in this group and less need to separate. Whilst the risk in itself is significant the strengths inherent to the family reduce the risk. |
|---|---|
| **Low concern/ low strengths**<br><br>Families in this group are highly unlikely to need care. These are the referrals that are likely to be referred on a number of occasions before they are willing to change. Community resources are the best outcome. This group of children/young people should not come in to care as generally there are no issues to put the child at risk at home. The risk is significant. | **Low concern/ high strengths**<br><br>Network of support and supervision is available to child/young person. Families in this group are generally of little worry and would probably benefit from standard support systems, school, GP etc. Generally these families should not be referred to social services as their needs are similar to the standard population. They may need advice and guidance from standard services. |

*Figure 10: Assessing (Unintentional) Harmful Parent-Child Interactions.*

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## Appendix II – Review of National data catalogue & other potential data sources or methods, mapped to evaluation questions

| Evaluation question | Potential Data Sources listed by PHS | Potential SCS Tool/Method/Data source |
|---|---|---|
| 1. What impact has Wee Minds Matter had on professionals' understanding of the risks to infant mental health? | None | Professionals Training Needs Assessment, [IMH Mapping Workshops]<br>Professionals Understanding of IMH Risk Survey<br>Inclusion of infant's voice in careplans<br>Inclusion of questions about parent infant relationship during appointments recorded within notes |
| 2. What impact has Wee Minds Matter had on women and families' understanding of risk and resilience factors relevant to infant metal health? | None | Understanding of IMH Families Survey / Data collected as part of national cultural awareness programme<br>Data gathered during clinical work |
| 3. What impact does social circumstance have on equality of access and timeliness of access for infants at risk of poor mental health? | None | GGC Needs Assessment (pre and post)<br><br>SIMD analysed for all Service Delivery data |
| 4. What proportion of infants at risk of poor mental health are **referred** for support?<br>a. What proportions across the levels of service provision?<br>b. And, how timely is this? | • HV notes<br>• FNP data<br>• Paediatric Clinical notes<br>• CHSP 'Future Actions'<br>• Number of children on the 'at risk' register (HSC data?)(ISD/PHS, Health boards) | GGC/NSPCC Needs Assessment<br>• Health Plan Indicator (HPI) status/risk category: unknown (newly registered babies), core (no need identified), low or high need by another service/agency (EMIS, Universal Pathway Template).<br>• CAMHS < 3yrs referrals?<br>• Prevalence estimate from literature?<br>a. Administrative data from IMH pathway on EMIS<br>b. Timely – age of infant/child |
| 5. What proportion of infants at risk of poor mental health are **offered** and **receive** appropriate support?<br>a. And, how timely is this? | None | Proportions using same data as above<br>a. Administrative data from IMH pathway on EMIS<br>b. Timely – age of infant/child; and time from referral to receipt |
| 6. What evidence is used to confirm Wee Minds Matter is appropriate for responding to poor mental health? [How well is Wee Minds Matter used to respond to poor mental health?]<br>a. Evidence collected by clinicians<br>b. Short-term impact on child – evidence of progression. | None | a. Assessment proforma/ validated measures<br>b. Goal Based Outcomes |

| Evaluation question | Potential Data Sources listed by PHS | Potential SCS Tool/Method/Data source |
|---|---|---|
| **7.** How well is Wee Minds Matter perceived by families? | None | Linked to external network pathway – is sufficient information provided universally<br>Reference Focus Groups / Lived Experience Steering Group<br>Experience of Service (ESQ) Questionnaires / Session Rating Scales / Interviews |
| **8. What is the impact of support (i.e. services and/or intervention) in response to poor infant mental health on the long term outcomes for the child?** | HV notes<br>FNP data | Follow-up studies – themed around social capital/social thinning; others TBD<br>Health economics study?<br>GGC Needs Assessment (pre and post) |
| 9. What impact has Wee Minds Matter had on professionals' understanding, knowledge and skills regarding healthy relationships between infants and caregivers?<br>a. Including assessment | None | Professionals Training Needs Assessment, IMH Mapping Workshops, Professionals Understanding Survey<br>Data gathered at Consultation<br>Data gathered at pre referral<br>Data gathered during any training |
| 10. What impact has Wee Minds Matter had on women and families' understanding of what constitutes a healthy relationship with their infant? | None | Understanding of IMH Families Survey / Data collected as part of national cultural awareness programme |
| 11. What support has Wee Minds Matter provided to parents to encourage a healthy relationship between them and their child?<br>a. And, how timely is this?<br>b. What reach does this have across the population?<br>**c.** What are the enablers and barriers to awareness of /access to support? | None | Administrative data from IMH pathway on EMIS?<br><br>Care Plan tab?<br><br>a. Timely – age of infant/child<br><br>b. Relative to population of infants<br><br>c. Understanding of IMH Families Survey / Data collected as part of national cultural awareness programme |
| 12. What impact has Wee Minds Matter had on professional awareness of what support is available both nationally and locally? | None | Professionals Training Needs Assessment, IMH Mapping Workshops, Professionals Understanding Survey |

