August 2025 | **Report**

‘PARTNERSHIP FOR CHANGE’

Co-production and feasibility randomised controlled trial of an intervention to improve the mental health of children with a social worker

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What Works Centre for Children & Families

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About Foundations, the national What Works Centre for Children & Families

Foundations, the national What Works Centre for Children & Families, believes all children should have the foundational relationships they need to thrive in life. By researching and evaluating the effectiveness of family support services and interventions, we're generating the actionable evidence needed to improve them, so more vulnerable children can live safely and happily at home with the foundations they need to reach their full potential.

About University of Glasgow

The Partnership for Change feasibility study was delivered as part of the University of Glasgow's *Centre for Developmental Adversity and Resilience (CeDAR) within the School of Health and Wellbeing*. Children who suffer difficult early experiences, such as illness, neurodevelopmental problems, neglect, or abuse can develop mental health problems that can burden them throughout their lives, holding them back in social development, family life, education, the workplace, and even their physical health. Our research, clinical work and teaching aims to understand and address the *many i*ssues that have their origin in childhood and that affect us across the lifespan, even into adulthood. The team is closely allied to the Gillberg Neuropsychiatry Centre: https://www.gu.se/en/gnc

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CONTENTS

GLOSSARY OF TERMS / ABBREVIATIONS & ACRONYMS

Abbreviation / acronym / terms	Description
ADHD	Attention deficit and hyperactivity disorder
ASD	Autism spectrum disorder
BCAPI	Brief Child Abuse Potential Inventory
BeST?	Best Services Trial
CAMHS	Children and adolescent mental health services
CPP	Child Protection Plan
FEW	Family Engagement Worker
GHQ-12	The General Health Questionnaire
HRQoL	Health related quality of life
ICECAP-A	ICEpop CAPability measure for Adults
ID	Intellectual disability
IFT	Infant and Family Team
IPS	Infant Parent Support
ITSEA	Infant and Toddler Social and Emotional Assessment
ITSEA	The Infant-Toddler Socio-emotional Assessment
LA	Local Authority
MRC	Medical Research Council
NDC	Neurodevelopmental condition
NIHR	National Institute for Health Research
NIM	New Orleans Intervention Model

NSPCC	National Society for the Prevention of Cruelty to Children
PREM	Parent-reported experience measure
PROM	Parent-reported outcome measure
PC	Parent collaborator
PedsQL	Paediatric Quality of Life Inventory
RC	Recruitment Co-ordinator
RCT	Randomised controlled trial
SAU	Services as usual
SDQ	Strengths and Difficulties Questionnaire
SNQ	Social Needs Questionnaire
WWCSC	What Works for Children’s Social Care

EXECUTIVE SUMMARY

Introduction

In many families where children have a social worker, parents have experienced challenges in their own childhoods or have neurodevelopmental conditions (e.g. attention-deficit/hyperactivity disorder or autism). These families often experience stress, which can be made worse by money or housing problems. This strains relationships within the family and can lead to child maltreatment and children's mental health problems.

Interventions that focus on improving the child–parent relationship show promise in preventing child maltreatment, yet they often fail to simultaneously address neurodevelopmental conditions and the impact of poverty. We have co-produced – alongside parents who have experience of child and family social work (experts-by-experience), researchers, local stakeholders (e.g. social work managers), and infant mental health practitioners – a new intervention called Infant Parent Support (IPS). IPS will address three important components that have not previously been tested within one intervention:

1. IPS will adopt a relationship-focused approach to comprehensive understanding of family functioning.
2. It incorporates child and parent mental health and neurodevelopmental awareness.
3. IPS ensures a poverty-aware approach throughout.

Objectives

Partnership for Change is an intervention development and feasibility randomised controlled trial (RCT) study undertaken in two stages. Our primary research question for phase 1 was: Can we co-produce, with parent collaborators, a new service, Infant Parent Support (IPS), aiming to improve the mental health of children with a social worker?

An intervention like IPS has never been tested before. Therefore, there are several areas of uncertainty that need to be addressed before moving on to a larger RCT that will assess the effectiveness of IPS when compared to services as usual. In phase 2, the feasibility RCT, our primary research question asked if it was possible to identify and randomise 30 eligible families across two social care services localities, Glasgow and Bromley, and can enough of these 30 families be retained in the study for three and/or six months? Our secondary research questions asked about the feasibility and acceptability of both the planned outcome measures and the IPS intervention. We also explored how feasible it would be to collect data to inform the future cost-effectiveness of IPS versus services as usual.

Methods

In phase 1, the IPS intervention was developed through working closely with parents with experience of child and family social work and multi-agency professionals, all with special interests and direct experience of working with Infant Mental Health. Through in-depth questionnaires and focus groups, all stakeholders' thoughts, feelings, and experiences of co-producing IPS were explored.

In phase 2, families whose children were aged 0–5 years and who had a social worker (children in need) were invited to participate. Twenty-two families were included in the study, with eight being randomly assigned to the IPS intervention and 12 to services as usual. We collected questionnaire data from participants who agreed to participate in the study, and a proportion also took part in an in-depth interview. Data was collected at the start and at the end of participants' involvement in the trial (3-to-6 months). We also conducted individual and group interviews with members of the research team and practitioners delivering the intervention.

Key findings

The data presented in this report refers to the early stages of IPS implementation that took place between April 2022 and March 2024, funded by WWCSC. As such, this is a preliminary report of our early findings and work will continue separately as we continue to build on our co-production work, feasibility RCT, and mapping of local service landscapes, to inform a randomised controlled trial (RCT) of Infant Parent Support (IPS).

Phase 1: the co-production of IPS

- Elements of transformational co-production were evident, such as the adaption and modification of existing IPS assessment tools and service/intervention information sheets, and changes to practice such as home visits and local appointments. Consistent across reports from stakeholders, including Parent Collaborators and practitioners, was evidence of personal growth and change.
- Areas for improvement included setting clear expectations of the project's goals, establishing individuals' roles and responsibilities within the project, communication between stakeholders, recruitment of parent collaborators from diverse backgrounds (fathers and minoritised groups), and overcoming power dynamics, for example ensuring that parent collaborators felt able to speak out and there was genuine shared decision-making
- Barriers to better working included resistance from the ethics committee, disparate views on the conceptualisation of co-production, greater training needs, time for developing relationships across multidisciplinary teams, and challenges in recruiting sufficient numbers of parent collaborators.

Phase 2: feasibility RCT

- In total, we were able to recruit 63% of our target of 30 families.
- High workloads and competing demands of social care services meant there were challenges in identifying suitable families into the study, for example with delays in social workers discussing the eligibility of the families with the research team. This information has allowed us to further refine our referral pathways into the study for a definitive RCT.
- We were successful in collecting data on parent and child mental health measures and demonstrated that data collection for an economic analysis is feasible and acceptable.
- Data from the in-depth interviews demonstrated that participants had a positive research experience, finding the measures and study procedures acceptable.
- Further piloting work is needed around possible modifications in the delivery of some measures, and the removal of others. There was also emergent evidence for the utility of newly developed parent report measures.
- There were challenges referring appropriate families into the study, relating to the sharing of information between local authorities and IPS and high thresholds of need. Our sample of 'children in need' was edging closer towards child protection.
- Child protection concerns needed to be addressed before IPS could continue to work with families, which had implications for the timescale of the study. Some families no longer met the study criteria and therapeutic work was not possible.
- Nonetheless, there was also evidence of IPS implementing both poverty-aware practice and neurodiversity awareness throughout the intervention.
- There was emerging evidence of changes in the organisation of and access to other specialist services (e.g. adult mental health, third sector organisations), through the successful partnership working between IPS and such services.
- Post intervention data from one parent was extremely positive, regarding the strengths-based and parent-led approach of IPS. Areas of improvement mainly related to frequency and mode of meetings, and delays in accessing services or support once needs had been identified.

Recommendations and next steps

Our initial findings suggest that families who have a social worker are presenting with a complexity of need that may not be appropriately met with a therapeutic intervention at this point in their journey, therefore demonstrating that this intervention may be more effective at an earlier point in a family's development.

Nonetheless, IPS teams have demonstrated the importance of understanding and responding to families as a whole and providing holistic support that considers the impacts of poverty, NDCs, and trauma on their material and psychological wellbeing needs. This learning needs to be taken forward if we are to make a difference for families with multiple and complex needs.

Policy and practice recommendation

Many of the families in the study identified as having a child in need by statutory services demonstrated high levels of need and risk, more akin to the child protection category. **Greater partnership is needed between early services** to identify the needs of families on the cusp between child in need and child protection and working together to improve outcomes for these families. This may be beyond the remit of IPS but we will make policy recommendations regarding this.

Research recommendations

- To intervene earlier in the family's development (i.e. before child protection proceedings are imminent) we need to **modify our referral criteria**, including families who use early intervention service providers, health visitors, as well as social work.
- To achieve this, **further mapping** work is needed to identify where IPS overlaps with existing early intervention services and to develop partnerships between these services and IPS.

We will continue to map key differences in the social services and legal contexts in Glasgow and Bromley, to best understand how we can **embed IPS within their local community/service context** and target the families likely to most benefit. **Place-based inequalities** will be a key focus in the next phase of Parentship for Change.

INTRODUCTION

Project background

It is estimated that in the United Kingdom 1.6 million children needed a social worker between 2012 and 2018, equivalent to 1 in 10 children (Department for Education, 2019). Child and Family social work may become involved with a family when concerns about a child's safety and wellbeing are raised, which may be a result of domestic abuse, alcohol and drug misuse, and parental and/or child mental health, physical disability, learning disability, and/or neurodevelopmental conditions (e.g. attention-deficit/hyperactivity disorder [ADHD] or autism). However, these factors cannot be understood without considering the social and economic context in which these issues are experienced (Skinner et al., 2021).

In many families where the children have a social worker, the parents have experienced challenges in their own childhoods or have neurodevelopmental conditions like ADHD or autism. These families inevitably experience stress, often exacerbated by money or housing problems, and the stigma of living in poverty. This strains child–carer relationships and can lead to child maltreatment and children's mental health problems that, in turn, burden families, services, and society (Hefti et al., 2020).

In 2019/20, UK referrals to child mental health services rose by 35%, yet access to treatment only rose by 4% (Lennon, 2021). Children with psychiatric diagnoses incur more than four times the health and social care costs than their peers (Waldmann et al., 2021). If placed in care, these costs multiply (Holmes & McDermid, 2012; Ward et al., 2008). Providing support sooner is right for the child, family, and society (Minnis et al., 2024). Health and social care organisations, and governments, believe organisations should work together to support families before children are taken into care (Independent Care Review, 2020). Yet our literature review found no trial evidence for programmes aiming to prevent child maltreatment, although relationship-focused interventions show promise, especially if involving child protection services (Self-Brown et al., 2017).

The Partnership for Change project aimed to develop an intervention that would incorporate a relationship-focused intervention, while also ensuring a poverty- and neurodiversity-aware approach throughout. Partnership for Change was undertaken in two phases (see Figure 1).

Overview of Partnership for Change

Phase 1: Co-production of Infant Parent Support (IPS)

In phase 1, we aimed to co-produce alongside parent experts-by-experience, local stakeholders, and infant mental health practitioners, a new intervention called Infant Parent Support (IPS) to improve the mental health of children under 5 years of age whose families currently have a social worker. Co-production is an approach that aligns well with early interventions aimed at improving outcomes for children or preventing escalating need (Slay & Stephens, 2013). Although there is wide variation in how co-production has been defined and applied in the literature (Masterson et al., 2022), the current study draws upon the definition provided by the Social Care Institute for Excellence (SCIE), stating it is:

> "a way of working whereby citizens and decision makers, or people who use services, family carers and service providers work together to create a decision or service which works for them all. The approach is value-driven and built on the principle that those who use a service are best placed to help design it." (SCIE, 2023:6)

Phase 1 builds on our ongoing NIHR-funded Best Services Trial (BeST$^{?}$)[1] by adapting our existing Infant and Family Team (IFTs) to form the new Infant Parent Support (IPS) teams. In BeST$^{?}$, families randomised to Infant and Family Teams (IFTs) – based on the New Orleans Intervention Model (NIM) (Zeanah et al., 2001) – received an intensive multidisciplinary attachment-focused assessment that provided a foundation for relationship-focused interventions where possible (NSPCC, 2022). IFTs uniquely incorporate a focus on the parent's own needs and, through intervention, aim to tackle the unresolved legacy of their childhood experiences that impedes attuned parenting. IFT aims to interrupt the cycle of intergenerational transmission of problems, enabling parents to make a change that might improve the safety of subsequent children (Zeanah et al., 2001) and the child's mental health in the present and longer term (Robinson et al., 2012).

