Service Evaluation Exploring the Successes and Barriers to Engaging Families in Parent-Infant Relationship Work with Little Minds Matter

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1. Introduction

Little Minds Matter (LMM) is a multi-disciplinary specialist Infant Mental Health Service, which sits within the Child and Adolescent Mental Health Service (CAMHS) provision in Bradford District Care NHS Foundation Trust. It aims to provide high quality support for the local community, which faces high levels of deprivation and health inequality. Little Minds Matter aims to support families and professionals with early intervention and prevention where possible through different service strands: direct clinical work, consultation, training, and community engagement. This service evaluation project (SEP) aims to evaluate the direct clinical strand of the service which offers therapeutic work to families with babies from conception up to age two who have shown difficulties in the parent-infant relationship.

1.1 Background

1.1.1. The Importance of the Parent-Infant Relationship

The first two years of infant life are crucial for healthy cognitive, emotional, and physical development, this has been supported by the 1001 Critical Days cross-party manifesto (Leadsom et al., 2013). This report recognised that what happens to infants from conception up to age two has a huge impact upon the infant's later life, thus prioritising infant welfare which has historically been overlooked. This view of infant welfare does not advocate for perfect care, in fact the idea of 'good enough' caregiving is a key message for infant mental health services. As Winnicott (1960) theorised, an infant will thrive if they have experienced 'good enough' care, which can be achieved through the carer holding the infant's dependence and being well enough attuned and responsive to their needs. In doing so the infant will develop a positive internal working model of themselves, other people, and the world around them, acknowledging that some failings are ok to manage, as long as they feel safe and secure in their attachment to their caregiver/s (Ainsworth et al., 2015; Bowlby, 1969).

However, consistent responsive care and attunement is not always possible due to factors including poor parental mental health, and extreme poverty (Department for Health and Social Care [DHSC], 2021; Edhborg et al., 2011). Consistent unresolved difficulties in the parent-infant dyad during this early stage will have a profound impact upon the infant and an insecure or disorganised attachment may develop (Ainsworth &

Bell, 1970; Main & Solomon, 1990). Insecure attachment has been shown to be predictive of difficulties with social competence, difficulties with mentalisation, and neurological developmental differences (Fonagy et al., 2002; Golding, 2008; Groh et al., 2016; Moutsiana et al., 2014). Disorganised attachment reflects a fearful and inconsistent attachment and has been shown to increase risk of externalising problems and stress management difficulties (Fearon et al., 2010; Luijk et al., 2010). In their review of the literature, Hunter at al. (2020) reported that neurological development is dependent upon environmental influence, and so how caregivers respond to their infant impacts their future brain architecture. This is in line with Gerhardt's (2015) acknowledgement that hormonal expectations are set in these early years, therefore if the primary caregiver experiences prolonged stress this can set the precedence for how the infant uses their stress response system and can impact upon emotional regulation.

Positively, one meta-analytic study showed efficacy of preventative attachment-based interventions upon attachment security across multiple studies (Bakermans-Kranenburg et al., 2003). It has furthermore been recommended by a parliamentary report that services working with infants are grounded upon preventative principles with a focus on supporting secure attachment relationships (Building Great Britons, 2015). Although research findings thus far are positive, the evidence base for preventative interventions requires further development (Asmussen et al., 2016). It is therefore important to evaluate parent-infant interventions at the service level to add practice-based evidence to the literature. This is imperative for services in deprived areas such as LMM, to ensure interventions are meaningful for the population they are serving, as research participants are often not representative of underserved populations (Ellard-Gray et al., 2015), and deprived populations have additional risk factors that may impact upon the parent-infant relationship and should be considered when conducting research (this topic is expanded upon in the later sections 'LMM Service Context' and 'Engaging the Disengaged').

1.1.2. Current Provision

Despite how integral early life is for subsequent healthy development, there is insufficient service provision for this age group. The Parent-Infant Foundation investigated current provision across the UK and found that although CAMHS are funded to provide mental health support for ages 0-18, 42% of CAMHS services reported they

do not accept referrals for children aged two and under. Only 27 services were found to provide support for this age group across the UK, thus showing a nationwide 'baby blindspot' (Parent-Infant Foundation, 2021). Positively, the NHS Long Term Plan (2019) has committed to developing services to support 0–25-year-olds, and an updated statistic shown on the Parent-Infant Foundation website now shows 39 current parent-infant teams across the UK (Hogg, 2019). Additionally, there is a new health and social care strategy 'The Best Start for Life' which has committed to improve services for families to ensure every baby has the best start to life (DHSC, 2021). Although it is positive that there is a new spotlight being shone on infant welfare, these strategies are to be implemented within a political climate that is still in a state of austerity and recovering from the Covid-19 pandemic which is costly. Thus, as one of the few infant mental health services in the UK, it is important that LMM evaluates their provision to expand the evidence base with the hope to increase funding of services.

1.1.3. Little Minds Matter Service Context

Little Minds Matter serves an ethnically diverse population (Appendix B) which faces some of the highest levels of deprivation and health inequality in the UK (Public Health England, 2021; Wright et al., 2021). Donkin and Mormot (2018) reported that factors associated with socio-economic adversity, such as poor mental health and housing stress, can place a strain upon families, and subsequently adversely affect the infant as caregivers may be less able to provide the physical and emotional support necessary for healthy development. Alongside this, sociodemographic variables including deprivation, ethnic minority origin, and young age appear to be associated with disengagement in mental health services (O'Brien et al., 2008). There is also a narrative in the literature of mistrust of mental health services amongst ethnic minority clients (DHSC, 2018; Scott et al., 2011). These may be important factors to acknowledge as they may impact the service uptake of LMM and such factors may increase the likelihood of disengagement or drop-out.

1.2. Aims

This evaluation aimed to explore the successes and barriers to engagement in direct clinical parent-infant relationship work at LMM. This was hoped to increase

understanding of how this service strand could become more accessible for the local community.

2. Method

2.1. Design and Procedure

A mixed-methods approach to data collection was used to gain insights that may have not been interpreted through either qualitative or quantitative methods alone (Creswell & Plano-Clark, 2011). LMM clients' complete routine parent-infant outcome measures (OMs) and a feedback questionnaire upon discharge as part of routine clinical practice. Thus, the service had pre-collected data from 70 families referred in the first two years of the service (July 2018-December 2020) which was anonymised for use in this evaluation. Descriptive statistics explored this quantitative parent-infant relationship data.

As qualitative data is interested in understanding human experiences through personal perspective (Ailinger, 2003), it was hoped to gain the perspective of discharged families (planned or unplanned endings) through telephone interview and open-ended questionnaire data, to explore what they thought were the successes of their parent-infant work and what were the barriers to accessing or engaging with the work from disengaged families.

2.2. Participants and Recruitment

Seventy clients who were discharged from LMM were sent consent and opt-in information forms inviting them for telephone interview (Appendix C and D). A follow-up letter was sent two weeks later (Appendix E). A sample size of 10 was aimed for, which was deemed sufficient for this small-scale project (Constantinou et al., 2017). Unfortunately, only two people responded. One participant dropped out due to not accepting the intervention offered by LMM at time of referral. One client participated in a 30-minute telephone interview. Sixteen clients provided qualitative feedback on the feedback questionnaire.

2.3. Ethical Considerations

Ethical approval was gained from the Doctorate in Clinical Psychology Research Ethics Committee, University of Leeds (DClinREC project number 20-013). Approval

was also given by the Research and Development team within Bradford District Care NHS Foundation Trust and by the Operational Lead of LMM.

2.3.1. Consent

Informed consent was ensured by sending an opt-in information form with the consent form. The consent form was re-iterated at the start of the telephone interview and verbal consent was audio recorded.

2.3.2. Confidentiality and Anonymity

Confidentiality was outlined in the information form and the participant was reminded of this prior to interview. A participant number was given if they wished to withdraw their data. The participant's data was anonymously stored according to University of Leeds Information Protection Policy and the DClinPsychol Policy on safeguarding sensitive data. Additionally, the commissioner sent a password protected anonymised spreadsheet of the existing quantitative data with any identifiable information removed and replaced with a participant number via a secure email server.