## Appendix III – Schedule for data collection and analysis, mapped to key evaluation questions

| Evaluation questions | Tool or Method or Data source | Administered by | Completed by | Time Frame | Data collation & analysis |
|---|---|---|---|---|---|
| **Aim I. Infants at risk of mental health problems are identified early and support is offered to them in the context of their primary caregiving relationships.** | | | | | |
| 1) What impact has Wee Minds Matter had on professionals' understanding of risk and resilience factors relevant to infant mental health? | | | | | |
| a) **Document service activity to raise professional awareness of support and services available to support IMH.** | Record of Outreach activity. Record of duty calls and actions. | IMH team | IMH team | Ongoing | RA/QIT collate quarterly. Review & analysis by Evaluation project team. |
| b) **Measure impact of service activity to support professionals' understanding of IMH risk and resilience.** | Record of Education/Esteem activity.<br>Pre/post confidence forms. Process feedback from professionals. IMH Professional ESQ.<br><br>Hold for later (trainee?): survey of IMH understanding at different time points? | IMH team<br><br>Anon. form? | IMH team<br><br>Professionals | Pre/post activity | RA collates 6-monthly. Review & analysis by Evaluation project team. |
| 2) What impact has Wee Minds Matter had on women and families' understanding of risk and resilience factors relevant to infant metal health? | | | | | |
| c) **Document service activity with families and professionals to support understanding of IMH risk and resilience.** | Record of Education/Esteem activity. EMIS record of Direct Intervention activity. | IMH team | IMH team | Ongoing | RA/QIT collate quarterly. Review & analysis by Evaluation project team. |
| d) **Measure impact of service activity to support families' understanding of IMH risk and resilience.** | Record of Education/Esteem activity. Pre/post confidence forms. Process feedback from families. IMH Family ESQ. | IMH team Possible option of anonymous feedback? | Families | Pre/post activity | RA collates 6-monthly. Review & analysis by Evaluation project team. |
| 3) What impact does social circumstance have on equality of access and timeliness of access for infants at risk of poor mental health?<br>4) What proportion of infants at risk of poor mental health are referred for support?<br>i) What proportions across the levels of service provision?<br>ii) And, how timely is this? | | | | | |

| Evaluation questions | Tool or Method or Data source | Administered by | Completed by | Time Frame | Data collation & analysis |
|---|---|---|---|---|---|
| e) **Document referrals to IMH service.** | EMIS | IMH team | IMH team | Entry to service | QIT provide bimonthly reports |
| f) **Describe characteristics of infants/families referred to service, including gestational age/age at which referred. Demographic data (including post code) will support equity of access analysis.** | EMIS, including info on referral template/patient summary. Standardised measures: ASQ, EPDS, PBQ, PAI, Karitane. | IMH team | IMH team | Entry to service | RA/QIT collate quarterly. Review & analysis by Evaluation project team. |
| 5) What proportion of infants at risk of poor mental health are offered and receive appropriate support?<br>i) And, how timely is this? | | | | | |
| g) **Describe timescales of service responses to referrals and offers of support.** | EMIS (need to confirm which time points) | IMH team | IMH team | Ongoing | QIT provide bimonthly reports |
| **Use f) to describe recipients of support.** | | | | | |
| 6) What evidence is used to confirm Wee Minds Matter is appropriate for responding to poor mental health? [How well is Wee Minds Matter used to respond to poor mental health?]<br>i) Evidence collected by clinicians – evidence of appropriate use of tools/adherence to pathway component delivered by NHSGGC IMH Team.<br>ii) Short-term impact on child – evidence of progression. | | | | | |
| h) **Evidence of: training in EBP practices; individual cases have formulation, and review, and evidence of progression.** | IMH Team CPD records.<br>Audit of adherence to agreed standards/targets on pathway.<br>Development day reflective template. | IMH team | IMH team | Ongoing<br>Annual<br><br>Quarterly(?) | |
| i) **Measure outcomes for infants - any change in developmental and infant/caregiver relational indices.** | Standardised measures: ASQ, PAI, PBQ, Karitane | IMH team | Infants and families receiving direct intervention from IMH team | Pre/post activity | RA collates 6-monthly. Review & analysis by Evaluation project team. |