IFT is the only example of such an infant mental health approach in the UK within the context of children's social care (Hogg, 2019) but until now has focused on children removed from care of biological parents (i.e. foster/kinship care). We hypothesise that using such an approach *earlier* in the family's development (i.e. before child protection proceedings) will have an enormous potential for change. Intervening to support parents in building family resilience before a crisis precipitates a child coming into care – with an emphasis on understanding, respect, reducing stressors, and improving resilience – may give parents a much greater opportunity for change (Harvard University, 2022). As well as focusing earlier in a family's journey, another difference between IFT and the new IPS intervention is the latter plans to explicitly incorporate poverty-aware practice and neurodiversity awareness. The co-production work will be to refine this intervention for this new context and optimise its usefulness for families in which the child has a social worker.

Another significant part of the co-production work was to explore what outputs and outcomes families would like to see from IPS (see Logic Model sections D and E, Figure 3) and whether we

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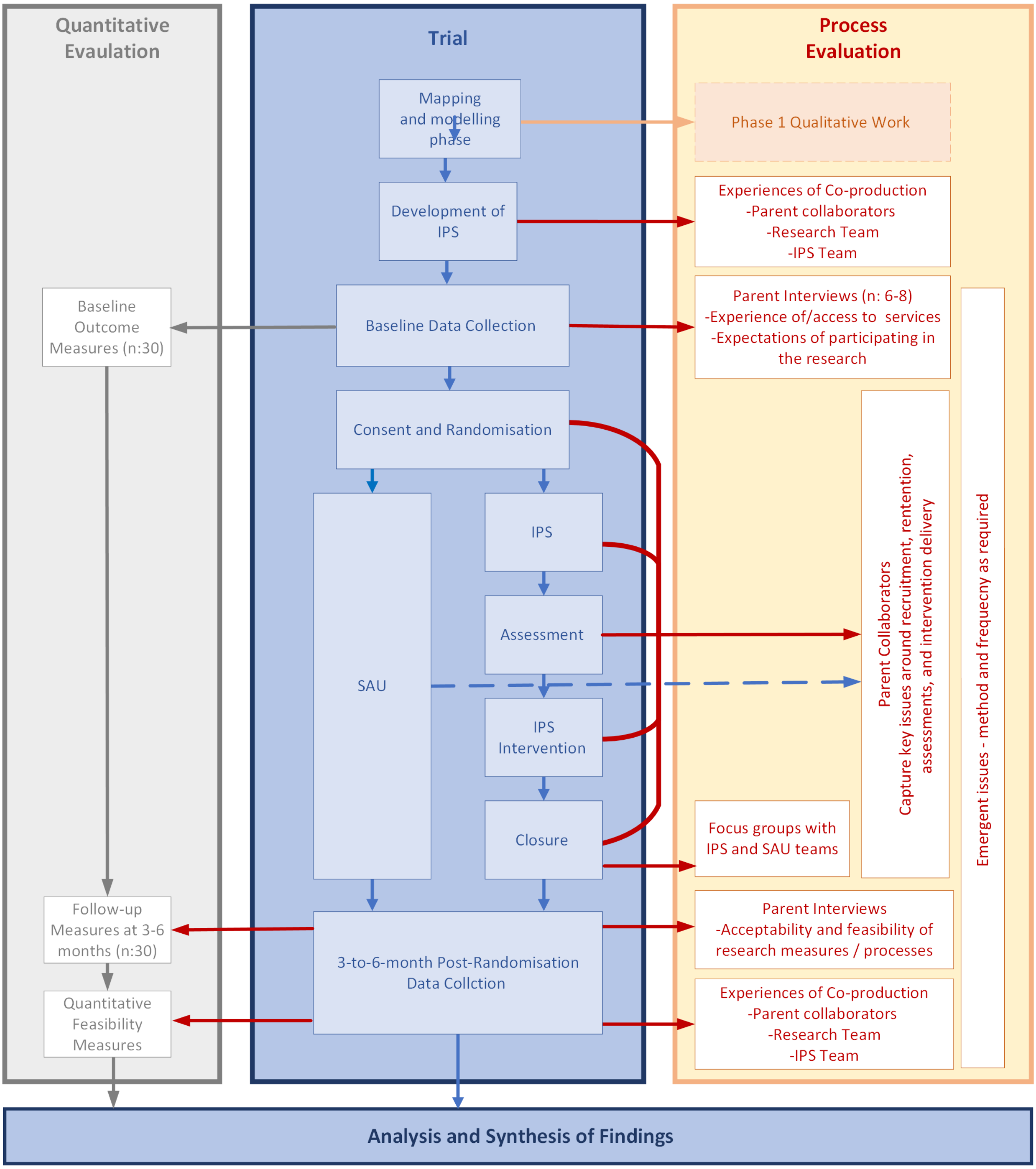
[1] See: https://fundingawards.nihr.ac.uk/award/12/211/54

could use this information to co-develop, with a group of experts-by-experience, a ‘parent-reported outcome measure’ (PROM) and a ‘parent-reported experience measure’ (PREM).

PROMs have been successfully used in healthcare to inform shared decision-making and to tailor care to individual needs and are increasingly used in randomised controlled trials to examine whether an intervention is effective and cost-effective from the perspective of service-users (Williams et al., 2016). PREMS are used to examine patients’ experiences of healthcare and examine factors such as empathy and respect (Gilmore et al., 2023). Although the role of PROMs and PREMs in health care is increasingly being recognised, to our knowledge this will be the first time PROMS and PREMS have been developed for a social care context. In line with the theoretical basis for this study that highlights how stigma, shame, and structural inequalities are key problem drivers, and that respect, reduction in shame, and development of trust are crucial in allowing relationship-focused interventions to be effective, we believe that development of these new tools will be essential.

Figure 1: Overview of the Partnership for Change study (go to accessibility text)



Phase 2: Feasibility RCT

In phase 2, following intervention co-production, we aimed to test the feasibility of a definitive randomised controlled trial (RCT) of IPS versus services as usual (SAU), where the initial plan aimed to recruit 30 families living in Glasgow and London. We utilised a pre–post and 3-to-6-month follow-up design with embedded mixed-method process evaluation and exploratory economic analysis. Families randomised to IPS receive an intensive multidisciplinary attachment-focused assessment that provides a foundation for relationship-focused interventions.

IPS are multi-agency infant mental health teams, including Family Engagement Workers (FEWs; expertise-by-experience of having a child in need) and IPS practitioners (consisting of social workers, psychologists, and psychiatrists). The formation of the IPS Teams and FEW roles are discussed further in the 'Co-production of Infant Parent Support intervention (IPS)' section below. Through home visits, or meetings in NSPCC centres or community buildings, IPS practitioners gather information and understanding about the child and family's social, material, mental health, and neurodevelopmental needs. Based on this understanding, IPS offers a bespoke relationship-focused intervention (up to 4 months) comprising therapeutic work for the child–parent relationship using interventions shown to reduce child abuse risk/increase parental sensitivity (Bakermans-Kranenburg et al., 2023), for example Child Parent Psychotherapy (Lieberman et al., 2006), Circle of Security (Powell et al., 2009), and Parenting Intervention or Video-interaction Guidance (Silhánová et al., 2011). The family's exit from IPS involves a 'warm handover' to other local community services.

Families randomised to SAU will receive treatment as usual; that is, they will receive the assessment and support that social services normally implement. The study settings were social services in two local authorities: Glasgow City Council (Scotland) and the London Borough of Bromley (England). There were no adverse events during the feasibility RCT. We will report these formally during the definitive phase as part of our regular reporting for the Data Monitoring and Ethics Committee which we will shortly be constituting.

OBJECTIVES

Phase 1: Co-production of Infant Parent Support (IPS)

Research objectives

Phase 1 took place between April 2022 and February 2023, with the intensive **mapping of the current services** landscape for struggling families in Glasgow and Bromley (Dalgarno et al., 2023; see Appendix A) and the **co-production of IPS** (Pownall et al., in preparation). The aim was to explore whether we could co-produce a new intervention, Infant Parent Support (IPS), developed from an existing NSPCC service called Infant and Family Teams, with parents who themselves have had children involved with social work (hereafter known as parent collaborators) that addressed three gaps in current service provision:

- A relationship-focused approach
- Mental health and neurodiversity awareness
- Poverty-aware practice, respectfully addressing money/housing problems.

Research questions

Our research questions for phase 1 were as follows:

Mapping and modelling of services

- What is the profile of services as usual (SAU) (including infant/adult mental health; social care statutory processes) at each site and can care pathways be improved?
- What are struggling families' experiences of, and barriers/access to, mental health services?
- Can the project expand to include new partners?

Intervention co-production

- Can we co-produce, with parent collaborators, a new intervention, Infant Parent Support (IPS), aiming to improve the mental health of children with a social worker?
- What outputs and outcomes would families like to see from IPS and can we use this information to develop a 'parent-reported outcome measure' (PROM) and a 'parent-reported experience measure' (PREM)?

Phase 2: Feasibility RCT

Research objectives

The second phase commenced in April 2023 and was completed in March 2024. It should be noted that data collection in Bromley commenced in August 2023, and in January 2024 in Glasgow. The aim of this phase was to investigate the feasibility of a definitive randomised controlled trial (RCT) of IPS compared with services as usual (SAU), and of the planned study procedures for a future definitive RCT to evaluate the intervention's clinical efficacy and cost-effectiveness. The main objective was to assess if enough families could be recruited and retained such that a full-scale RCT is likely to be possible. The secondary objectives are to assess the acceptability and feasibility of both the planned outcome measures for a definitive RCT and the IPS intervention to families and professionals. An intervention like IPS, that uses a relationship-focused approach to child and parent mental health, neurodevelopmental and money/housing problems, has never previously been tested. Therefore, there are several areas of uncertainty that need to be addressed before moving onto a definitive RCT. The information collected here will be used to inform a decision on whether a full randomised controlled trial is warranted and achievable.

The detailed protocol paper describing this study is currently under review by Pilot and Feasibility Studies (Pownall et al., in preparation; see Appendix B) and is also published on the WWCSC website.[2]

Research questions

Our primary research question for the second phase was:

- Can we test the feasibility of an RCT of IPS compared with services as usual? Specifically:
    - Can 30 eligible families be recruited and retained across Bromley and Glasgow, such that a full-scale RCT is likely to be feasible?

Our secondary research questions were:

- How acceptable and feasible are planned outcome measures and study procedures for a definitive RCT trial to parents and professionals?
- How acceptable and feasible is the IPS intervention to parents and professionals?

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[2] See: https://whatworks-csc.org.uk/research-project/partnership-for-change/#:~:text=Partnership%20for%20Change%20is%20an,child%20has%20a%20social%20worker

METHODS

Protocol registration and ethical review

Trial registration

Registered in ClinicalTrials.gov Identifier: NCT06003582. Co-production and Feasibility RCT of Intervention to Improve the Mental Health of Children with a Social Worker. Registered 22/08/2023. See: https://classic.clinicaltrials.gov/ct2/show/NCT06003582

Ethical review

Ethical approval was granted by the College of Medical, Veterinary and Life Sciences Ethics Committee for Non-Clinical Research Involving Human Subjects, University of Glasgow (Ref. 200220080). Informed consent was obtained from all participants. Participants were able to withdraw from the study at any point without giving a reason; however, any reasons were recorded and monitored. Participants were consented to the trial by research staff prior to all data collection and we sought permission to link to their routine health and social care data.

Research design

The study settings were social care services in the local authorities feeding into the two trial sites: Glasgow City Council (Scotland) and the London Borough of Bromley (England). Although each site is in the UK, the social services and legal contexts in each differ considerably. With regards to levels of deprivation, Bromley is a relatively small borough and relatively prosperous. Nonetheless, there are pockets of deprivation particularly in the north-east and north-west of the borough.[3] Glasgow City council is one of the largest local authorities in the UK. Although it does cover prosperous areas there are extensive areas of multiple deprivation (Scottish Government, 2020a).

Phase 1: Co-production of Infant Parent Support (IPS)

Mapping and modelling of services

Early in the intervention development process, in-depth interviews and focus groups were carried out with numerous stakeholders, including parents with lived experience of child and family social

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[3] See: https://www.bromley.gov.uk/downloads/file/1387/demography-jsna-update-chapter-2021#:~:text=North%20West%20and%20North%20East,Bromley%20have%20much%20lower%20levels.&text=The%20population%20of%20Bromley%20perform,for%20both%20males%20and%20females

work, health and social care workers, and key policy leaders (Dalgarno et al., 2023; see Appendix A). The focus of this work was to gain a greater understanding of infant and parent journeys through services when social work services become involved, to map the landscape of statutory and voluntary sector services, to optimise the new intervention's usefulness for families, and to create new multi-agency partnerships.