2.3.3. Potential Distress

There was potential for participants to experience distress when exploring dissatisfying experiences. The information form signposted participants to local supporting services. The participant was reminded that they could end the interview at any time and answer only what they wished to share.

2.4. Measures

2.4.1. Interview Schedule

An interview schedule was developed in consultation with the commissioner to ensure questions which corresponded with the evaluation aims were explored (Appendix F).

Table 1

MORS-SF Scoring Interpretation

Score	Concern Level
<11 (warmth subscale)	High
11-15 (warmth subscale)	Moderate
16+ (warmth subscale)	Low
17+ (invasion subscale)	High
12-16 (invasion subscale)	Moderate
<11 (invasion subscale)	Low

2.4.2. Mothers Object Relations Scale Short-Form (MORS-SF)

The MORS-SF (Oates et al., 2018) is a validated outcome measure given to clients that explores parent-infant relationships (Appendix G). The measure screens for early parent-infant relationship problems by assessing caregivers' perception of their infant's feelings towards them (Invasive/Distant and Warmth/Coldness; Oates, 2019). A 6-point Likert scale is used '0' (never) to '5' (always) to answer questions such as, 'My baby/child smiles at me'. Reliable change was calculated using Evans (1998) reliable change calculator, using the original community sample survey data (Oates et al., 2018). A change from pre-to-post that is greater than 5.13 on the Warmth subscale (where an increase in score indicates positive change), and of 5.20 on the Invasion subscale (where a decrease in score indicates positive change), suggests reliable change that is likely attributable to the intervention rather than measurement error (see Table 1) (Milford & Oates, 2009).

2.4.3. Feedback Questionnaire

Families complete a feedback questionnaire which consists of a 5-point Likert scale ranging from '1' (negative experiences) to '5' (positive experiences) on questions such as, 'Thinking about my relationship with my baby was helpful'. There are also open-ended questions including, 'Is there anything we could do to improve our service?' (Appendix H).

Table 2

Reasons for Discharge for Little Minds Matter Clients

Discharge Criteria	n	%
N/A - referral rejected	1	1
No longer fits service criteria (planned)	5	7
Planned discharge – goals met	13	19
Planned discharge – group completed	4	6
Planned discharge – therapy not appropriate	4	6
Support not needed/wanted (planned)	19	27
Unplanned discharge – did not attend/engage	3	4
Unplanned discharge – dropped out/disengaged	15	21
Moved out of area	3*	4
No discharge status recorded	3	4
Total planned discharges	47	67
Total unplanned discharges	19	27
Total discharges (including N/A and where data was not recorded)	70	100

Note. Data for the first two years of service 2018-2020 (N=70)

*Two clients had planned 'move out of area' discharges, whilst one client had an unplanned 'move out of area' discharge.

It was evident that the service had experienced difficulties in routinely collecting OM data, therefore there was less quantitative data than expected. Complete data (pre-post scores for the same participant) for the MORS-SF was N=10, and for the feedback questionnaire N=21 (from 19 families as two parents from two families completed feedback separately). See Table 2 for LMM discharge criteria and Appendix I for criteria definitions.

2.5. Data Analysis

Due to difficulties with data collection, a case series method was adopted to follow the narrative of families (N=10) who completed the MORS-SF and feedback questionnaire. Their service experiences and any reliable change were analysed to seek to understand experiences of change and to see if there were any similarities or disparities across cases. This was hoped to meet the evaluation aims of obtaining family perspectives of what went well and what could be improved from those who had engaged with the service. Descriptive statistics were used to analyse pre-post change for the participants in the case series (N=10). The available feedback questionnaire data was separately analysed (N=21)

It was furthermore decided to analyse the interview and open-ended questions using an approach informed by framework analysis (Gale et al., 2013; Ritchie & Lewis, 2003). This approach does not sit with a particular epistemological stance, making it a flexible and appropriate method for analysing data systematically into predetermined categories of what would be expected to be found in the data (Gale et al., 2013). See Appendix J for how this evaluation interpreted the stages of framework analysis (Ritchie & Spencer, 1994). The predetermined categories decided upon what would be expected to be seen in the data were, 'Positives/Successes', 'Negatives/Barriers', and 'Change'. Participant quotes were systematically organised into the three themes. By merging the interview and qualitative case series data, it was hoped to increase the validity of the analysis by systematically determining whether the quotes from case series participants fitted within the proposed framework. Credibility checks were conducted to ensure face validity of the qualitative data (Elliott et al., 1999). The categories were checked by a peer on the Clinical Psychology Doctorate to ensure the quotes fit within the categories they had been placed.

3. Results

The results are divided into three sections. The first section reports the standardised feedback data from 2018-2020 (N=21). Section two reports the case series data (N=10) which presents participant demographic data (see Table 4), followed by participants experiences of the service reported both narratively and in table format (see Table 5 for pre-post change descriptions, and reliable change). The third section analyses data from the telephone interview and open-ended feedback questions.

3.1. Part One: Standardised Service Feedback

Table 3 reports the LMM feedback data. Seventeen clients who had completed the questionnaire had a planned discharge, one no longer fit service criteria, for two clients support was no longer needed/wanted, and there was one missing data point. The data shows all questions had the majority response as either 'Agree' or 'Strongly Agree' indicating positive self-reported experiences with the direct clinical strand of LMM.

Table 3

Little Minds Matter Feedback Questionnaire Data 2018-2020

Service Feedback Question	N (total N=21) % (total 100%)					
Q1. It was easy for me to be referred and start receiving care from Little Minds Matter	Strongly agree 15 71%	Agree 3 14%	Neither 2 10%	Disagree 0 0%	Strongly disagree 1 5%	Missing data -
Q2. I am satisfied with the level of support my baby and I received	Strongly agree 20 95%	Agree 1 5%	Neither -	Disagree -	Strongly disagree -	Missing data -
Q3. Thinking about how events from my childhood were affecting me was helpful	Strongly agree 8 38%	Agree 6 29%	Neither 4 19%	Disagree -	Strongly disagree -	Missing data 3 14%
Q4. Having a chance to discuss my baby was helpful	Strongly agree 18 85%	Agree 2 10%	Neither 1 5%	Disagree -	Strongly disagree -	Missing data -
Q5. Thinking about my relationship with my baby was helpful	Strongly agree 19 90%	Agree 2 10%	Neither -	Disagree -	Strongly disagree -	Missing data -
Q6. Information about my baby's development was helpful	Strongly agree 19	Agree 2 10%	Neither -	Disagree -	Strongly disagree -	Missing data -

	90%					
Q7. Thinking about things from my baby's point of view was helpful	Strongly agree 16 76%	Agree 5 24%	Neither -	Disagree -	Strongly disagree -	Missing data -
Q8. I felt understood by my practitioner and this helped my situation	Strongly agree 19 90%	Agree 2 10%	Neither -	Disagree -	Strongly disagree -	Missing data -
Q9. Overall, I am happy with the Little Minds Matter Service	Strongly agree 21 100%	Agree -	Neither -	Disagree -	Strongly disagree -	Missing data -
Q10. The service Little Minds Matter offered me made my situation	Much better 15 71%	Better 6 29%	No difference -	Worse -	Much worse -	Missing data -
Q11. How likely are you to recommend us to friends or family if they needed similar care?	Extremely likely 19 90%	Likely 2 10%	Neither -	Unlikely -	Extremely unlikely -	Missing data -
Q12. Were you able to contact your practitioner when needed?	Yes 16 76%	Occasionally 4 19%	No -			Missing data 1 5%
Q13. Is there anything we could do to improve our service?	Yes 2 10%	No 17 80%				Missing data 2 10%

3.2. Part Two: Case Series

Table 4 presents demographic data for the case series participants. A brief description of the participants follows, which indicated most participants evaluated the service positively and showed improvements, particularly on the warmth subscale of the MORS-SF, see details below. See Table 5 for a breakdown of pre and post MORS-SF scores, what the change means in terms of level of concern and any reliable change reported.