| Evaluation questions | Tool or Method or Data source | Administered by | Completed by | Time Frame | Data collation & analysis |
|---|---|---|---|---|---|
| 7) How well is Wee Minds Matter perceived by families? | | | | | |
| j) **Measure families' experience of service.** | IMH Family ESQ, including inquiry around infant experience and impact. Parent-infant questionnaire on progress towards own identified goals (pre/during/post intervention). | IMH team provide link/ slip with discharge letter | Families | Post activity | RA collates 6-monthly. Review & analysis by Evaluation project team. |
| 8) What is the impact of support (i.e. services and/or intervention) in response to poor infant mental health on the long-term outcomes for the child? | | | | | |
| k) **Hold for later sub-project/study.** | | | | | |
| Aim II. Primary caregivers and families are supported to meet the needs of their infant/s, and to form and maintain a healthy relationship with their infant/s. | | | | | |
| 9) What impact has Wee Minds Matter had on professionals' understanding, knowledge and skills regarding healthy relationships between infants and care givers?<br>i) Including assessment<br>10) What impact has Wee Minds Matter had on women and families' understanding of what constitutes a healthy relationship with their infant? | | | | | |
| a) **Document service activity with families and professionals to support understanding of infant needs and healthy relationships.** | Record of Education/Esteem activity. EMIS record of Direct Intervention activity. | IMH team | IMH team | Ongoing | RA collates 6-monthly. Review & analysis by Evaluation project team. |
| b) **Measure impact of service activity to support understanding of infant needs and healthy relationships.** | Pre/post confidence forms. Process feedback from families and professionals. IMH Family ESQ. IMH Professional ESQ. | IMH team | Families, professionals | Pre/post activity | RA collates 6-monthly. Review & analysis by Evaluation project team. |
| 11) What support has Wee Minds Matter provided to parents to encourage a healthy relationship between them and their child?<br>i) And, how timely is this? [covered by Aim I data]<br>ii) What reach does this have across the population? [covered by Aim I data]<br>iii) What are the enablers and barriers to awareness of /access to support? | | | | | |
| c) **Add questions regarding enablers & barriers to: Professionals feedback forms 1) b) & IMH ESQ 10) c)].** | Process feedback from families and professionals. IMH Family and Professional ESQs. | IMH team Anon forms | Professionals Families | Post activity | RA collates 6-monthly. Review & analysis by Evaluation project team. |
| | | | | | |

| Evaluation questions | Tool or Method or Data source | Administered by | Completed by | Time Frame | Data collation & analysis |
|---|---|---|---|---|---|
| 12) What impact has Wee Minds Matter had on professionals' awareness of what support is available both nationally and locally? | | | | | |
| d) Capture professionals' experiences and perceptions of working with the IMH team. | IMH Professionals ESQ. Process feedback from professionals. | IMH team Anon form | Professionals | Ongoing | RA collates 6-monthly. Review & analysis by Evaluation project team. |
| **Aim III**. To implement a well-functioning, high quality and sustainable IMH service that engages in ongoing service improvement to meet the needs of infants and families in NHSGGC. | | | | | |
| a) **Consider/identify potential enablers and barriers to accessing IMH supports, and timeliness of access. Capture areas of success/excellence and areas of challenge in service development and delivery.** | EMIS. Record of Outreach activity. Record of participation activity and feedback. IMH Family and Professional ESQs. Development day reflective template (quarterly). Record of excellence in practice. | IMH team | IMH team, families, relevant professionals | Ongoing | RA collates 6-monthly. Review & analysis by Evaluation project team. |
| a) Evidence service response to identified enablers/barriers. | Development day reflective template (quarterly). Record and action log from 6-monthly meeting of IMH leadership group. | IMH team | IMH team; IMH leadership group. | Ongoing | RA collates 6-monthly. Review & analysis by Evaluation project team. |

## Appendix IV – Validated Tools and Outcome measures

A range of measure have been identified for use within clinical practice, and to inform the evaluation. There is no 'ideal' outcome measure, especially for this new service, and the limitations of specific measures need to be acknowledged (e.g. whether tools are validated for babies, infants, or older children). Hence the development of which measures to use, and when, is being decided as part of the formative evaluation process. The range of tools under consideration are:

- Ages & Stages Questionnaire (ASQ)
- Generalised Anxiety Disorder Assessment (GAD-7)
- Patient Healthcare Questionnaire for Depression (PHQ-9)
- Postpartum Bonding Questionnaire (PBQ)
- Prenatal Attachment Inventory (PAI)
- Karitane Parenting Confidence Scale (KPCS)
- Health of the Nation Outcome Scales for Infants (HoNOSI)
- Family Experience of Service Questionnaire (Family ESQ)
- Professional Experience of Service Questionnaire (Professional ESQ)

The team are also, planning to use the Parental Questionnaire (a goal setting tool) or an equivalent.