Intervention co-production

The IPS intervention was developed through working closely with service users and multi-agency professionals. Two groups of parent collaborators (PCs), one in Bromley and one in Glasgow, were formed with five parents with experience of child and family social work in each. These groups were led by our coinvestigator and lived experience lead. Twenty-two multi-agency professionals including researchers, social workers, social work managers, members of the existing IFTs (comprised of clinical psychologists, child and adolescent psychiatrists, social work, and family liaison workers, all with special interests and direct experience of working with Infant Mental Health) were involved in the intervention development. Initially, it was anticipated that the Parent Collaborators would host small, fortnightly workshops and invite members of the wider Intervention Co-production Team to explore and discuss each aspect of the intervention in turn. However, owing to the part-time hours of the lived experience lead and the need for the entire IFT teams to understand the change required to develop IPS from IFT, this was not possible. Therefore, a significant development that occurred during the early phases of the research was the formation of three working groups (see Figure 2) at which PCs and professionals worked together to refine IPS.

These groups were invaluable in making sure the voice of lived experience remained at the core of our work and decision-making. Groups met approximately fortnightly to explore and discuss each aspect of the intervention in turn. There were also four hybrid development days in Glasgow and London where all stakeholders came together to share ideas, learn, and shape the future of the trial and intervention. One of the first tasks was for intervention team members (Infant Parent Support team) to become familiar with our draft Logic Model (see Figure 3) and to work with the project team to challenge and refine it.

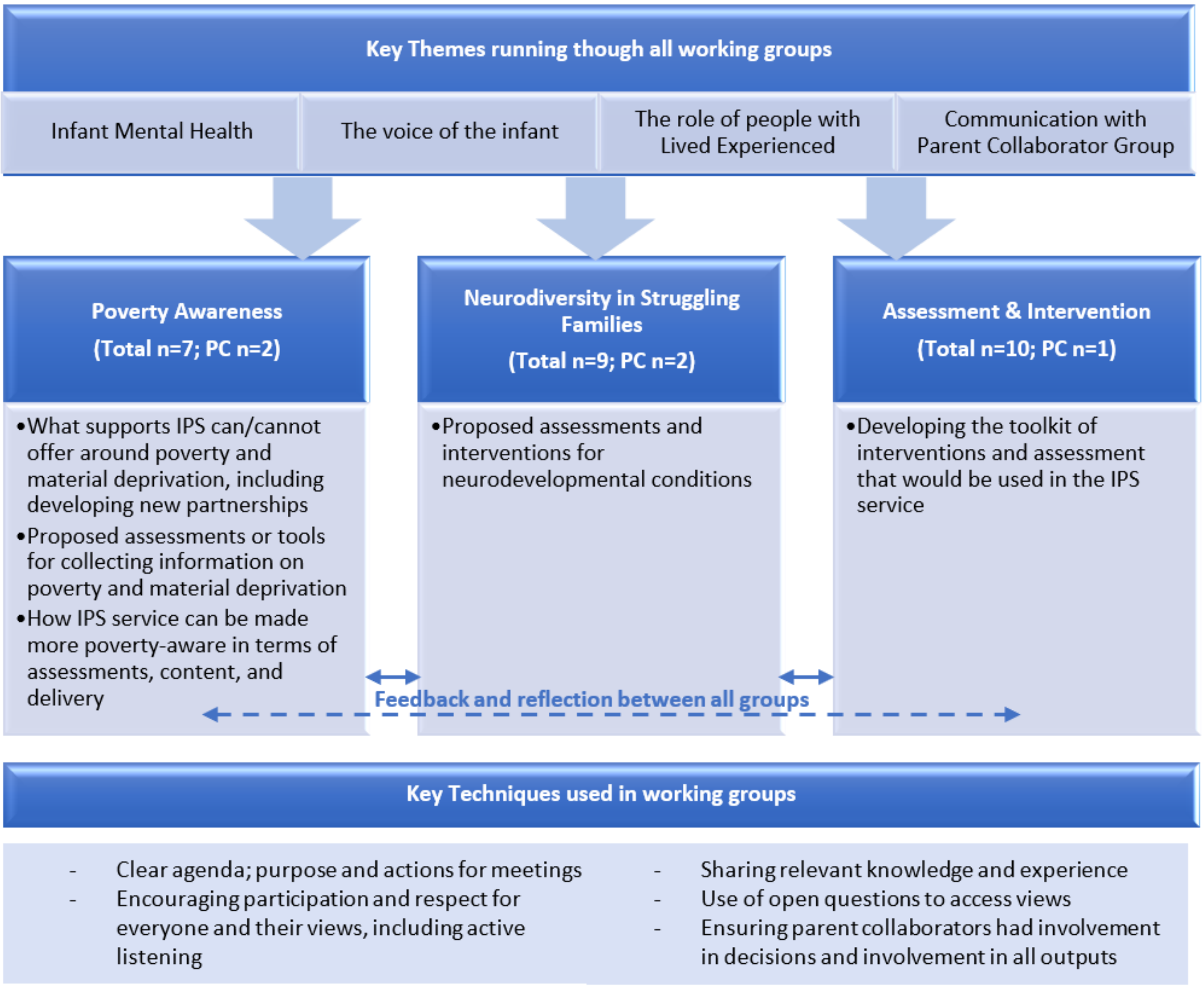
Parent-reported outcome measure (PREM) and parent-reported experience measure (PROM)

The aim was to develop a parent reported outcome and experience measure with families whose children have experience of engaging with social work that could be used to in the feasibility RCT. A series of focus groups were used to collect data on issues that families perceive to be important as they navigate child and family services, and this information was used to develop a prototype measure that would be used in the feasibility RCT.

Phase 2: Feasibility RCT

The aim was to randomise 30 participants: 15 to receive IPS and 15 to receive SAU across the two sites. Participants were stratified by site (Bromley or Glasgow) and then randomised within site to either IPS or SAU (1:1) via computer-generated randomisation through www.graphpad.com. The study was single blind. Participants and providers were aware of treatment allocation, whereas the researchers who carried out the baseline and follow-up assessments were not.

Figure 2: Working Group composition and terms of reference (go to accessibility text)



- What supports IPS can/cannot offer around poverty and material deprivation, including developing new partnerships
- Proposed assessments or tools for collecting information on poverty and material deprivation
- How IPS service can be made more poverty-aware in terms of assessments, content, and delivery

- Proposed assessments and interventions for neurodevelopmental conditions

- Developing the toolkit of interventions and assessment that would be used in the IPS service

- Clear agenda; purpose and actions for meetings
- Encouraging participation and respect for everyone and their views, including active listening
- Sharing relevant knowledge and experience
- Use of open questions to access views
- Ensuring parent collaborators had involvement in decisions and involvement in all outputs

Sample recruitment and selection criteria

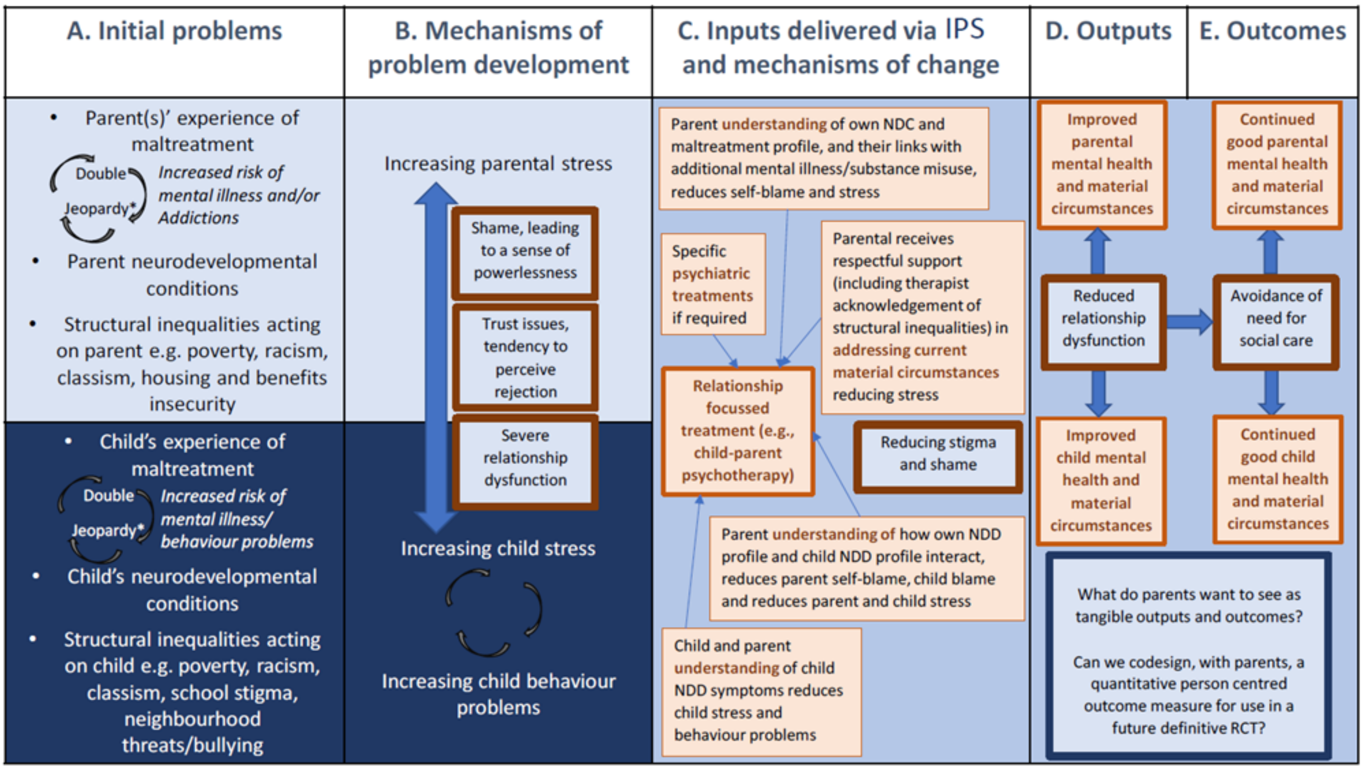
Phase 1: Parent collaborators involved in co-producing IPS

The opportunity to work on our project was advertised through a mixture of leafleting of community organisations in Glasgow/Bromley and social media posts. Interested Parents were invited to a one-to-one interview with the lived experience lead to discuss the project. The lived experience lead was involved in the study due to their personal and professional experiences of supporting parents on their journeys to recovery. The interview helped to establish that parents were in a position practically and in relation to their wellbeing and resilience to participate, and to identify whether additional support would be required to be involved (e.g. IT equipment).

Ten participants consented to be involved, five at each site. Five parent collaborators (3 in Bromley and 2 in Glasgow) were retained for the duration of phase 1. Every effort was made to reach both male and female parents and a range of ethnic groups; however, the parents who agreed to take part were all white and female.

Parent collaborators were parents who, at some time in their life, have had a child who had a social worker, they had experienced a range of difficulties that have resulted in their child or children having a social worker, including addictions, adult mental health problems, or neurodevelopmental conditions in an adult or child in the family. All had experienced poverty.

Figure 3: The Logic Model, IPS (go to accessibility text)



Note: *See Gajwani and Minnis (2023)

Phase 2: Families in the feasibility RCT

With regard to the feasibility RCT, our target population was children in need (or the Scottish equivalent); that is, "a child who is unlikely to reach or maintain a satisfactory level of health or development, or their health or development will be significantly impaired without the provision of children's social care services" (HM Government, 2023).

Eligible participants are families in the Glasgow or London trial sites where:

- The infant(s) are aged 0–5 years (having additional children aged above 5 will not exclude the family from participating)
- The family has an allocated social worker plus a multi-agency support plan (e.g. child and adolescent mental health services, paediatrics, or educational psychology, and where an infant and/or parent has a mental health problem or neurodevelopmental condition).

Potential participants were excluded from the study:

- If the infant has a Child Protection Plan (CPP) or is on the Child Protection Register (CPR)
- If the family is in the process of 'stepping down' from a CPP or CPR
- If the infant is currently engaged in therapeutic work
- For parent participants who are currently accessing addiction and/or mental health services, cases will be examined on an individual basis.

The trial recruitment co-ordinators (RCs) worked with organisations to identify the target population, facilitate referrals to the study, and screen for eligibility. Potential participants could be identified by social workers (and other support services via a social worker) who conducted the initial eligibility assessment and provided families with the study participant information leaflet explaining the study, its intent, and what participation would entail. With the family's consent, their details were passed on to the RCs who talked to the interested families to further discuss the study, answer any questions, and, if proceeding, go through the informed written consent process. Consent to access routinely collected health and social work data about the child and parent for future research was also sought.