Table 4

Case Series Participant Demographic Data

Participant Number	Ethnicity	Referral Information	Type of Parent-Infant Work	Reason for Discharge
1	African	Single parent on refugee visa, lived in shared accommodation. Wanted to understand her child's needs to be able to provide support. Also wanted to feel more confident as a parent.	Attachment related work. Adult therapy. Circle of Security group.	Planned discharge - goals met
2	Asian/British-Asian	Bereavement in immediate family. Mother experiencing bonding difficulties with children and was socially isolated. Wanted support with communicating with her children.	Attachment related work. Psychoeducation states & cues). Watch wait & wonder. Adult therapy.	Planned discharge- goals met
3	White British	Mother did not want past trauma to impact on her relationship with her child. Wanted support with bonding, communication and attunement.	Attachment related work. Psychoeducation (states & cues, neurodevelopment). Video feedback.	Planned discharge – goals met
4	Asian/British-Asian	Maternal difficulty in tolerating infant crying and irregular sleeping patterns. Maternal anxiety impacting on parent-infant relationship. Wanted to	Attachment related work. Psychoeducation (states & cues,	Planned discharge – goals met

		become more mindful to enjoy time in the present with her child.	neurodevelopment). Video feedback. Family/systemic therapy.	
5	White British	Poor maternal mental health and was worried that this would impact on the parent-infant relationship.	Attachment related work. Psychoeducation (states & cues, neurodevelopment). Adult therapy. Circle of security.	Planned discharge – group completed
6	Asian/British-Asian	Maternal anxiety and low mood, traumatic birth experience and social isolation. Mother wanted a stronger attachment with child.	Attachment related work. Psychoeducation (states & cues, neurodevelopment). Adult therapy. Family/systemic therapy. Circle of security.	Planned discharge - goals met
7	Asian/British-Asian	Maternal worries around attachment with child, worried the child would not attach to anyone other than her.	Attachment related work. Psychoeducation (states & cues, neurodevelopment).	Planned discharge - goals met
8	Other White Background	Sought support with separating from child and reduction of maternal anxiety as this was impacting upon sleep.	Attachment related work. Psychoeducation (states & cues, neurodevelopment). Adult therapy.	Planned discharge - goals met
9	Asian/British-Asian	Intrusive thoughts and sought a reduction in anxiety around baby.	Attachment related work. Psychoeducation (states & cues, neurodevelopment). Video feedback.	Planned discharge - goals met
10	White British	Concerned about maternal mental health and the impact this had on children. Wanted support in developing parenting skills.	Attachment related work. Psychoeducation (states & cues, neurodevelopment). Video feedback.	No longer fits service criteria

3.2.1. Participant One

P1 reliably deteriorated on the MORS-SF Warmth subscale, with no change on the Invasion subscale. P1 either 'Agreed' or 'Strongly Agreed' that they had positive experiences, that LMM made their situation 'Better', and they were 'Extremely Likely' to recommend the service.

3.2.2. Participant Two

P2 reliably improved on the MORS-SF Warmth subscale, there was no change on the Invasion subscale. P2 was unsure whether the referral process was easy, and whether thinking about the impact of their own childhood was helpful. Otherwise, they either 'Agreed' or 'Strongly Agreed' that the service had been positive, that LMM made their situation 'Better', and they were 'Extremely Likely' to recommend the service.

3.2.3. Participant Three

P3 reliably improved on the MORS-SF Warmth subscale, there was no change on the Invasion subscale. P3 either 'Agreed' or 'Strongly Agreed' that they had positive experiences, that LMM had made their situation 'Much Better', and they were 'Extremely Likely' to recommend the service. However, P3 'Strongly Disagreed' that the referral process was easy (see Table 7).

3.2.4. Participant Four

P4 did not meet reliable change on the MORS-SF, and they either 'Agreed' or 'Strongly Agreed' that they had a positive experience, that LMM made their situation 'Much Better', and they were 'Extremely Likely' to recommend LMM.

3.2.5. Participant Five

P5 did not meet reliable change on the MORS-SF, and they either 'Agreed' or 'Strongly Agreed' that they had overall positive experiences, that LMM had made their situation 'Much Better', and they were 'Extremely Likely' to recommend LMM.

3.2.6. Participant Six

P6 reliably deteriorated on the MORS-SF Warmth subscale, no change was seen in the Invasion subscale. P6 'Strongly Agreed' that they had overall

positive experiences, that LMM had made their situation ‘Much Better’, and they were ‘Extremely Likely’ to recommend LMM.

3.2.7. Participant Seven

P7 showed no change on the MORS-SF Warmth subscale and reliably improved on the Invasion subscale. P7 ‘Strongly Agreed’ that they had overall positive experiences, that LMM had made their situation ‘Much Better’, and they were ‘Extremely Likely’ to recommend LMM.

3.2.8. Participant Eight

P8 reliably improved on the MORS-SF Warmth subscale, there was no change on the Invasion subscale. P8 either ‘Agreed’ or ‘Strongly Agreed’ that they had overall positive experiences, that LMM had made their situation ‘Much Better’, and they were ‘Extremely Likely’ to recommend LMM.

3.2.9. Participant Nine

P9 showed no change on the MORS-SF. P9 ‘Strongly Agreed’ that they had overall positive experiences, that LMM had made their situation ‘Much Better’, and they were ‘Extremely Likely’ to recommend LMM.

3.2.10. Participant Ten

P10 reliably improved on the MORS-SF Warmth subscale, there was no change on the Invasion subscale. P10 either ‘Agreed’ or ‘Strongly Agreed’ that they had overall positive experiences, that LMM had made their situation ‘Better’, and they were ‘Extremely Likely’ to recommend LMM.

Table 5

Mothers' Object Relation Scale Pre-Post Measures of Change

Participant Number	Pre-Warmth Subscale	Post-Warmth Subscale	Difference**	Change in Concern Level	Pre-Invasion Subscale	Post-Invasion Subscale	Difference	Change in Concern level
1	35	30	-5*	Remained low	8	10	+2	Remained low
2	13	23	+10*	Moderate to low	11	12	+1	Low to moderate
3	24	32	+8*	Remained low	16	18	+2	Moderate to high
4	31	34	+3	Remained low	17	16	-1	High to moderate
5	30	32	+2	Remained low	7	3	-4	Remained low
6	34	18	-16*	Remained low	13	9	-4	Moderate to low
7	35	35	0	Remained low	24	8	-16*	High to low
8	25	31	+6*	Remained low	17	16	-1	High to moderate
9	33	35	+2	Remained low	18	17	-1	Remained high
10	21	30	+9*	Remained low	12	13	+1	Remained moderate

Note. An increase on the Warmth subscale indicates positive change. A decrease on the Invasion subscale indicates positive change.

**An * indicates either reliable improvement or reliable deterioration.

3.3. Part Three: Qualitative Analysis

The telephone interviewee (pseudonym Amira) was referred to LMM due to concerns that her baby was not bonding with significant others aside from his parents, and he was sleeping in the parent's room, which was subsequently affecting the relationships between his parents and with Amira and her daughter. Amira's family was accepted for attachment related work, psychoeducation (states and cues, and neurodevelopment), and the circle of security parenting group. Amira's ethnicity is Asian/British-Asian, and although the discharge was recorded as 'unplanned dropped-out/disengaged' the family had to drop-out due to circumstances out of their control, reporting disappointment that they had to drop-out as they had a positive experience.

Table 6 presents the quotes from the interview and the open-ended feedback questionnaire responses which were categorised into the predetermined themes, 'Positives/Successes' (N=18), Negatives/Barriers' (N=6), and 'Change' (N=13). See Appendix K for remaining relevant interview quotes not included in Table 6. The theme interpretations are further explored in the discussion section.