The timing of follow-up, i.e. repeat of measures, is to be determined. An overview, with timepoints, similar to the table below will be developed.

| Time point | Measures & (time required to complete) | Link to measures |
|---|---|---|
| | | |
| **Assessment (0-5 sessions)** | PAI (prenatal)<br>PBQ<br>Karitane | |
| **Follow-up (3 months into treatment dependent on extent of involvement)** | GADS & PHQ<br>Development questionnaire (ASQ or other TBC) | |
| **Final appt** | • Family ESQ (5-10 mins)<br>• Professional ESQ (5-10 mins) | |

## Appendix V – Activities undertaken to develop and support delivery of a quality Infant Mental Health service

- Co-creation workshops were led by Andrew Dawson, Professional Lead For Child Psychotherapy, who has supported the leadership of the team since the start. He conducted a series of co-creation and planning workshops with the third sector, MNPI and Perinatal Services, Services Supporting Families Through Pregnancy, HSCP multi-agency networks including service user representative groups, Family Nurse Partnership, Specialist Health Visitors, other existing services in health, social work and education and Scotland's Commissioner for Children. The feedback from these events was used to inform the service structure, values, and logic model. 'Outreach and inclusion' was included as a core workstream for service development as a result of these workshops. Stakeholders clearly wanted a service that would work alongside them, develop the whole sector rather than developing a silo for experts, and would get involved as early as possible in supporting infants and families. Importantly, partners wanted services that would take a relational and developmental approach rather

than a diagnostic one with the understanding that infant distress can lead to disturbance and then diagnosis and that early identification and intervention can prevent devastating mental health problems for children and families.

- The evaluation team provided workshops during the whole team induction, and once the team was functioning to include their views and expertise in the evaluation process, and as part of the programme theory development (Rachel Harris & Andrew Dawson in Sept 2021 and then Rachel & Alice Macfarlane in 2022)
- Contribution to research:
  - Andrew contributed to research focusing on service barriers and enablers, led by Prof Minnis and Dr MacFadyen, see Weaver et al (2022). The learning from this work was also used to shape the service.
  - The evaluation team presented a poster and shared the evaluation plan with the IMH and wider MH research network.
  - A number of abstracts accepted for the World Association for Infant Mental Health Congress in 2023.
- The team have received two Learning From Excellence Awards from Specialist Children's Services for:
  - Multi-disciplinary work and success in launching service.
  - Kasia Zych for working in partnership with third sector, specifically Home Start.
- Pro-active clinical outreach work has involved:
  - Partnership with Art at the start, engaging families in cultural venues and joining a national research consortium to share learning across Scotland.
  - Connecting with 'With Kids' to develop a referral pathway for discharged infant and families that no longer require specialist intervention, but who would benefit from further support.
  - Discussions with Dad's Matter about potential referrals or redirecting referrals where appropriate
  - Home-Start, reflective practice for voluntary organisation providing family supports.
  - (Following meeting with Children's Commissioner), providing reflective practice for HVs working with asylum seeking families. Feedback to this has been positive:

"*… Art at the start sounds like a great resource to be able to give to our families, they appreciate all we give them, art supplies are definitely something the children won't have access to. Thanks for also taking the time to support the families, [HV] and myself.*" (Health Visitor, Rowan Business Park)

"*... We both appreciate you [Kasia] and Jen taking the time to listen to our concerns. I wish nothing more for these families than getting the supports that they need. We will continue to make a positive impact to promote, support and safeguard the children and their families, they need a voice, they need us to say this is not ok and to make sure that we keep on supporting their needs. There is no doubt the hotel has a detrimental effect on their overall health and wellbeing needs. For us it's just been nice for someone to listen and to be involved in the assessment of care. It is a difficult and challenging process, however I can only imagine what that feels for the families, they deserve access to health, consistency and continuity of care. Its so difficult for them to build any trusting professional relationships particularly when they are feeling vulnerable. The children's needs are even greater with no room to play, interact, no one to engage with. … We want to strive to provide an excellent universal however do not feel that we are able to. I know the families need more and that make me feel terrible. Granted we have made some real positive changes, but we need to keep chipping away! Art at the Start sounds fantastic, the families will love this.*" (Health Visitor)

- A comprehensive training programme for staff, as part of the induction and set-up of a specialist service. Specific supported training included: Circle of Security Parenting; Brazelton N-BO; Warwick IMH course.
- Programme of reflective practice and learning from patient feedback and clinician experience (weekly group for whole team).
- Team development days and workshops, covering specialist topics, such as how to identify and work with unintentional emotional harm and GIRFEC based risk assessment; and protective planning and reviewing of initial service design feedback to anticipate service problems while remaining within service values, and underlying strategy.
- Attendance and Participation Presentations to the following fora:
  - Scottish Government IMH forum, chaired by Dr Anne McFadyen.
  - Parent-Infant Foundation Service Development Forum
  - Scottish Government IMH Programme Board Evaluation Sub-Group, chaired by Prof Helen Minnis.