The research nurse contacted consenting families and invited them for baseline research assessments. Participants were then stratified by site (Bromley or Glasgow) and then randomised within site to either IPS or SAU (1:1) via computer-generated randomisation through www.graphpad.com. Families were given the option of assessments taking place remotely or face-to-face. After randomisation, the RC passed the referral information to the IPS Team Managers, and the IPS Family Engagement Worker contacted the family to commence assessments. In both arms of the trial the RC informed the family and SW of randomisation outcome. For the process evaluation, all parents taking part in the study were invited to participate in a semi-structured interview following completion of baseline and follow-up assessments. Study procedures are summarised in Table 1.

Data collection

Phase 1: Co-production of Infant Parent Support (IPS)

Mapping and modelling of services

Intensive mapping and modelling were achieved through conducting in-depth interviews (n=15) and focus groups (n=5) with stakeholders from health and social care services, including parent collaborators (see Appendix A for further detail).

Intervention co-production

Twenty-four members of the Partnership for Change team were interviewed about their experiences of co-producing IPS. This included parent collaborators, members of the GIFT and LIFT teams and managers (clinical psychologists, child and adolescent psychiatrists, social work, and family liaison workers), the research team and trial manager, partnerships development and partnership service manager, and partnerships and development director NSPCC.

Parent-reported outcome (PROM) and experience measure (PREM)

For the development of the PROM and PREM, two focus groups were conducted with six parent collaborators. The first focus group explored issues that parents face as they navigate services, the outcomes and changes they would like to see for their families, and how they would like to be treated by services. Parents' perspectives on how best to capture these outcomes and experiences in a measurement tool were also elicited. Following this, a prototype measure was developed by the research team. This was presented to the parent collaborators at a second focus group, where the content of the measure and issues relating to the format and design were discussed and the measure was refined (Appendix F).

We aimed to pilot the PROM and PREM during phase 2 to explore its acceptability and feasibility. It is our intention to further refine and explore the psychometric properties of these measures at a later timepoint.

Phase 2: Feasibility RCT

Data collected was focused on the acceptability and feasibility of both the proposed evaluation methodology and the intervention itself. This was predominantly examined through a detailed process evaluation (qualitative data), although quantitative data regarding assessment completion rates and missing data also supported our analysis.

The following outcome measures were administered to families at pre-randomisation and 3-to-6 months follow-up to determine the feasibility and acceptability of their inclusion for a definitive trial. These measures were selected through our review of the literature and some are being used in ongoing RCTs in similar populations (BeST[?], Barlow et al., 2019). We also explored the feasibility and acceptability of a bespoke service use questionnaires, data collection forms and health related quality of life (HRQoL) measures, that will be used to inform the future cost-effectiveness of IPS versus SAU. Study procedures are summarised in Table 1.

- Infant Mental Health (all parent report):
    - Brief Child Abuse Potential Inventory (BCAPI; [Ondersma et al., 2005]), measures risk of child maltreatment. To be completed for all children. We had originally planned to use the RADA (Reactive Attachment Disorder and Disinhibited Social Engagement Disorder Assessment). However, during co-production, parent collaborators and participants felt it asked questions that were not relevant to their situation. Consequently, it was replaced with the BCAPI.
    - Strengths and Difficulties Questionnaire (SDQ[4]) to be completed for children aged 2 and over, according to age of child (versions available for 2–4 years, 4–17 years).
    - Infant-Toddler Socio-emotional Assessment (ITSEA [Carter & Briggs-Gowan, 2000]) to be completed for children aged 2 and under.
    - The Paediatric Quality of Life Inventory (PedsQL [Varni et al., 2003]), which assesses health-related quality of life and, depending upon the child's age (versions available for 1–12 months, 13–24 months, 2–4 years, 5–7 years).
- Parental mental health:
    - General Health Questionnaire (GHQ-12 [Goldberg & Williams, 1988]) which is a well-validated measure of non-specific psychological distress.
    - ICEpop CAPability measure for Adults (ICECAP-A, [Al-Janabi et al., 2012]) collects data on five attributes: stability, attachment, autonomy, achievement, and enjoyment, which can take four levels from full capability to no capability. The ICECAP-A approach is based on Sen's capability (Flynn et al., 2015) approach and aims to measure a person's ability to achieve important 'functionings', incorporating health and non-health dimensions.
- *Parent-Reported Outcome Measure and Parent-Reported Experience Measure:* to capture outcomes and experiences that are salient to participating families when engaging with social care.
- *Demographics and Service Use Questionnaire:* A parent self-report questionnaire on service use has been developed to capture background demographic and socioeconomic information as well as use of health, education, and social care services both within IPS and SAU arms.
- *Data capture on resource use for service/intervention delivery for each arm:* A service as usual data collection tool, adapted from the BeST? Trial, to be completed by social workers. This was designed to capture information on date, nature of the contact, duration, attendees, and referral to outside services for participants receiving services as usual. For the IPS arm, data collection for the intervention arm: we aimed to use the National Society

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[4] See: https://www.sdqinfo.org/

for the Prevention of Cruelty to Children (NSPCC)'s data collection automated system to understand resource use for participants receiving the IPS intervention. However, due to a delay in approval of the data sharing agreement we were not able to access collected data at the time of writing the report.

Process evaluation

A detailed process evaluation ran parallel to the entire project (Figure 1) including the co-production and intervention development stages as outlined above, following the Medical Research (MRC) process evaluation framework for Complex Interventions which emphasises the importance of considering interactions between implementation, mechanisms, and context (Moore, 2015). This enabled a rich understanding of participating families and key stakeholders' views regarding acceptability and feasibility of the proposed evaluation measures, as well as capturing issues around the implementation of IPS as they unfold within the current context. The number and frequency of interviews and focus groups conducted as part of the process evaluation are show in Table 3 (see the Key Findings section).

Table 1: Study procedures

Activity / Assessment	Staff member	Initial referral	Prestudy screening/ consent	Prestudy baseline assessment	Randomisation	Follow-up 3/6 months postbaseline
Eligibility Assessment	SW	✓				
Participant Information Sheet	RC		✓			
Consent	RC		✓			
Privacy Notice	RC		✓			
Randomisation	TM				✓	
Infant-based measures						
b-CAPI *To be completed for all children*	RN			✓		✓
SDQ *To be completed for children aged 2 and*	RN			✓		✓

over, according to age of child: 2-4y, 4-17y						
ITSEA *To be completed for children aged 2 and under*	RN			✓		✓
PEDs-QL *To be completed for all children, according to age of child: 1-12 m, 13-24m, 2-4y, 5-7y*	RN			✓		✓
Parent-based measures						
Demographic and Service Use Questionnaire	RN			✓		✓
GHQ-12	RN			✓		✓
ICECAP-A	RN			✓		✓
PREM	RA/FEW			✓		✓
PROM	RA/FEW			✓		✓
Parent Qualitative interview	RA			✓		✓
Professional-based measures						
Professional Focus group	RA					✓(+ as required)
Parent Collaborator Focus group / interview	RA					✓(+ as required)

Key: **SW** (Social worker); **RC** (recruitment co-ordinator), **TM** (trial manager); **RN** (research nurse); **RA** (research associate); **FEW** (family engagement worker); **b-CAP** (Brief Child Abuse Potential Inventory, b-CAP), **SDQ** (Strengths and Difficulties Questionnaire); **ITSEA** (Infant-Toddler Social & Emotional Assessment); **PEDs-QL** (Paediatric Quality of Life Inventory); **GHQ-12** (General Health Questionnaire); **ICECAP-A** (ICEpop CAPability measure for Adults); **PROM** (parent-reported outcome measure); **PREM** (parent-reported experience measure).

Parents

All parents taking part in the study (IPS or SAU) were invited to participate in up to two semi-structured interviews. The first interview took place soon after baseline and explored parent's experience of, and access to, mental health services and expectations of participating in the research, including their experience and understanding of the randomisation and consent process, suitability of the assessments and practical aspects of participating in the research. Nine parents, of whom were all mothers, completed individual interviews (see Table 3).

At follow-up at 3 to 6 months, all parents were asked to take part in a second interview, centring around their engagement with the research process, as well as the acceptability and feasibility of the planned outcome measures and the IPS intervention/SAU. To date, one interview has been completed. Individual one-to-one interviews are the preferred method of data collection given the potential sensitivity of topics raised and the need for flexibility. Participants received a voucher for taking part in research interviews.

IPS and SAU practitioners

Focus groups and interviews were conducted with each of the teams delivering IPS across both sites, including Family Engagement Workers focusing on the perceived changes in the organisation, access to, and quality of services. Practitioners were encouraged to explore referral pathways into IPS or other services within SAU, the perceived acceptability of intervention components, including any drivers and barriers to successful implementation (from their own or the families' perspective), how it fits within the local context, highlighting potential differences across settings, as well as perceptions of the research process itself. The data presented below refers to the early stages of IPS implementation and will be supplemented with further data as it is collected and analysed during the bridging phase.

Data management, processing, and analysis

Quantitative data

All instruments were uploaded into the Qualtrics platform for online surveys[5] and administered by an experienced research nurse. The SPSS software for Windows (version 28) was used to perform the data analysis. Descriptive statistics were used to report frequencies and percentages relating to

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[5] See: www.qualtrics.com

participant recruitment, eligibility, and randomisation, as well as questionnaire completion rates, errors, and missing data from questionnaires.

In addition, while pilot studies would usually evaluate outcomes for sample size calculations for a definitive RCT, we did not call this study a pilot study because we did not intend to use it for the purposes of sample size calculation. Such calculations are already available for our principle outcome from previous studies with similar samples. Our sample is too small for such analyses to be meaningful.

Qualitative data

Data was audio-recorded, transcribed, anonymised, and analysed using the qualitative data management software NVivo 12 (QSR International, Warrington, UK). Focus groups and interviews were semi-structured, guided by pre-developed topic guides and using open-ended questioning. Data was analysed thematically following Braun and Clarke's steps which include independent reading of transcripts to develop a coding frame, review and naming of codes, and development and reporting of key themes (Braun & Clark, 2006). This is an iterative process and is continually reviewed and agreed upon as the research progresses to ensure that it continues to meet research needs.

Both quantitative and qualitative data collected was kept securely and separate from any individual participant identifiers. Participants were assigned a unique ID number to link their data throughout the trial.

KEY FINDINGS

Key findings are discussed below in relation to phase 1 and 2 separately. It should be highlighted that the data presented in this report refers to the early stages of IPS implementation that took place between April 2022 and March 2024, funded by WWCSC. As such, this is a preliminary report of our early findings and work will continue separately as we continue to build on our co-production work, feasibility RCT, and mapping of local service landscapes, to inform a randomised controlled trial (RCT) of Infant Parent Support (IPS).

Phase 1: Co-production of Infant Parent Support (IPS)

Mapping and modelling of services

Findings from the mapping of service contexts are discussed in detail in Appendix A with some key findings highlighted below. Our work has shown how services as usual are often complex and fragmented, involving health, social care, and third sector, where:

- Child *or* parent needs only are considered and do not usually support families in a holistic way. Parents can be left isolated with a range of unmet needs which can contribute to escalating problems. Services do not always have the scope or flexibility to consider people's parenting needs within the contexts of service design and delivery.
- Service providers are not always cognisant of practical barriers to attending services such as money to travel, ability to travel to appointments, lack of childcare, centralised rather than locally situated services, parental commitments such as school runs, inappropriate appointment times, multiple appointments with multiple services clashing (e.g. D&A services, SW meetings, etc.).
- Drug and Alcohol, AMH and SW services approach to working in silos exacerbates problems for people who use substances to self-medicate to cope with personal traumas, stresses and adversities.
- Practitioners working directly with children recognise that there are gaps where children under 5 may not be visible to any service or support (e.g. not engaging with HV services, not engaged with nurseries).
- Social work thresholds are high, with parent/child's access points more likely to be at a point of crisis rather than at levels where preventive support would be more appropriate. Similarly, health visitors reported cases of parents and families that may not yet have reached crisis but who are facing a range of adversities continue to be 'held' by stretched HV services.
- When families do access services common denominators to service access/input included multiple vulnerabilities and adversities. These are often material, financial, and psychological. The impacts of trauma (ACEs, Domestic Violence, and multi-generational

trauma and NDCs), poverty (lack of money, poor housing, and being situated in areas of multiple deprivation), and social isolation (lack of support, no partner, and asylum-seeking families) are key indicators to people encountering services or not.