Table 6

Framework Analysis Quotes

Theme	Participant Group	Participant Quotes
Positives/Successes	Case series participants	**P1** - "If I cannot help myself then I cannot help my baby. I feel good about my relationship with my baby." **P3** - "I really appreciate the work. I have found we are communicating better as a couple and it has really helped us bond with our baby." **P4** - "You've come in and you've helped me loads" **P6** - "It has been a great help in the times I really questioned the relationship between me and my son" **P7** - "We had such a lovely time and will miss you so much" **P8** - "Can't suggest anything [changes], for me everything has been fantastic", "I was lucky to receive the support from LMM and I hope people in my situation will be as lucky as me to receive the support. Because it is worth it to do the process with LMM. A big thank you" **P9** - "I am grateful and happy I was referred to LMM"
	Clients not included in case series	**P13** - "The topics the team used were so useful. The team were very kind, helpful with us and our children" **P14** - "Offer to other parents who are struggling. Providing information about baby's development was good", "This should be approached with everyone: mums, dads, children - very important" **P15** - "Keep on doing what you are doing. You are doing a fantastic job. I wouldn't be in this place where I am without your help. I don't like to think about where I would be, I may not even be here. So thank you", "I have not got no complaints. It was very helpful" **P16** - "I did not feel judged when I explained that I can no longer be part of the group, instead they tried to accommodate me as much as they could"

	Telephone interview participant (Pseudonym Amira)	• "She [LMM practitioner] was absolutely amazing she was so understandable and understood where I was coming from and the struggles I was going through. Honestly she helped me quite a lot with everything" • "[LMM practitioner] was giving me advice on both of them...she was able to help me with [daughter] as well" • "You know when you're not yourself and you just want someone to talk to, it was like that… she [LMM practitioner] supported me in so many ways… I used to put too much pressure on myself and have this expectation of myself… She would give a different perspective" • "She [LMM practitioner] was giving me her own examples… like how she was brought up, culture comes into it as well… she was able to relate to me and I was able to relate to her, she was able to understand where I was coming from which made it easier for me"
Negatives/Barriers	Case series participants	**P1** - "Before I thought that language would get in the way" **P3** - "Referral took too long - I felt forgotten" **P5** - "I think it would be good if Little Minds Matter was available to more people i.e. in more areas and to parents with children." **P10** - "Had to amend the form to make sense!"
	Telephone interview participant (Pseudonym Amira)	• "The only thing I would change is that they only do it up to two years…I would have liked to have carried it on…there's things still that I would've liked to get some support and help on… if that could get changed that would be good" • "It was a shame because of lockdown that we weren't able to meet up… I would've liked it face to face, obviously that wasn't [LMM] fault, it was lockdown"
Change	Case series participants	**P1** - "You have helped me feel confident and made me realise that I do not need to wait for things to happen and I can be part of the change I want to make", "Before I thought that language would get in the way but after calling people about my housing situation, I felt that I can ask for support myself" **P3** - "We are communicating better as a couple and it has really helped us bond with our baby" **P4** - "I was at rock bottom and now I feel I'm at the stage where I can do this on my own and before I felt I couldn't get through it on my own" **P9** - "I'm stronger with [my baby] and glad someone could hear my voice"

Clients not included in case series	**P11** - "Feel like things improved on their own during the process of spending time discussing these relationships during the assessment" **P12** - "The work with Little Minds Matter made me think of my own relationships with my family and I am starting to repair them" **P15** - "Me opening up where I usually wouldn't have with other services", "Talking to [LMM practitioner] has helped me strengthen the bond with my son. Making me feel it is ok for my son to leave me, to go out and explore, but he will still need me. Giving me new techniques to help me calm and keep peace in my head"
Telephone interview participant (Pseudonym Amira)	• "My main concern was him not sleeping in the cot…it was affecting mine and my husband's relationship… there was no me and my husband time, it was a struggle… Now it's like we've got our own space, own beds, my sons in his cot" • "I always think negative… I end up locking myself away at home and it has an effect on the kids…now I take my kids out swimming, play gym areas… shopping… funfairs, theme parks we've been going as a family to the beach and it's been so nice, I don't care anymore about what people say" • "At first…I'm like oh they're gonna judge me, I feel all negative thinking coming in to my head like it's not gonna work, how can it work just by talking…but actually listening to them, understanding them, applying what they say and you actually see a difference…I've seen how much it makes a difference, somebody that's listening to you, understanding your perspective" • "I would recommend it [LMM] because it's done me wonders, I've seen more and more changes and you know if you stick to it you will eventually get them to where you want them to be at and yourself as well"

Note. P1-P10 are case series participants (P2 provided no qualitative feedback). P11-16 have quantitative and qualitative data from the feedback questionnaire however insufficient data to be included in the case series (no MORS-SF data), the feedback questionnaire is the only data for these participants in this SEP, they gave no feedback that fit into the 'negatives/barriers' theme.

4. Discussion

This evaluation aimed to explore the successes and barriers to engagement in direct parent-infant work with LMM. It was hoped to gain insight into how the service can reach more families at risk of disengagement. However, due to recruitment difficulties these experiences were not captured by the current SEP. Nevertheless, there were findings which highlighted the successes and positive changes for clients following intervention from LMM.

4.1. Feedback Questionnaire

All families strongly agreed that they were happy with the service, and that LMM had improved their situation. The referral process was a positive experience apart from one family who experienced feeling forgotten. It is important to ask about referral experiences into infant mental health services due to barriers that families may experience in accessing services including, fear of judgement, lack of understanding from professionals, lack of knowledge of where families can get support, fear that their infant may be 'removed', and communication barriers (Mental Health & Social Care Directorate, 2021). With such barriers in mind, it is also important that LMM asks about the working alliance, which is associated with therapeutic outcome (Wampold, 2015). All families agreed that they felt understood by their practitioner and this helped their situation. Families indicated more ambivalence regarding the helpfulness of thinking about their own childhood, which may reflect an assumption that direct parent-infant work will focus on the here-and-now, thus being explicit in this expectation may be helpful at assessment stage where appropriate. Overall, all families reported they would recommend LMM, with the majority stating there is nothing they would do to improve the service.

4.2. Case Series

The data reflected an overall positive experience as most clients were discharged due to meeting therapeutic goals. All participants engaged with attachment-related work and due to self-reported improvement, these findings may indicate that attachment-related intervention can improve the parent-infant relationship (Bakermans-Kranenburg et al., 2003). Five participants met reliable improvement on one subscale of the MORS-SF, particularly on the Warmth subscale. Whereas most participants made no reliable change on the Invasion

subscale. In the MORS-SF validation studies it was reported that mothers who experience heightened stress, depression and/or anxiety experience their infant as more invasive and are likely to perceive their infant as irritable and difficult to soothe (Oates et al., 2018). This is reflected in the referral reasons of six participants who ended in the moderate or high concern ranges on the Invasion subscale, as these participants noted concerns around parental mental health/past trauma affecting the relationship with their infant. In this sample there was improvement in the level of positive feelings from parents towards their infants, however 60% of the sample remained feeling overwhelmed by caring for their infant as reflected by the lack of reliable improvement on the Invasion subscale and being in the moderate and high concern range at discharge.

4.3. Qualitative Data

The Positive/Successes theme included quotes reflecting a general appreciation of the help received, and quotes pertaining to positive changes that clients were able to make within themselves and their immediate family which ultimately improved the parent-infant relationship. Amira explained how the input from LMM had improved the relationship with her daughter as well, which had a positive impact upon the whole family. There were also quotes reflecting strong working alliances represented by trust, non-judgement, relatability and understanding. Amira stated that she appreciated the practitioner being understanding of her cultural background which made it easier for her to engage with the process.

The Negative/Barriers theme included quotes that reflected potential cultural/language barriers, as one client reported a concern about language being a barrier to engagement. Although this did not materialise as the quote reflected a relief that this was not a barrier, it may reflect a concern that some clients may have at the outset. There were also organisational/structural barriers, such as P5 potentially referring to a postcode lottery of support as they stated it would be good if more people were able to access this service and support. Amira similarly stated a downside that LMM is only available until the child is two years old. As discussed in the literature review, the 1001 critical days rationale for this age criterion is understandable. However, it is notable from Hogg's (2019) report that 42% of the CCGs who would not accept referrals for young children (aged 12-36 months) only offered

services for children over age three, and in some cases only over age five. Reflecting a gap in service provision for this age group, which is hopefully to be captured by organisational changes as a result of the 1001 critical days report. Finally, one quote reflected disappointment of online appointments, however stated this was out of LMM hands due to the Covid-19 pandemic, and the work remained valuable.