- Psychological stressors for parents can heighten a felt need to remain invisible as fear can override any perceived benefit to involvement. SW involvement with families is particularly stressful for parents. Stigma and fear are key themes that practitioners and parent collaborators identify for parents (see also Appendix C for preliminary data from the process evaluation around families' experiences of social care services).

In relation to our research question regarding expanding the project to include new partners we plan to hold expression of interest events, particularly for London Boroughs, to explore interest from other sites that can be delivered from the resource we have in NSPCC, Camden. In addition to this we are keen to explore sites outside of London, subject to additional funding.

We have kept all of the boroughs who previously participated in the BeST? trial informed about this project through the steering group they all attended, and we are exploring whether Southwark and Lambeth may be suitable.

Co-production of Infant Parent Support (IPS) intervention

Formation of the IPS teams and the introduction of Family Engagement Worker and Family Engagement leads

IPS are multi-disciplinary infant mental health teams operating to the NSPCC's (National Society for the Prevention of Cruelty to Children) safeguarding and equality and diversity policies, with local authorities retaining ultimate safeguarding responsibility subject to Scottish (Scottish Government, 2020b)/English (HM Government, 2023) requirements. Like the IFTs already operating in Glasgow and London, the IPS teams use evidence-based relationship-focused interventions (up to four months) of the kind shown to reduce child abuse risk/increase parental sensitivity (Baggett et al., 2017; Rosenblum et al., 2020). This will ensure families receive a bespoke relationship-focused intervention that aims to be tailored to their unique needs.

However, our early co-production work highlighted the need for a lived experience workforce to help bridge the gap between IPS and the families that use the intervention. As a result, the IPS teams was modified to include one Family Engagement Worker (FEW) and a Family Engagement lead. The Family Engagement Worker, informed by their own experiences of working with services, works alongside families as they are recruited into the study, discussing the intervention, arranging appointments (which could include preference for home visit or office appointments, transport/childcare needs, and identifying any learning, language, or cultural needs). The FEW role has focused on supporting the practitioner undertaking the assessment and helping to build communication and relationships between practitioners and families and consequently, removing barriers to engagement. The lived experience lead ensures FEWs are fully supported to deliver safe, quality interventions with families within the wider team, and ensuring that decisions and practices are informed by lived experience at all levels. Their role is to recognise and consciously work to remove barriers for the lived experience workforce, including practical constraints, attitudes/workplace culture, and bureaucratic processes that restrict effective and authentic lived experience work.

Consequently, within IPS, FEWs (see also Appendix E) have expertise-by-experience of having a child in need, other IPS practitioners have expertise-by-training and working in social work, psychology, or psychiatry, and some have both types of expertise.

Co-production: points to celebrate

All the stakeholders interviewed gave clear examples of benefits of working in partnership with parent collaborators and the conviction with which they discussed these far outweighed the challenges. This spanned from tangible impacts, such as influencing the research design, shaping both the research and intervention tools, assessments, and service/intervention information sheets, changes to practice such as home visits and local appointments, to establishing new roles within the workforce (the FEW and FEW lead). In addition, participants reported personal growth and change, as well as embedding the voice of lived experience in wider areas of their work.

One example of developing new tools was the addition of the Social Needs Questionnaire (SNQ) for use during the IPS formulation phase. The SNQ assesses families' personal, social, and financial needs, allowing the identification of supports required, as well as facilitating access to these supports.

A key output from the neurodiversity working group was the development of resources to support families during their involvement in the project, such as providing information on NDC, signposting to other sources of support, and developing a glossary of clinical terms that may be unfamiliar to families. There was on a strong focus on making this information accessible, in terms of font, colours, layout, and so forth.

The working groups ensured that a poverty-aware approach was embedded in all aspects of the assessment and intervention. Some of the developments included: the early identification of support needs and how they may impact upon the family's engagement throughout, offering practical support in accessing help from other organisations and agencies, basic provisions being available to all families (food/drink and practical items, e.g. nappies and sanitary wear), careful consideration of other costs arising from participating in the study, and offering choice in assessment locations and arrangements so the intervention fitted with their work and lifestyle patterns. Although our logic model specified a strong focus on poverty and neurodiversity, our co-production work confirmed its importance.

Areas for improvement

Although there were numerous tangible impacts from the co-production work, for some participants this felt like the tip of the iceberg and more needed to be done if we were going to achieve genuine co-production. Some of the key challenges are discussed below.

Timeline

For genuine co-production to be meaningful the process takes more time than was factored in initially. We had estimated the co-production would take approximately six months. However, there were numerous delays relating to recruitment and ethics approval that this extended to 12 months. This included research team recruitment; parent collaborator recruitment, involvement, and needs; multiple stakeholder involvement across services; meeting coordination; the need to reduce power imbalances where possible, and the inception and setting up of a number of specific IPS intervention design working groups. Extending original timelines led to feelings of frustration within teams.

Shared visions, goals, and expectations

Setting clear expectations of the project's goals, establishing individuals' role and responsibilities within the project was critical and more time was needed for developing relationships across multidisciplinary teams. With the various levels and types of engagement, it was perhaps inevitable for conflict to arise. For example, participants described challenges around power sharing and joint ownership of the project, and the negotiation of different attitudes and beliefs. When conflict was not addressed and dealt with, the outcome was feelings of upset and frustration.

At times there were disparate views on the conceptualisation of co-production. Establishing common values and aspirations for the project was sometimes challenging as it involved the formation of a large multidisciplinary team, including academia, practitioners, and parent collaborators. Participants discussed a need for more training around co-producing interventions much earlier in the project's development.

IFT are accustomed to working with families whose child is on a child protection plan and with families often in crisis, this necessitates thinking in terms of high-risk and safeguarding. Consequently, delivering the new intervention IPS required a shift in focus from a child protection risk management perspective to one that strives to promote and increase client/parent autonomy in IPS. At times this was challenging, with practitioners' concerns that the parent's needs could overshadow the voice of the child.

Protocol for communications

Participants discussed the need for a protocol for communications to be developed much earlier, including preferred ways of communicating (email, online meetings, face-to-face meetings, use of language and acronyms), expected frequency and timing of communications and meetings, and a shared framework for decision-making and feedback. This was particularly important when working alongside parent collaborators who were coming into what was likely an unfamiliar environment, full of new terminology and ways of working, and equally for professionals who may not have worked alongside people with lived experience previously.

Ethics committees and funding boards

Uncertainty is inherent in co-production, and it is not always possible to predict what direction the research will take or anticipate all costs and benefits. This can create difficulties for ethics committees and funding boards, with their heavy focus on risk avoidance. Delays contributed to lengthening timescales. Researchers described how the need to obtain ethical approval prior to eliciting parent collaborator involvement in the early stages of the project hindered genuine co-production. Parent collaborators were essential to informing the logic model, identifying research questions, shaping the research design and overall direction of the project. However, the way that research systems are set up fuel power inequalities; PCs were not viewed as professionals and therefore not full members of the research team, resulting in additional barriers to their participation being imposed.

Practitioner to parent collaborator ratio

A challenge that was raised unanimously by participants was the low number of PCs involved in the project, creating a high practitioner to parent collaborator ratio. The low numbers of PCs in part contributed towards their lack of voice, predominantly at the start of the project when the lived experience lead reported they found it intimidating to speak out, particularly in settings where teams and ways of working were already established. There were also imbalances in the composition of other teams, with both the parent collaborators and research teams being fewer in numbers than NSPCC and IPS. This meant at times discussions were felt to be dominated by certain groups.

Barriers to parent collaborator engagement

Participants' views around what prevented PC engagement and prompted drop-out centred around meeting times (such as conflicting with employment, school drop off/pickups), childcare commitments, accessibility of meetings, and travel. In addition, collaborators may have additional challenges that necessitate the team thinking more carefully about how to keep them involved. Parent collaborators themselves appreciated the flexibility and support offered to sustain their involvement and all referred to their own learning and personal growth which had taken place as a result. The direct, 1 to 1 and group support provided by the parent collaborator lead throughout was reported to be the key reason for this outcome.

Reciprocity

'Reciprocity' is central to genuine co-production (SCIE) and reflects the idea that people are rewarded for their input. This does not just relate to financial reimbursement, but also to parent collaborators feeling that they are valued and that they are making a real difference. Participants raised concerns that there wasn't a shared framework for decision-making and feedback to allow all stakeholders to be kept up to date with actions and outcomes, in particular parent collaborators, to avoid it feeling tokenistic. This was in part a result of the number of people involved in the project and the number of meetings taking place.

It was perceived that there were power imbalances in how the project was set up in the first place, with several participants questioning the ethics of asking people to contribute to the project and not employing them. Not being salaried employees created ambiguity around job parameters, such as contactable hours and levels of support/supervision.

Inclusiveness and representativeness

There was some concern among participants that the co-production work was not inclusive or representative of the target population, which could serve to further increase inequalities. All parent collaborators were white females, and it would have been beneficial to draw on a broad range of people who represent different communities, as well as being diverse in terms of gender, age, disability, and socioeconomic status. One participant stated that we need to be more proactive if we are to avoid reinforcing existing inequalities and marginalisation.

Parent-reported outcome measure (PREM) and parent-reported experience measure (PROM)

We successfully developed a parent-reported outcome measure (PROM) to assess the lived experiences of families accessing social care services, and capturing their perspectives on aspects of their lives that are important to them and help to capture any changes resulting from IPS. We have also developed a parent-reported experience measures (PREMs), which assesses participants' experiences of using services (Appendix F).

Phase 2: Feasibility RCT

The findings from phase 2 are divided into three main sections: Section 1 addresses the primary research question of recruitment and retention; Section 2 addresses the secondary research question regarding the acceptability and feasibility of outcome measures; and Section 3 addresses the secondary research question regarding the acceptability and feasibility of the IPS intervention. For all sections, findings are subdivided into findings from the quantitative data and qualitative data (process evaluation). Time 1 refers to the baseline assessments, and Time 2 to the 3-to-6-month follow-up assessments.

Section 1: Recruitment and retention

The primary research questions are:

- Can we identify and randomise 30 eligible families across Glasgow and Bromley?
- Can a sufficient proportion of these 30 families be retained in the study for 3 and/or 6 months post-randomisation?

Quantitative data

As can be seen from Table 2 below, we received a high number of initial referrals into the trial from social work: 108 in Bromley and 23 in Glasgow, despite the Glasgow site only joining the study in

January 2024 (owing to a lengthy delay in getting the Data Sharing Agreement; see Limitations section). Out of these families, 59 (56 in Bromley and 3 in Glasgow) were not progressed any further as they did not fit the study inclusion criteria. In addition, for 44 of the families (30 in Bromley and 14 in Glasgow), further information was required from the social worker before eligibility could be confirmed, but this information wasn't received at the time of writing this report.

Of the remaining families that were deemed eligible for the study, nine parents declined to participate (five in Bromley and four in Glasgow). This left 19 families, 17 in Bromley and 2 in Glasgow, who were randomised into the trial.

In total, we were able to recruit 63% of our target of 30 families. Seven families were randomised to IPS (all in our Bromley site).

Table 2: Summary of referrals and randomisation into the trial

	Referrals	Randomised	IPS	SAU	Withdrawn
Bromley	108	17	7	10	
Glasgow	23	2	0	2	1 (SAU)
Total	131	19	7	12	

As of April 2024, IPS is actively working with three of the families (discussed further in the section 'Withdrawal of families from IPS'), all of whom are based in Bromley. This was not attrition; these participants have not left the trial but, owing to complexities within the families, the intervention has had to be paused. Although this means that at the time of writing this report families were not as far along in the intervention as anticipated, this has helped develop understanding of which families are likely to benefit from IPS the most (See 'Research recommendations and next steps')

It should be noted that not all these families have completed their 3-to-6-month follow-up assessments. Glasgow only started assessments in January 2024, meaning follow-up assessments are not due until after the writing of this report.

Table 3: Process evaluation: Data collection methods, participants, and frequencies

Participant	Stage in trial (n)	Method	Number	Site[2]
Parents	Baseline	Interview	9	Both
	Post-intervention[1]	Interview	1	Bromley

IPS Practitioners /Managers	Assessment/formulation	Interview Focus group	9 1	Both Bromley
	Post-intervention	Interview	2	Bromley
Research Team	Baseline / early stages	Interview	2	Both
[1] Completed at of 3 to 6 months follow-up; [2] Researcher is blinded to trial arm.				

Qualitative data

Interviews with IPS Practitioners and research co-ordinator

In-depth interviews were conducted with IPS practitioners and the research co-ordinator to explore any challenges around referral and randomisation into the trial.