Participants spoke of the change they experienced because of LMM, with one theme relating to increase in confidence and autonomy, reflecting that LMM practitioners were able to provide a secure base for families and provide support in promoting independence/exploration and self-confidence. There was also a theme representing improvement in wider relationships, including self-improvement, with partners, other children, and the wider family. This may show a change in the importance of relationships to these participants, showing that clients were able to transfer relational knowledge to their wider environment which fits with the relational ethos of LMM. Importantly there were quotes pertaining to being listened to and the impact of being heard in a non-judgemental way which ultimately freed clients up to begin the work to improve their parent-infant relationships. Positively, the Change quotes represented an overall improvement in the parent-infant relationships through a strengthened bond which was able to develop with the support of a service who were able to understand the perspective of the client.

4.4. Engaging the Disengaged

It is important to acknowledge the lack of voice from the disengaged client in this evaluation. This has been reflective of difficulties facing researchers with groups who are typically underserved and excluded from social research (Ellard-Gray et al., 2015). Barriers that 'easy-to-ignore' groups face have been highlighted in the literature, such as exploratory models of illness, help-seeking/negative attitude towards psychotherapy, language barriers, lack of trust, and sensitive research subject matter (Ellard-Gray et al., 2011; Lightbody, 2017; Waheed et al., 2015). Some of these barriers may have been experienced by the potential participants in the current evaluation, including language barriers, as LMM reports that approximately one in three families may require an interpreter. Therefore, the information and cover letters may have been inaccessible for some clients. It may also be posited that

clients who disengaged, and therefore may have had an unsuccessful intervention, may have feared their children being taken away (Mental Health & Social Care Directorate, 2021), or concerned about consequences for future support or current access to other services. Ellard-Gray et al. (2015) recommend the use of community partners when conducting research with underserved populations, which can improve the recruitment process. The current evaluation aimed to involve the LMM community engagement worker, and although they were consulted during interview question development, they left the service shortly after. A community engagement worker could support following evaluations, as they could support with many of the barriers previously stated as an ongoing co-supervisor.

5. Strengths and Limitations

This SEP was the first to evaluate the direct clinical strand of LMM, and considering the service is in its infancy service evaluation is valuable. Additionally, considering the limited number of infant mental health teams (Hogg, 2019), practice-based research is important to add to the evidence base to support continued commissioning. However, there are important limitations to acknowledge with this SEP. Firstly, the limited qualitative and quantitative data meant a small sample size was adopted for this evaluation. Thus, the findings are not generalisable to the wider LMM population. Additionally, the routine data collection for the MORS-SF appears to be inconsistent which had a negative impact upon the available data analysis options for this evaluation. Response bias should also be considered with regards to the telephone interviewee. During the interview, the participant was reminded that the interviewer was independent to LMM to reduce bias and encourage honest feedback, however limited negative feedback was shared. There was also potential for response bias in the feedback questionnaire. Most clients who had completed the questionnaire had planned endings, usually due to meeting therapeutic goals. Although encouraging, social desirability should be held in mind when interpreting this feedback. No clients with an unplanned ending were able to complete the feedback questionnaire since they were no longer engaging with the service. Therefore, the experiences of these clients have not been captured and potential dissatisfaction was not able to be reported.

6. Conclusion and Recommendations

The direct clinical work strand of LMM has shown positive outcomes in improving parent-infant relationships from the sample included in this evaluation, which warrants further exploration. Little Minds Matter actively aim to engage the local community and build the service with the needs of the local community in mind. That said, there are still people who the service is missing and who appear reluctant to engage with research into exploring disengagement. Further evaluations will be valuable with the potential for an alternative data collection strategy such as focus groups where community engagement workers could be more involved in the recruitment and data collection process. The following are recommendations for the LMM service which arose from this evaluation.

- Encourage the completion of OMs with clients routinely, as this is important for research and evaluation.
- When completing the MORS-SF at mid-point clinicians could look at the Invasion subscale scores, as in this sample this was where there was the least change. This may help to tailor the intervention to meet client needs.
- Due to difficulties in recruiting clients who had disengaged, it may be proactive to complete process measures throughout the direct work to measure the therapeutic alliance. Clinicians may be better able to assess the likelihood of disengagement with the use of process measures.
- As the LMM feedback questionnaire was developed by the service, there may be flexibility to include an open-ended question regarding perceived barriers faced by clients, this may support further research and evaluation looking into barriers to engagement, as recruitment is likely to be a challenge.
- It may be useful to gain consent to send feedback questionnaires (with freepost envelopes) in the case of disengagement/drop-out to try to capture these experiences. Alternatively, an anonymised mobile phone survey may yield more responses.
- Further research/evaluation to work closely with a community engagement worker to enhance the recruitment and data collection process.
- Future replication of this evaluation with a larger dataset.

7. Dissemination

The findings of this SEP have been presented at the University of Leeds trainee clinical psychology SEP conference to staff and peers. The report will be shared directly with the commissioning service including the field supervisor. The findings will also be included in the LMM annual report 2021-2022, which is presented to the service's commissioners to support continued funding.

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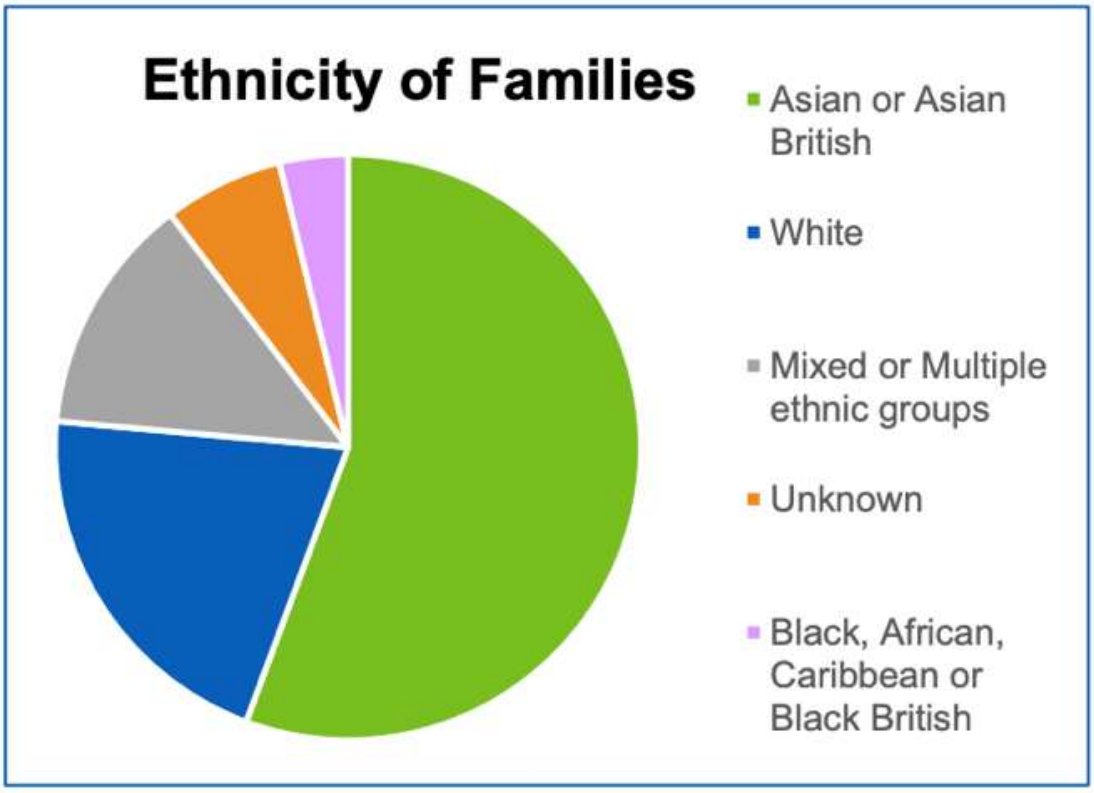
9. Appendices

9.1. Appendix A: Self-appraisal form (removed)

9.2. Appendix B: Proportion of ethnicities seen within Little Minds Matter

(Copied with permission from LMM annual report)



9.3. Appendix C: Consent form

Consent to take part in a service evaluation exploring the successes and barriers to engaging families in parent-infant relationship work with Little Minds Matter.