Identifying suitable families

Reasons for exclusion with the trial included: families declined to consent; they did not meet inclusion criteria due to age; risk of escalation to child protection; complexities in the families and its impact on their capacity to engage with therapeutic work *(including housing issues, number of services already involved [e.g. Drug and Alcohol Servies] which meant families were highly stressed and overwhelmed);* multiple children *(impact on consent/engaging)*; parental learning disability (*parent couldn't consent and fear removing child, frustrated not getting help).* In addition, older mums were more likely to be interested in participating in the study.

Central to the success of this process was employing experienced social work-trained Recruitment Co-ordinators, who could ask the right questions about potential families and understand their position in the process. In Bromley, the Recruitment Co-ordinator had previously worked in the area team so was able to build professional relationships to obtain referrals.

Challenges of identifying families

There were several challenges in identifying suitable families. Succeeding in getting the social worker to discuss the study with potential families and agree to the research team contacting them caused huge delays. High workloads and competing demands of social care services may mean that identifying families for the trial was a low priority. Understandably the RC was concerned that this meant we were missing or might lose potential families:

> "If I push the social workers too much because they're so busy they would just be like, okay fine, they're not interested." (Recruitment co-ordinator)

Similarly, there were challenges obtaining thorough information from the local authority at the point of randomisation to facilitate IPS to make assessment of eligibility for therapeutic work.

As researchers and practitioners began to sift through potential families referred into the trial, it became apparent that cases were much more complex than anticipated. Families were large and had long-standing involvement with children's services, although they were still on a child in need plan and had not become involved in formal child protection proceedings. This brought with it high levels of complexity and ongoing child protection issues/investigations, for example "deeply entrenched domestic abuse", "deep-rooted and high levels of (maternal) mental health need". This had a huge impact upon how IPS was able to work. This is discussed further in section 3 ('Complexity of cases').

> "Striking features so far are the families coming through about the level of complexity, and also the, um ... big themes in relation to child protection issues and active child protection investigations." (IPS Practitioner)

Place-specific thresholds of need

In part, the level of complexity of referred families was a result of the changing service landscapes in Bromley and a need to understand place-specific thresholds of need. As families have not yet been seen by IPS in Glasgow, we cannot comment in detail on place-specific thresholds yet, but similar challenges in identifying families with the right level of need to benefit from IPS are also emerging in Glasgow.

There were suggestions that child in need thresholds (the point at which the local authority's Children's Social Care are likely to accept a referral for a child) are high. This means children in need may be closer to needing child protection than expected and may be reflected in the level of complexity seen with referred families. This has implications for thinking about how we approach recruitment in the definitive trial (see Figure 4).

Sharing information between LA and IPS

Practitioners discussed how at times there was a misfit between the information provided when initially identifying families and at the point of entry into the study, resulting in families being referred in who were not appropriate. This could arise because information was not being adequately shared, was outdated, or the family's situation had changed from when referral to IPS was first completed. There was also a feeling that services may be 'tight lipped' about a family's circumstances in order that they could proceed into the trial and receive the intervention.

> "I do understand also why they have referred the families to us that they have referred to us, because these families have been under social services for a few years, and they're thinking we've done all that we can at our end and maybe this service will add something different." (IPS Practitioner)

On several occasions, the lack of information resulted in IPS identifying child protection concerns. Owing to the time lag in receiving information about families, safeguarding risks may have been addressed, but without knowledge of this IPS were required to follow it up as part of the NSPCC safeguarding procedures. An added complexity to this is the understandable reluctance of LAs to share information about families where IPS was not able to work with these cases within the trial context. Following up on child protection and relevant information had an immense impact upon the timescale of the trial and staff workloads.

Defining and developing the referral criteria was an iterative process between the research team, IPS teams, and local authorities. For instance, there were some uncertainties remaining regarding which families can and cannot be included in the trial. For example, if a case is being escalated to child protection, does this mean that should be excluded from the trial? Or can the processes happen in parallel; that is, recruitment into the study and child protection proceedings? If in conclusion, families are below the threshold of child protection can they enter the trial? These questions will be discussed during the bridging phase to ensure optimal delivery of IPS.

In-depth interviews with participants

In-depth interviews were also conducted with participants to explore their understanding and acceptability of recruitment/randomisation processes, as well as their motivations to engage in the research study. Most participants stated that they had agreed to participate in the research study as there was a chance that they could receive additional support and services that would benefit their families. For some families, this was the main driver as historically they felt social care services had not met their needs. Several participants agreed to participate because they wanted to help other families.

Families demonstrated a good awareness of the overall research procedures and concept of randomisation within the study. Nonetheless, it was clear that there was still some confusion around what IPS or SAU involved and the activities between completing the Time 1 and Time 2 questionnaires. One participant perceived that in both arms of the trial, there would be some intervention over and beyond what social care services were already offering, although one would be more intensive than the other. Another participant was unaware that there were two possible outcomes (IPS or SAU). English was not this parent’s first language.

It also became apparent that participants weren’t clear on what the next steps were in the study following baseline data collection, although this was most notable for participants randomised to SAU. One mum talked about how chaotic life can be, and how having a monthly reminder of the stage she was at in the research study would be useful. Another discussed how emails were confusing and she often deleted or forgot to check.

Participants stated they were content knowing that there was a possibility they would not receive the new intervention (randomised to SAU). However, it should also be noted that these parents also expressed a great deal of hope and enthusiasm for receiving the new intervention and would be disappointed if not randomised to IPS.

Participants reported being satisfied with the consent process and the associated statements they agreed to, for example relating to the anonymity of the data, sharing of data, and the need to access health records.

Two participants discussed having additional needs which impacted their ability to understand and retain information. Both participants described how the research nurse took additional steps to ensure the consent and information form was fully understood.

Section 2: Acceptability and feasibility of outcome measures

Our secondary research question assessed whether the planned outcome measures for a definitive RCT were acceptable (e.g. in terms of content, format, time required) and feasible (e.g. proportion of missing data). It was not the aim of the RCT to report differences between time 1 (T1 = baseline) and time 2 data (T2 = follow-up). In addition, we cannot report on missing data by group allocation (IPS versus SAU) owing to the very small numbers. Nonetheless, this data informs our main objective, which was to assess the acceptability and feasibility of the outcome measures.

Quantitative data

Data is presented here for each planned outcome measure in relation to completion rates and missing data (see Table 1 for a summary of study procedures). Where information is available on mean scores, it is also presented to give context to the sample. Overall, 17 participants completed T1 assessments (IPS n=7; SAU n=10) and seven T2 assessments (IPS n=4; SAU n=3). However, we are still in the process of collecting follow-up data at time of writing this report.

Infant-based measures

Brief Child Abuse Potential Inventory (BCAPI)

The Brief Child Abuse Potential Inventory (BCAPI) is a measure of child abuse potential (Ondersma et al., 2005). It consists of 33 items, 24 of which are summarised in a child risk scale. The rest of the items form validity scales: a three-item Random Response Scale and a six-item Lie Scale.

Owing to the late addition of this measure to the assessment battery (three months into data collection), there were only a small number of questionnaires completed and some participants only completed it at their T2 assessment.

In total, five questionnaires were administered at T1 (IPS n=1; SAU n=4) and five at T2 (IPS n=2; SAU n=2). Participants were different at times 1 and 2.

There were several items on this questionnaire that could not be scored, owing to participants responding '*not sure*' to a target item, rather than '*agree/disagree*' (see also 'Qualitative data'). As a result, three out of the five questionnaires in T1 and T2 could be scored. Therefore, it was apparent that participants found it difficult to answer some of the items. Further piloting work is needed to investigate whether modifications to wording might be needed for this measure.

Of the completed measures, all but one participant scored above the cut-off for the abuse risk scale (scores over 9) in both T1 and T2 data.

Strengths and Difficulties Questionnaire (SDQ)

The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioural screening questionnaire about 2–17-year-olds.[6] The SDQ asks about 25 attributes, some positive and others negative; respondents use a three-point Likert scale to indicate how far each attribute applies to the target child. The 25 items are divided between five scales of five items each, generating scores for emotional symptoms, conduct problems, hyperactivity–inattention, peer problems, and prosocial behaviour; all but the last are summed to generate a total difficulties score (described here). Results for the total difficulties score range from 0 to 40, with higher scores representing more problems.

There were 15 participants who completed the SDQ at baseline assessment. The mean total difficulties score for the SDQ:2–4y was 17 (SD=4.8) and for the SDQ:4–17y the mean was 17.4 (SD=4.7). Participants were therefore scoring 'high' in number of difficulties (threshold for high number of difficulties: 16–18).

At follow-up assessment, six participants completed the SDQ. The mean total difficulties scores for the SDQ:2–4y was 20.3 (SD=5.6) and for the SDQ:4–17y the mean was 15 (SD=0). Younger children were therefore scoring 'very high' in number of difficulties (threshold for very high number of difficulties: 19–40), and children aged 4 years and over were in the 'slightly raised' number of difficulties category (threshold 13–15).

There were no missing values for any of the participants in the baseline or follow-up assessment.

Infant-Toddler Social and Emotional Assessment (ITSEA)

The Infant-Toddler Social and Emotional Assessment (ITSEA; Carter & Briggs-Gowan, 2000) is an empirically validated clinical tool that was developed to assess social-emotional and behaviour problems, and competence delays in children aged of 12–36 months. Only one participant completed this measure, so summary data is not reported. The ITSEA was administered for children aged 12 to 24 months, of whom there were a low number.

As with previous trials (BeST[7]), it was decided to post it to participants, rather than deliver it by telephone like the other measures. Unfortunately, the response rate was low. There were two main reasons for choosing not to administer the ITSEA with other measures:

- The ITSEA has 170 items, each requiring a response from three choices. As the assessment was currently taking on average 40 minutes minimum to complete when the family had **one** child, this was not deemed by the research nurse/team as feasible and would risk losing participants at the 3-to-6-month follow-up.

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[6] See: https://www.sdqinfo.org/

- In addition, having very young children being present when the research nurse phones the family to administer the measures, which was common, would also impact upon participant families to complete the assessment. The lack of success in using ITSEA has made us decide to remove it from the assessment battery in the future and we are currently scoping, alongside parent collaborators, a more suitable measure.

Paediatric Quality of Life Inventory (PedsQL)

PedsQL is a generic instrument to measure health related quality of life (HRQoL) across diverse paediatric populations (Varni et al., 2003). The results for PedsQL range from 0 to 100, with higher scores indicating higher HRQol. Furthermore, PedsQL can be mapped to Child Health Utility-9 Dimensions (CHU9D) utility weights to be used in an economic evaluation (Kelly et al., 2023).

There were n=25 children who had parents complete the PedSQL at baseline assessment and n=9 at follow-up (T2).

Children 0 to 12 months:

Four participants completed the PedsQL at baseline and 1 at follow-up. Due to technical issues with Qualtrics software data for children in the 0 to 12 months age group was not available for analysis.

Children 13 to 24 months:

Four children in the 13 to 24 months age group completed the assessment at baseline and three at follow-up. However, results for one child at baseline could not be calculated as more than 50% of the responses for this child were incomplete. If more than 50% of an answer is missing it should be excluded, thus leaving a sample size of 4 at baseline.

The mean Total Score at baseline was 93.5 (SD=7.5). The mean Psychosocial Health Summary Score at this stage was 93.3 (SD=5.4), while the mean Physical Health Summary Score was 93.9 (SD=10.6).

At follow-up mean Total Score was 93.5 (SD=6.7), mean Psychosocial Health Summary Score was 93.6 (SD=5.9) and mean Physical Health Summary Score was 93.4 (SD=8.2).

Children 2 to 4 years old:

Sixteen children completed the assessment at baseline and 5 at follow-up. There were no missing values for any of the participants, and the scores could be calculated for every child.

Mean Total Score at baseline was 87.9 (SD=10.3), mean Psychosocial Health Summary Score was 87.3 (SD=13.4) and mean Physical Health Summary score 89.1 (SD=10.1).

Results for the follow-up assessment were as follows: a mean score of 80.7 (SD=9.4) for the Total Score, 78.5 (SD=14.4) for the Psychosocial Health Summary Score and 84.3 (SD=7.0) for the Physical Health Summary Score.

Children 5 to 7 years old:

Only one participant was in this age category and therefore only one completed this assessment; thus summary data is not presented. There were no missing observations for this participant.

With regards to PedsQL, it is feasible and acceptable to collect this outcome data; however, there is more missing data in the under 2 assessments, and therefore this will need to be considered going forward to a large trial to ensure appropriate data capture for the under 2yrs children.

Parent-based measures

General Health Questionnaire (12 items; GHQ-12)

The General Health Questionnaire assesses the presence and severity of some psychological and psychosomatic symptoms over the previous few weeks using a self-reported four-point scale, resulting in a total score of 36 points. Higher scores indicate higher levels of distress.

At baseline, 17 participants completed the GHQ-12. The mean total score was 15.5 (SD=7.0). At follow-up, seven participants completed the GHQ. The mean score was 16.8 (SD=11.9). There was only one missing value on the GHQ completed at follow-up assessment.

Higher scores (threshold cut-off is 11/12) in the GHQ-12 are indicative of levels of distress in the parent. Therefore, our sample displayed high levels of distress/mental ill health at baseline and follow-up.

ICEpop CAPability (ICECAP-A)

ICEpop CAPability measure for Adults (ICECAP-A) was developed in the UK as a generic measure of an individual's wellbeing (Al-Janabi et al., 2012). It measures five attributes: stability, attachment, autonomy, achievement, and enjoyment, which can take four levels from full capability to no capability. ICECAP-A scores can then be translated into capability values using a UK population tariff.[7] Values range from 0 for a state of 'no capability' to 1 which is a state of 'full capability' (Flynn et al., 2015). These values are important for an economic evaluation for incorporating preference-based wellbeing for the parents.

Seventeen participants had completed the ICECAP-A baseline assessment. The average capability value at baseline was 0.591 (SD=0.22). Six participants completed the follow-up assessment. Their average capability value was 0.63 (SD=0.23). There were no missing values for any of the participants in the baseline or follow-up assessment.

This has shown that the ICE-CAP is both feasible and acceptable to collect from this population, and also indicates that we can see a change in score (indicating improvement) in capabilities over

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[7] See: https://www.bristol.ac.uk/population-health-sciences/projects/icecap/icecap-a/

time, even though this is unstratified by arm. The ICECAP would appear to be an appropriate outcome measure to capture parents' wellbeing/capabilities.

Parent-reported outcome measure (PREM) and parent-reported experience measure (PROM)

Owing to the difficulties of recruiting families into the trial overall, and also into the process evaluation of IPS, we are delayed in piloting the new measure. We have, however, piloted it with one parent collaborator, who has past and current experience of social care services. The measure was highly successful in engaging the participant in an in-depth conversation about sensitive topics, such as areas of her life that she was struggling with (e.g. parent mental health, trauma, addiction, money/financial support, and housing [overcrowding]) as well as assessing her experiences of using social care services (e.g. the importance of communication and transparency, using a trauma-informed, strengths-based approach, and being non-judgemental). Through the combination of verbal prompts and visual tasks, the participant was able to describe her current situation and ascribe a numerical value to each area. In this way, change could be tracked over the course of the intervention. The participant also provided positive feedback on the relevance of tool content, accessibility, perspicuity, user friendliness, format, attractiveness (visuals, colours, format, layout), and time taken to complete. She positively commented on the strengths-based approach and conversational style of the measure.

Bespoke patient baseline questionnaire and follow-up questionnaire

These questionnaires were designed to collect comprehensive baseline demographics information and resource use data from participants. Based on previous experience from the BeST? Trial, we anticipated getting resource use data from services as usual could be challenging and therefore planned to additionally capture parent-reported use of services in each arm as an alternative data source in case we were unable to gather intervention/service delivery data from social services and the NSPCC.

At the time of the analysis 17 participants had completed the baseline questionnaire and 7 participants the follow-up questionnaire.

Participant's mean age was 31 years (SD = 7.0), range 23 to 45, for the baseline questionnaire and 33 (SD = 9.0), range 22 to 43 in the follow-up questionnaire. There were no missing observations; however, records for three participants were incorrect for baseline questionnaire and one for follow-up questionnaire (parents aged 4, 9, and 13). Data from these participants was not included in the analysis.

Through the questionnaire we were able to collect comprehensive baseline demographic data such as ethnicity, parent level of education, average household income, children affecting parent's ability to work, income and benefits received by the household. This dataset was complete, with only data for benefits received missing for one participant at baseline and one participant at follow-up (not the same participant).

We were able to collect data for 24 children at baseline and 10 at follow-up, including sex, age, ethnicity, and any institution the child attended (i.e: school, nursery, playgroup).

Regarding the resource use section of the questionnaire, despite being able to collect relevant information, many resource use fields were left blank. Upon discussion with personnel in charge of administering the questionnaire, we were advised that filling in every field when there was no resource use was troublesome and time-consuming, so despite going over the full questionnaire, not every field was completed. This has been identified as an opportunity area for improvement in question design to avoid respondent fatigue, and adjustments will be made moving forward.

Overall, the questionnaire was feasible and acceptable to parents with minimal missing data. There appears to be no issues with memory/recounting services attended/used. However, we have identified an issue with completion fatigue where no services were used and will make some adjustments as appropriate in terms of being user friendly and saving time.

Resource use data collection on service/intervention delivery for each arm

Service-as-Usual data collection tool:

A Service-as-Usual (SAU) data collection tool, was adapted from the BeST? Trial, to be completed by social workers. This was designed to capture information on date, nature of the contact, duration, attendees, and referral to outside services for participants receiving services as usual. However, this tool was not implemented.

We know from previous experience from the BeST? Services trial, that collecting this data in Glasgow is feasible, albeit in a retrospective fashion (i.e: data extracted from social worker’s case notes and transferred into the questionnaire). Getting patient-level data from London was not possible in the BeST? Trial.

For a full randomised controlled trial it would be key to find feasible ways to collect data prospectively from social services for the services as usual arm. One potential method would be to have a nominated individual liaise with Social Services and have regular meetings and check-ins to ensure forms are being completed prospectively. Adequate resources and expectation setting for services as usual as to the data requirements will need to be established and agreed if accurate data from social services is to be collected from both Glasgow and London sites.

NSPCC data for patients in the IPS arm:

Previous experience from the BeST? Trial indicates that detailed information on resource use can be obtained from the NSPCC data collection automated system. Throughout the course of this feasibility study, we held meetings with the NSPCC team and reviewed the data the system was able to collect. We requested additional resource use information to be gathered for this particular project, which NSPCC advice that this would be feasible; however, we did not receive any in time for this feasibility analysis.

Qualitative data

In-depth interviews were also conducted with parent participants and the research nurse to explore the acceptability and feasibility of the research measures.

Length to complete assessments and content

Overall participants were happy with the time required to complete the questionnaires and the content of the questions. Additional areas to address could include cultural issues (particularly when spouses are from different backgrounds) and financial difficulties. Although at times some felt the questions were a bit repetitive and irrelevant, the research nurse had explained this to participants before commencing the interview which helped to prepare them. The research nurse raised the concern that it can be quite difficult to complete all the baseline questionnaires in one sitting. We are now considering involving recruitment co-ordinators (after appropriate training) in administration of research questionnaires since they will already have developed a relationship with participants during the information and consent process.

Participants didn't always understand why they were being asked the questions; for example, what were the wider aims of the study/trial? One participant stated after having experienced IPS it was much clearer why she was being asked the questions, although this wasn't so clear at baseline assessment.

Overall, participants reported that the topics were not overly sensitive or difficult to answer, and indeed the research nurse did not experience resistance from participants in answering more sensitive topics. One participant, however, did state that questions raised sensitive content and some topics were 'triggering'. She stated she didn't feel able to 'open up' to the research nurse who didn't know her or her families' situation. This might be an additional reason to engage recruitment co-ordinators, including those with expertise by experience, in conducting research assessments.

The research nurse commented on the order the questionnaires are administered, suggesting that we should lead with the demographics questionnaire as it is the least sensitive. She also noted that the primary outcome measure(s) should not be left too near the end to avoid fatigue affects. The research nurse's extensive experience in conducting interviews was paramount in the success of this part of the study and we aim to engage this nurse to lead training of future data collectors.

Response format

Both the research nurse and two participants discussed how some of the topics covered quite emotive issues that couldn't always be answered with the required yes/no response, and this was most notable with the BCAPI. Not having the opportunity to expand on items could leave participants feeling anxious or uncomfortable and may affect the validity of their response.

Mode of data collection

Participants were happy with the mode of data collection, namely via the telephone, particularly for more sensitive topics. The research nurse and participants highlighted how conducting interviews via the telephone might act as a barrier to engaging in the assessments for some participants (opening up) yet was helpful for others (avoid need for childcare/travel). In addition, conducting questionnaires over the phone can be problematic when there are several closed responses to choose from.

Section 3: Acceptability of the IPS intervention and feasibility of delivery

The data presented below refers to the early stages of IPS implementation and will be supplemented with further data as it is collected and analysed. It should be noted that none of the participants will have completed the IPS intervention at the time of writing this report and, as such, findings should be interpreted cautiously.

Acceptability of IPS and feasibility of delivery: In-depth interviews with IPS practitioners

Ten focus groups and interviews have been conducted with members of the IPS team, and two with members of the research team focusing on the acceptability of the IPS intervention to both families and professionals (see Table 3 above).

Complexity of cases

As mentioned earlier, the cohort of families that was referred into the intervention was much more complex than originally envisaged, which had implications for the delivery of IPS. Many families were much larger and had long-standing involvement with children's services, although they still had a child in need plan.

> "What we're seeing is like lots of intergenerational issues, lots of domestic violence, and then probably a more surprising pattern has been very large families, which I don't think we had anticipated, so, that feels quite unusual in some ways, but there's lots of the same issues around concerns about neglect, lots of points of contact with social services, um, and, yeah, just complex intergenerational issues." (Clinical Psychologist)

Indeed, it seemed that our sample of 'child in need' was in fact edging closer towards child protection. This is visualised in Figure 4, where we consider the families that we managed to recruit were 'unidentified child protection', rather than child in need.

> "From what I have seen [families] have been in and out of that stage for a while, and then kind of edged on child protection, and then maybe gone back into child in need. I did think that we would be kind of intervening at the more CAF [child

> and family], a team around the child stage, um, but I guess the nature of the families that being referred to us, there's just the little bit more going on with them, it's just a bit more history there." (FEW)

Although the primary focus of the IPS team is the infant (i.e. under 5 years of age), including families who also had older children had quite a substantial impact on how IPS worked. Even when focusing on the younger child, there is a need to consider the wider family dynamics and relationships within the family to be able to provide sensitive and timely support. Yet, practitioners raised concerns over how well this could be achieved, and indeed whether it was possible, particularly in the short timescale of IPS. A lot of this was centred around the parent having the resources to fully engage with the intervention while balancing it with her other children's needs, childcare, and other commitments. IPS undertakes an in-depth, therapeutic assessment and interventions and due to this the time and emotional commitment needed from the family is quite high.

> "When we're concentrating on the under 5s only we don't get involved with the children who are over 5, but dependent on what's going on with them it obviously has an impact, it all becomes intertwined. With one family there are concerns about the older children. So, when we go along to the child in need meetings, we're hearing these updates, and having to think about how is that going to impact her [mum] and our work with the younger children? So, there's no escaping it, there's not much, though, that we can do to intervene and do anything about it." (FEW)

At times this was frustrating for practitioners, as they were aware of the older children's needs, but owing to the remit of IPS, they couldn't work to the same extent as the younger child(ren).

> "It does feel a bit uncomfortable to not work with the older children when they're there, or they're aware of your visits, so, just as a professional that feels difficult to not hold in mind the other children." (Social Worker)

The complexity of cases being referred into the trial had a large impact upon the original envisaged timescale: for example, the high number of CP concerns that had to be addressed before continuing to work with families; child protection conferences, statutory discussions, local authority involvement, escalation of cases to child protection (as well as logistical challenges; see Table 4), all meant that the assessment had to be paused:

> "What is slowing the assessment down is all these other things that come in – risk, meetings, adult mental health, waiting for certain things to happen, checking something out, waiting for a social care meeting ... then, more recently, logistics, room bookings, we haven't got a proper system where we see people that's quite suitable." (Clinical Psychologist)

Withdrawal of families from IPS

Of the eight families that were randomised to IPS, only three of these have been able to be actively worked with (the implications for recruitment and conclusions are discussed in the '<u>Recommendations and next steps</u>' section). All the families that have been referred have presented with issues related to domestic abuse and a significant number of families have presented with significant parental mental health issues. The complexity of needs that families are presenting with and cases being escalated to child protection services has meant that they no longer meet the criteria and therapeutic work is not possible – the safety of the child is always prioritised and families need to be in a place of physical and emotional safety for them to undertake this piece of work.

Practitioners felt frustrated when they were unable to work with a family that they could potentially help because of the parameters of the trial. One example is that after referral into the trial, the child's home situation changed in that they were now under a temporary kinship setup. This information could still be used to inform future trials, helping to define recruitment/referral criteria.

Initial findings from the feasibility study suggest that families who have an allocated social worker are presenting with a complexity of needs that may not be appropriately met with a therapeutic intervention at this point in their journey within the statutory system. When families have competing priorities, this can also create circumstances whereby there is a split in where that priority lies.