Please familiarise yourself with the following consent form. If you consent to take part in this research, the researcher will ask you for verbal consent regarding the following points.

Name of lead researcher: Bethany Carrington (Psychologist in Clinical Training)
Research Supervisor: Dr Clare Randall/ Dr Hannah Sawn (Clinical Psychologists, Little Minds Matter).

I confirm that I have read and understand the information sheet (dated 20.05.2021), that was posted to me from the Little Minds Matter service explaining the above research project.
I understand that my participation is voluntary and that I am free to withdraw prior to or during the interview without giving a reason and I can withdraw my data one week post interview without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline. Please contact a member of the research team if you wish to withdraw on, 01274 251 298. Upon withdrawal, your data will be deleted from the University of Leeds record and will not be included in the research report.
I understand that members of the research team may have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research. I understand that my responses will be kept strictly confidential.
I understand that by consenting to take part in this research, that I will be contacted by telephone by Bethany Carrington (Psychologist in Clinical Training) for a telephone interview.
I understand that the interview will be audio recorded and transcribed. I understand that any identifiable information will be removed from transcriptions.
I understand that direct quotes from my interview may be used in the research report.
I understand that the data collected from me may be stored and used in relevant future research in an anonymised form**.**
I understand that relevant sections of the data collected during the study, may be looked at by individuals from the University of Leeds.
I agree to take part in the above research project.

Project title	*Document type*	*Version #*	*Date*
Service evaluation exploring the successes and barriers to engaging families in parent-infant relationship work with Little Minds Matter.	Consent for participants	1	29.03.21
As above	As above	2	08.04.21

As above	As above	3	20.05.21

9.4. Appendix D: Information sheet

Participant Information Sheet

Service evaluation exploring the successes and barriers to engaging families in parent-infant relationship work with Little Minds Matter.

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the project?

The project aims to explore the experiences of families who have had involvement with the Little Minds Matter service, to understand what was helpful about the service and what could have helped to improve the experience. It is hoped through this developed understanding, that families at risk of finding the service unhelpful will be better supported to engage with Little Minds Matter in the future.

Why have I been chosen?

You have been contacted because you have been seen by the Little Minds Matter team. Families who have had involvement with this service are being contacted for us to find out what they found positive about the service and what they think could be improved.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you can still withdraw at any time, without having to give a reason.

What will happen if I choose to take part?

You will have received a letter explaining that if you are interested in taking part in the project, then can you opt in by telephoning or texting the numbers provided on the letter. After this, Beth Carrington (Trainee Clinical Psychologist), who is independent from the team will call you for a telephone interview which will last no longer than 30 minutes. You do not have to answer any questions that you do not wish to answer. If you indicate that you would like to take part, we will ask you to give verbal consent over the telephone which will be recorded along with the interview, this is so the interview can be transcribed and the findings analysed. You will be free to withdraw at any point during the interview and up to one week after the interview date without having to give a reason and with no negative consequences on your care from the Trust. After the interview, the researcher will transcribe the interviews and take out any identifiable information, therefore the transcripts will be anonymous. You will not be asked to do anything further as part of the research project.

Will I be recorded, and how will the recorded media be used?

The audio recording of your interview will only be used for analysis for this project. No other use will be made of the recording without your permission, and no one outside the project will be allowed access to the original recordings. Once the audio recording of your interview is saved onto a secure university server (this is done immediately after interview), it will be deleted from the

dictaphone used to record it. Direct quotes may be used in the final report, there will be no identifiable information used so you will remain anonymous. Your data will be archived with the University of Leeds for three years after the completion of the project.

What are the possible disadvantages and risks of taking part?

Taking part in this research will not put you at direct risk, however it can be uncomfortable speaking about negative experiences that you may have faced during your time with the Little Minds Matter service. However, it can feel useful to speak about some of these experiences so the service can take on board your comments for service improvement. During the interview you will be encouraged to only share what you feel comfortable sharing and you may stop the interview at any point if you feel the interview is not a helpful experience.

What are the possible benefits of taking part?

It is hoped that this project will help Little Minds Matter to understand what was helpful about the service and what were some of the barriers to people having a helpful experience. It is hoped through this developed understanding, that families at risk of not having a helpful experience will be better supported by the service in the future. You will be providing valuable information from your direct experiences which is very helpful when thinking about how to change services in the best way for service users.

What will happen to my personal information?

With your consent, your name and contact number will be given to the researcher in order for her to conduct the interviews. Your name and contact number will be sent via a secure NHS email server, after you have been contacted this information will be deleted straight away from the email server. You will be assigned a participant number which the researcher will use instead of your name hereafter, this is to protect your confidentiality and anonymity. The researcher will be the only person who knows what participant number you have been assigned. Any information that you provide that may result in you being identified (e.g. name, place of work, where you live) will be removed from the transcripts.

What will happen to the results of the research project?

The University of Leeds requires all Psychologists in Clinical Training write up the results of the service evaluation project as a written report. The project may be used in other ways too such as presented at the University of Leeds poster conference, summarised in the Little Minds Matter annual report and there is potential for the results to be published in academic journals. You will not be identifiable in any report or publication of this research.

What type of information will be sought from me and why is the collection of this information relevant for achieving the research project's objectives?

You will be asked about your experiences of your involvement with the Little Minds Matter service such as; what you think they could be doing better as a service, any positive experiences you may have had, any worries or concerns that you had during your involvement with the service and anything you think could benefit from being changed about the service that could help families in the future to have helpful experiences.

Who is organising/ funding the research?

The evaluation project is being commissioned by Dr Matthew Price, Principal Clinical Psychologist and Infant Mental Health Pathway Lead. The project has been given ethical approval by the Doctorate in Clinical Psychology Research Ethics Committee at the University of Leeds (DClinREC project number 20-013).

External Services

If after the interview you feel that you would like to contact somebody for some support you can make an appointment with your GP to discuss further referrals to any services you feel may be helpful to you and your family. There is also Mind Bradford who you can contact for mental health and psychological wellbeing support, their website is: https://www.mindinbradford.org.uk/ and their telephone number is: 08001 884 884. If you would like further support for your family and you are either expecting a child and/or have children aged 0-3 then you can also get in touch with Better Start Bradford who run projects and activities for families in Bowling and Barkerent, Bradford Moor and Little Horton. Their website is https://www.betterstartbradford.org.uk/, their email is: hello@betterstartbradford.org.uk and their telephone number is: 01274 723146.

Thank you for taking the time to read through this information sheet and considering taking part in this research. If you have any concerns about the study, please contact Bethany Carrington, Dr Beckie Yeates, or Dr Matthew Price/Dr Hannah Swan using the details below.

Number: 01274 251 298

Email address: littlemindsmatter@bdct.nhs.uk or r.a.yeates@leeds.ac.uk

Project title	*Document type*	*Version #*	*Date*
Service evaluation exploring the successes and barriers to engaging families in parent-infant relationship work with Little Minds Matter.	Information sheet for participants	1	29.03.21
As above	As above	2	08.04.21
As above	As above	3	20.05.21

9.5. Appendix E: Follow up letter template

Dear Parent/Caregiver,

We have already written to inform you about some research that we are doing at Little Minds Matter, this is a follow-up to the previous letter.

To make sure we offer the best service possible, we want to understand your experiences of using our service.

An independent researcher (Beth, a Trainee Clinical Psychologist) will be carrying out this study. Those families that are happy to take part will be contacted by Beth over the phone to answer a few questions about their experiences. This will include how you were referred to the service, your experience of the team, being discharged and whether you found the service helpful or not. There are no right or wrong answers to these questions, we are just interested in hearing your honest experiences. For more information, please find enclosed the participant information sheet and consent form.

It is your choice if you would like to take part in this research and it will not affect your care from the Trust. If you would like to take part in this research then please either text Georgie (Assistant Psychologist, 07740 422 726) saying “opt in for the research project” or call the Little Minds Matter Service (01274 251 298) to let us know. If you do not contact us we will assume you do not wish to take part and you will receive no further correspondence from us about the research.

Kind regards,

The Little Minds Matter Team

9.6. Appendix F: Interview schedule

Planned Discharge
(Questions to be adapted and used as a guide for the interview)

1. Can you remember how old your baby was when you were referred to Little Minds Matter?

2. What was your experience of being referred to Little Minds matter?

3. How would you describe your experience of Little Minds Matter?
   Prompt: what support did you receive? What did you find helpful? How do you explain the change? How did your time at the service end? Did you feel actively involved in the work?

4. Did you have any worries or concerns?
   Prompt: would you mind providing me with some examples?
   Prompt: did you feel able to voice these to the person you were working with?
   ... if yes- what do you think made this feel ok to talk about?
   ... if no- what do you think got in the way of voicing these concerns?

5. Did you feel you like you could relate to the person you worked with?
   Prompt: ask them to expand on their answer if they feel able to.

6. What would you have changed about your experience?
   Prompt: how would you improve the service.

7. What would you say to someone who was thinking about accessing support from Little Minds Matter?

8. Is there anything that you feel we haven't covered that you would like to talk about or add about your experience of Little Minds Matter?

Unplanned Discharge
(Questions to be adapted and used as a guide for the interview)

1. Can you remember how old your baby was when you were referred to Little Minds Matter?

2. What was your experience of being referred to Little Minds matter?

3. How would you describe your experience of Little Minds Matter?

Prompt: what support did you receive? What did you find helpful? How did your time at the service end? What made it difficult to meet with Little Minds Matter? What ideas do you have to make it easier for other families?

4. Did you have any worries or concerns?
   Prompt: would you mind providing me with some examples?
   Prompt: did you feel able to voice these to the person you were working with?
   ... if yes- what do you think made this feel ok to talk about?
   ... if no- what do you think got in the way of voicing these concerns?

5. Did you feel you like you could relate to the person you worked with?
   Prompt: ask them to expand on their answer if they feel able to.

6. What would you have changed about your experience?
   Prompt: how would you improve the service.

7. What would you say to someone who was thinking about accessing support from Little Minds Matter?

8. Is there anything that you feel we haven't covered that you would like to talk about or add about your experience of Little Minds Matter?

Project title	*Document type*	*Version #*	*Date*
Service evaluation exploring the successes and barriers to engaging families in parent-infant relationship work with Little Minds Matter.	Interview schedule	1	07.04.21
As above	As above	2	08.04.21

9.7. Appendix G: Mothers Object Relations Scale Short Form (Oates et al., 2018)

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My Baby / Child (Under 3s)

Your name	
Your child's name	
Your child's date of birth	
Your address	
Today's date	
Interpreter used?	

Please circle one of the choices for each of the questions below. There are no 'right' or 'wrong' answers; many of these are true of all babies and young children at times.

1. My baby / child smiles at me…					
Never	Rarely	Sometimes	Quite often	Very often	Always
0	1	2	3	4	5

2. My baby / child annoys me…					
Never	Rarely	Sometimes	Quite often	Very often	Always
0	1	2	3	4	5

3. My baby / child likes doing things with me…					
Never	Rarely	Sometimes	Quite often	Very often	Always
0	1	2	3	4	5

4. My baby / child 'talks' to me…					
Never	Rarely	Sometimes	Quite often	Very often	Always
0	1	2	3	4	5

5. My baby / child irritates me…					
Never	Rarely	Sometimes	Quite often	Very often	Always
0	1	2	3	4	5

6. My baby / child likes me…					
Never	Rarely	Sometimes	Quite often	Very often	Always
0	1	2	3	4	5

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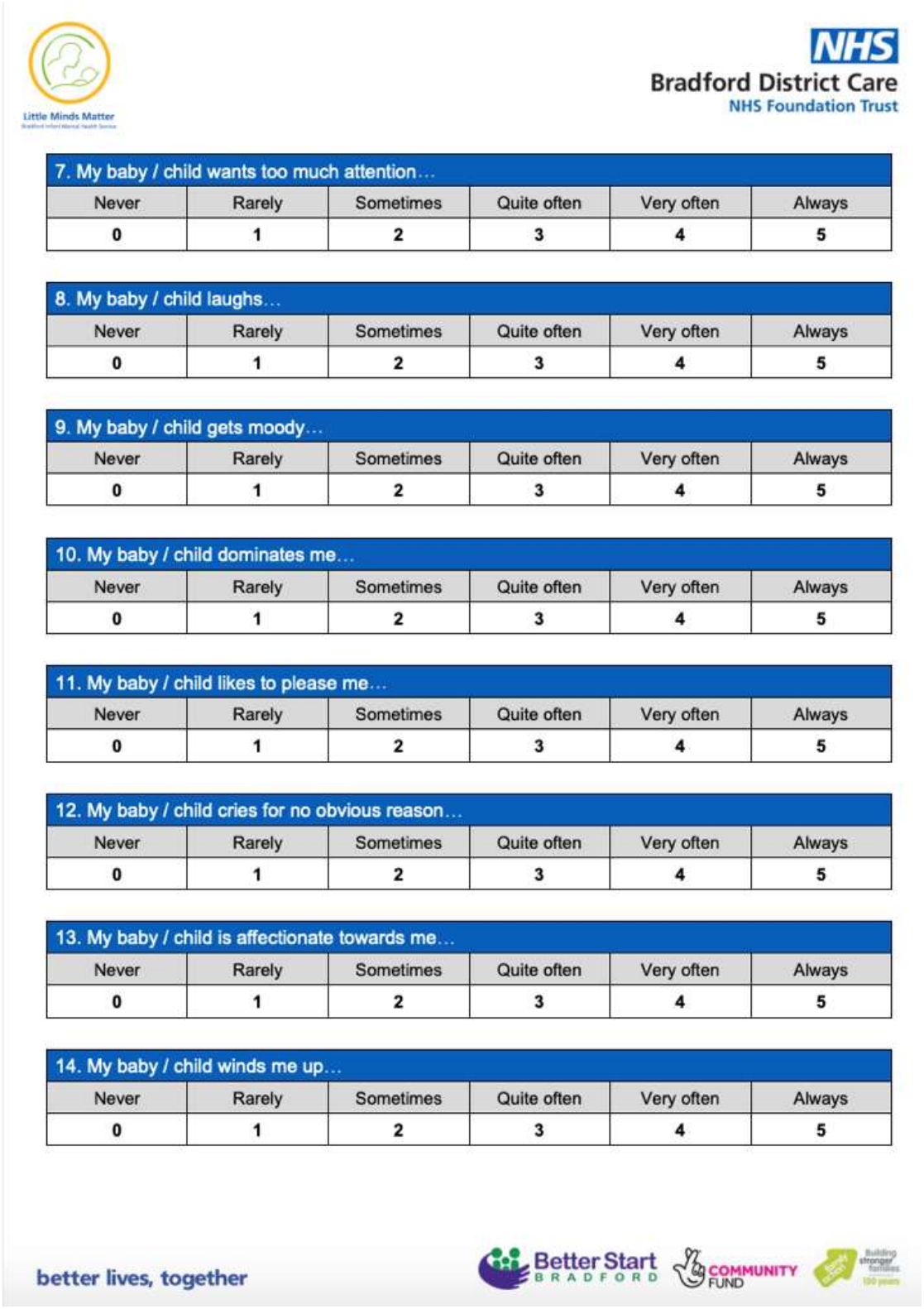

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Bradford District Care
NHS Foundation Trust

7. My baby / child wants too much attention…					
Never	Rarely	Sometimes	Quite often	Very often	Always
0	1	2	3	4	5

8. My baby / child laughs…					
Never	Rarely	Sometimes	Quite often	Very often	Always
0	1	2	3	4	5

9. My baby / child gets moody…					
Never	Rarely	Sometimes	Quite often	Very often	Always
0	1	2	3	4	5

10. My baby / child dominates me…					
Never	Rarely	Sometimes	Quite often	Very often	Always
0	1	2	3	4	5

11. My baby / child likes to please me…					
Never	Rarely	Sometimes	Quite often	Very often	Always
0	1	2	3	4	5

12. My baby / child cries for no obvious reason…					
Never	Rarely	Sometimes	Quite often	Very often	Always
0	1	2	3	4	5

13. My baby / child is affectionate towards me…					
Never	Rarely	Sometimes	Quite often	Very often	Always
0	1	2	3	4	5

14. My baby / child winds me up…					
Never	Rarely	Sometimes	Quite often	Very often	Always
0	1	2	3	4	5

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9.8. Appendix H: Little Minds Matter Service Feedback Questionnaire Template

Relationship to Infant ……..

Date Completed …...……..…….

Strongly disagree = 1 Neither agree nor disagree = 3 Strongly agree = 5	
It was easy for me to be referred and start receiving care from Little Minds Matter	
I am satisfied with the level of support my baby and I received	
Thinking about how events from my childhood were affecting me was helpful	
Having a chance to discuss my baby was helpful	
Thinking about my relationship with my baby was helpful	
Information about my baby's development was helpful	
Thinking about things from my baby's point of view was helpful	
I felt understood by my practitioner and this helped my situation	
Overall, I am happy with the Little Minds Matter Service	

Much worse = 1 No difference = 3 Much better = 5	
The service Little Minds Matter offered me made my situation	

Extremely unlikely =1 Neither likely nor unlikely = 3 Extremely likely = 5	
How likely are you to recommend us to friends or family if they needed similar care?	

Please answer in your own words…	
Were you able to contact your practitioner when needed?	

Is there anything we could do to improve our service?	
Please use the box to provide more details.	
Any other comments?	

9.9. Appendix I: Little Minds Matter discharge criteria definitions

Reason for Discharge	Definition	Example
No Longer Fits Service Criteria	A family no longer meets our service criteria relating to age, social care involvement, adult mental health etc.	Infant reaches the age of two, but goals are not yet met. Intervention would have continued if age was not a factor.
Planned Discharge – Goals Met	There has been significant progress and the family and clinician are satisfied that the family no longer require intervention from LMM.	Personalised goals are scored highly, and caregiver is happy with progress. Clinician can see observable improvements in parent-infant relationship.
Planned Discharge – Group Completed	The caregiver has completed the Circle of Security programme.	The caregiver has completed the Circle of Security programme.
Planned Discharge – Therapy Not Appropriate	An intervention from LMM was not seen as the most appropriate source of support at this time.	After the assessment other services would help the caregiver meet their goals more appropriately than LMM.
Support Not Needed / Wanted	The family does not want an intervention from Little Minds Matter or clinician cannot identify a need.	The family is unable / unwilling to identify any parent-infant relationship goals.

Unplanned Discharge – Did Not Attend / Engage	Used if clinician and family never meet.	The family cancel or DNA all arranged initial visits.
Unplanned Discharge – Died	Used only if caregiver and / or infant dies.	The caregiver and / or infant dies.
Unplanned Discharge – Dropped Out / Disengaged	Used during assessment or intervention if a family stop attending sessions.	The family and clinician meet at least once but then subsequent sessions are cancelled or not attended. Goals are not met.
Unplanned Discharge – Moved Out of Area	Used only if caregiver and / or infant moves out of the Bradford area.	The caregiver and / or infant moves out of the Bradford area.
N/A - Referral Rejected	Used only if we did not accept the referral in the first place.	The family was on a Child Protection plan and the referral was not accepted.

9.10. Appendix J: How the current SEP interpreted framework analysis stages

Table A

Five Stages of Framework Analysis (Ritchie and Spencer, 1994)

Stages of Framework Analysis	Example	The Current SEP
Familiarization	Immerse in the data. Listening to interviews and reading transcripts. Develop preliminary codes with extracts from the data.	During the interview the evaluator wrote process notes and initial thoughts. The evaluator then re-listened to the interview straight after to expand on initial thoughts, and again prior to data analysis to re-familiarise with the data. Notable quotes were transcribed.
Identifying a framework	Organise data in a meaningful and manageable way. Framework categories are developed through predetermined categories as well as those that emerge from data familiarisation. Group codes into categories (data management rather than interpretive).	Framework categories were developed a priori, Ritchie and Spencer (1994) proposed themes develop through predetermined categories from what is expected from the data, as well as themes emerging from the data. This evaluation aims supported the development of the categories 'positives/successes', 'negatives/barriers', and 'change' to help answer the evaluation aims.
Indexing and Charting	Organise the qualitative data into the framework categories- apply the framework to each transcript using the participant quotes. Then transfer to a chart/table format	Applied the framework categories to the interview quotes using a table format (Table 6).

Mapping and interpretation	Interpretation stage, find patterns and researcher applies their sense-making of the data by developing themes.	This evaluation relied less on interpretive themes due to the lack of data, therefore a more systematic view was taken with the use of a priori categories of 'positive/Successes', 'Negatives/Barriers', and 'Change'. Therefore, relying more on frequency of themes rather than interpretation.

Note. Example taken from Parkinson et al. (2015) who used framework analysis in their study.

9.11. Appendix K: Telephone Interview Quotes

Table B

Telephone Interview Quotes

Positives/successes
• "[LMM practitioner] helped me through the struggles I was going through with how I was feeling, she gave me tips on what to do and information on how to deal with it, the techniques she told me about with breastfeeding, how to put him to sleep." • "She [LMM practitioner] helped me with my mental health as well, you know my low moods and stuff" • "She [LMM practitioner] was so flexible and was able to work around my timetable… there were days when I wasn't in the right frame of mind, I don't feel like talking and she understood rather than judging me, she was like just let me know when you're up for it and we can have it then when you're ready" • "Her [LMM practitioner] giving her own [experiences] makes you feel more comfortable and makes you understand that the person [LMM practitioner] isn't just there to listen, they're actually understanding where we're coming from because they've been through situations like that themselves" • "I recommended it [LMM] to a friend …LMM they really do help you, they listen to you they give you tips and ideas on what to do how to deal with it…they can give you other support groups too that you can join"
Change
• "Honestly she [LMM practitioner] helped me with a lot… I was at the lowest point at that time and I was really struggling and you know with the advice and everything she [LMM practitioner] was giving I was taking on board. Sometimes I had days where I was like I can't do this it's not working and she [LMM practitioner] explained to me that these things take time and you can't give in like that, you've got to carry on with it to see results, things take time… I have done that and I have seen there is a difference" • "She [LMM practitioner] used to say when [son] is asleep and [daughter] is awake, to give that time to [daughter]… because I never used to do that I'm not gonna lie it was all about [son], don't make too much noise [son] will wake up, don't do this [son] is going to cry, it was basically all around my son at the time, and she [LMM practitioner] was like you need to give time to your daughter as well…" • "There's so much that I've changed in myself and in my thinking, I still do get frustrated over little things but then I have my husband to calm me down… I still have my days but it's not as bad as it was and I've done it without medication" • "I know now how to deal with it… you've got to keep it up and you'll see progress in your child • "Obviously it was going to be a struggle, at first you're gonna find it a bit hard, but as you keep to it you will see the changes, and actually I did, because now I have my son who sleeps in the cot" • "I joined the gym to make changes for myself… I used to think so negative, I've started turning it into positive thinking"

Note. These quotes were not included in the main table due to the size of the table in the main body. There were no quotes in the theme 'Negatives/Barriers'.