> "I think, there's something about readiness for change. So, there was one family where there was just so much going on, and there were no indicators to suggest that bringing in another service at this juncture that the parent was in any way able to make use of that kind of service. So, there has to be sort of thought about the timing of referrals in terms of where a family is at." (Clinical Psychologist)

> "We've had to kind of like step away from our assessment time frame, because there are certain conversations that we can't be having with the statutory process investigation that's going on." (Team Manager)

There were numerous logistical challenges impacting the implementation of IPS, including travel, accommodation, staffing, and childcare. These are summarised in Table 4 below.

Meeting IPS's key objectives

Poverty awareness

One of the objectives of IPS was to incorporate poverty-aware practice. Although practitioners reported they were much more attuned to families' needs, for example using the SNQ, this was an area where more could be done in terms of actual help offered to families. This was a result of numerous factors, including administrative systems, stigma associated with poverty, and competing priorities:

> "So, we are trying to now kind have more of a focus on it, because we felt in the beginning it was safeguarding, safeguarding, safeguarding, and actually then in-between that we were picking up some neurodiversity, but the poverty wasn't front and foremost." (Team manager)

There weren't adequate systems in place to be able to provide families with financial support. This meant staff were having to claim back money/pay out of their own pocket or factor in additional time, travel, and organisation to obtain cash for families. This was particularly difficult when practitioners were visiting families away from the base and weren't aware of what was in the local facility.

> "At the start, there was talk of giving families, vouchers, or giving them, you know, taxi rides to come and meet us if that was needed, um, but we found that quite difficult, staff are spending out of their pocket and then trying to claim money back, um, which we didn't think was great, especially as the, um, no one seems to be able to put in an expense claim and get it passed first time. So, there's that waiting for expenses to come back." (FEW)

Nonetheless, there were changes to how the NSPCC worked, for example giving families money beforehand rather than having to claim it back.

As families' trust with IPS developed, they were more likely to disclose financial difficulties with practitioners, suggesting families were very much aware of the stigma surrounding poverty. It also reiterates the importance of practitioners being aware of this stigma and keeping it at the forefront of practice. It became clear that financial worries were a significant concern for families, with practitioners frequently referring families onto services, such as local food banks, even if they were not part of the trial. Indeed, practitioners did a lot of work around sourcing local support for families.

> "It felt like for every family, they named some level of, um, financial strain, even the ones that we weren't going to take forward they've mentioned some kind of financial restriction or … so, food bank, even for the ones, for example … we've got a list of food banks, I think, that would be helpful to link them in with."
> (Team manager)

Table 4: Logistical challenges faced implementing IPS

Challenge	Description	Key aspects	Illustrative quotes
Travel & accommodation	Practitioners discussed their frustrations over finding appropriate accommodation in Bromley (where families are located) and the lack of a permanent base for staff, particularly for the family engagement workers.	• No rooms with facilities to observe parent and child within easy access for families. • Teams have had to make adjustments and be creative with arranging appointments (using children and family centres, schools, conducting home visits, making appointments portable [e.g. laptops]). • Repercussions for family engagement and reliable, timely, and smooth operation of assessments. – Implications for assessment reliability and validity • Not having a permanent work base, or one that was accessible to families, was perceived to impact how IPS was viewed as an organisation.	"It's [room available] not set up for the type of assessment we do, we're no one-way mirror. So really the model has been diluted quite a lot." "The place they've got access to is pretty much like a big meeting room ... it's not child friendly, need a lot of arranging things. It's not very containing space, maybe to big for the kind of more clinical approach. [They are] very adaptable the team but can you adapt things to get a good enough understanding of the relationship when you don't have the right kind of setup for that." "It means that the families really have a sense of us as an organisation. We go to see them at home but they won't come to our hub (NSPCC), so, I think, maybe that makes it feel more informal... there's something maybe about us not having a team identity for families to access or getting the benefit of our resources in the same way."

Challenge	Description	Key aspects	Illustrative quotes
Childcare	Childcare was a frequent challenge for the families involved, and this impacted upon their engagement with IPS and the assessment timescales.	• Meetings often had to be rearranged owing to lack of childcare, child ill health etc. • Bringing children to meetings could delay the assessment process as certain elements of the assessments are not appropriate to do in front of children. • This was in part a result of the (uncharacteristically) large families that were part of the trial.	"With one family, it's a large family with multiple children 5, just time-wise, just that mother's time constraints and between nursery drop offs and getting children to school it is just a bit tight for her. So assessments especially have taken quite a while to get stage where we can finish." "We haven't done all the assessments we would have hoped, because it's been quite difficult trying to talk about [mum's] experiences whilst there are children there, whilst there are other people's children there, it has been ... very hard to find the, for her to find the time to be alone to, you know kind of dedicate herself to answering the questions." "Thinking about who is in the home while we are doing this potentially exposing or vulnerable interview, or just having to attend to the children, because they are like hungry, they need a nappy changed, or whatever, just as kids are." [A]

Challenge	Description	Key aspects	Illustrative quotes
Staffing	Staff working part time, reduced team capacity, and large family size had huge impact on the project timescale.	- Implications for arranging appointments - A high proportion of the team/resources went to one family - The complexities of the families being referred to the study also meant that, even if ultimately families were not allocated to/suitable for IPS, staff workloads dramatically increased. For the most part, this was due to following up safeguarding concerns.	"Depending on the combination of staff that's around the ... the team of staff that's around the family, we're limited with when we can even start." "There's a couple of people have left the team, and so, um just getting new people on board, being able to schedule all the visits and assessments within a reasonable timeframe, according to everybody's diaries, I think that's the next challenge that we're going to face." "It just means actually reaching families and actually being able do what we designed as an intense assessment it's near impossible and then it feels like we're setting them up to fail because actually we're signing them up, and we’re saying 'yeah, this is something that can help you', in terms of us, and for us to do the assessment is probably a couple of times a week for 3 weeks, and on these families we're not even able to gain every week, even once."

Neurodiversity awareness

As a team, IPS (previously IFT) were already neurodiversity aware and cognisant of the complex interplay with neurodevelopment conditions and trauma. This was developed further within the current trial, through the co-production (with experts by experience) of information sheets, resources, and reports, ensuring that materials were in an accessible format for neurodivergent families.

The FEW played an important role in ensuring neurodiversity awareness ran through assessments, for example picking up cues from interacting/observing with the child while the psychologist is working with the mother. It is important to note that the assessment phase hasn't been completed at this point, and as such neurodiversity hasn't been as salient when compared to social needs/poverty etc.

> "Things are very much front loaded with thinking about social needs very early on and there's definitely indicators in relation to neurodiversity in both of the families that are around, but they're not at the stage of having gathered all the information and yet there's definitely a lot of liaisons with education and health visiting going on, but no referrals that I'm aware of." (Clinical psychologist)

Partnership working

Through working with families in the trial, successful partnership working between IPS and other specialist services, such as adult mental health, CAMHS, domestic abuse advocacy and support services and financial support services was evidenced. Even at this early stage, changes in the organisation of and access to services was emerging. Practitioners felt that having such in-depth knowledge of the families put them in an excellent position to refer onto other services.

> "The mum needed psychiatric assessment, and we linked in with the psychiatrist to kind of say, 'this is the work we want to do, and we need to wait to see whether mum's in a place she can do that work, but also it would be really helpful to have your view on her capacity to be able to do that work as an adult psychiatrist working with her'... it's really helpful to be able to do that because we work *with* the parent *for* the child in the therapeutic way, but if she's not in a place where she can do that." (Team manager)

Practitioners also called for better communication and more regular meetings between all of the teams. It was felt that more frequent updates from the research team for practitioners would be of benefit to them and the families, helping us to present more of a partnership:

> "Sometimes it's not clear, how does it work on the other side [research] for families? So, sometimes it's not clear exactly what they've been told, and obviously we're happy to share information, but maybe it would feel confusing if I was a family member where they maybe think of us as one team who all know

> each other and see each other regularly, but that's not the reality." (Social worker)

The role of the FEW

All practitioners were extremely positive about having Family Engagement Workers (FEWs) as part of their IPS team and unequivocal regarding the positive impact it had on families and the overall service, in particularly in representing the parent's voice throughout, as the FEW explains:

> "I kind of know how the mothers feel and where they're coming from. There is an affinity and understanding between us that makes it much easier for us to talk … having an understanding of the system, or having to engage with services in a point in your life where you're having difficulties or you don't feel you're in control, kind of helping them to find their voice, reminding them that they *do* have a voice and especially when their feelings are quite negative towards services. I try and get them to focus on what they can do to engage more, or drive the process forward rather than disengage or give up. … I've been there, have been in that position where I felt that not enough was being done, or I wasn't getting enough from the service, and at a point of what's the point in even trying or feeling criticised by services. … Being there and coming through the other side, I can kind of talk to them and make them see a different perspective." (FEW)

Building relationships with families was discussed as being one of the most fruitful aspects of having a FEW. As FEWs could focus on spending time talking with families and listening to their concerns, incorporating their localised knowledge of services, and advocating for families, this was invaluable. For example, while working with a family a child protection concern had been raised; however, because there was a FEW supporting the family and being transparent about the process, it didn't impact on the relationship between IPS and the mother.

> "She [the FEW] comes in and kind of bridges that gap as someone who's had services, but also works alongside them. That trust seems to be so important, and it's really good." (Team manager)

The FEW played a significant part in ensuring the voice of the parent was embedded throughout contact with IPS, including how families are approached, the tools used in assessment, maintaining awareness of neurodiverse issues as they arise, communication with parent and child, as well as taking an active part in the assessment process itself.

> "I feel like it's … changed the way in which, not just families are receiving us … I almost feel like it's completely transformed the way in which the team think about work … it's a constant reminder to be thinking from a family perspective … I'm like, okay, 'what about mum?'… the support for mum actually will be supportive to that child as well." (Team manager)

> "Thinking about the way in which we ask questions, make sure they're not judgemental, because some of them are standardised tools, and they do feel quite

> judgy, so, we adjusted all of that with the help of our family engagement worker and lead. We have taken it from this is what we think, as professionals, they [FEWs] are professionals, but also they've been service users. I think, this is the best thing that we have done, family engagement, definitely." (Team manager)

FEWs were commended for respecting boundaries despite there being some concern over how this would develop in the beginning.

Challenges

Despite the positive impact that having a FEW has had on the intervention and to the families accessing it, there have been several challenges with this new role. This includes administration systems, lack of a permanent base, and needing a more defined role. Regarding administration systems, there were several difficulties getting the role initially set up, including criminal disclosure checks, advertising positions, and recruitment into posts. In particular, ambiguity in adverts, their reach, and the challenge of seeking people with lived experience from small communities created challenges for the advertisement of the posts.

Currently, there is not a permanent base available for the FEW to work from, meaning the FEW is often required to do 'hot spot' working in the library or work from home. This has ramifications for how embedded their role is within the team. However, from the FEW's perspective, this also has connotations for working with families in a way that will facilitate their engagement and have a real impact upon their lives. For example, having a community base where families could drop in would help alleviate some of the difficulties around childcare, around lone working particularly as domestic violence was present in each case, but also allow relationships to develop further and develop a holistic approach to the family.

> "If she could get to a children's centre the kids could play, and we could talk, you know, I could observe her and the kids there, and, you know, play together kind of thing. So, to see if that would help her as well." (FEW)

It was acknowledged that the FEW position is new within IPS and still being established. However, several participants discussed the importance of continuing to develop and define the role, particularly if we are to avoid it becoming tokenistic and to ensure its sustainability. One way this could be achieved is for FEWs to take on greater responsibilities within the intervention. It was anticipated that FEWs would conduct some of the early assessments with families, and more progress is needed here.

> "In some way or brought up to speed what to look for with the children then when we're playing with the children we can bear all the developmental things in mind, um, as that's appropriate for their age and their stage, we can observe and see if there's anything that we pick up in our play with them that will be helpful to the team and also, um, like basic modelling to the parents if that's what they need, basic modelling, so we're able to kind of show them how they can do things with the children." (FEW)

Careful mapping of the FEW roles would also recognise the importance of having structures in place to ensure staff are fully supported, such as a permanent line manager to safeguard the success of such positions and the safety and support of FEWs. In addition, when thinking about the longevity of such posts, we need to consider how to make them more attractive and rewarding; for example, skills that can be developed, and qualifications gained.

Conversely, one practitioner cautioned against the FEW taking on too many of the psychologists remit, as to do so may lose some of the strengths and nuances of their unique role, such as:

> "having the confidence to have a different view ... when you're in a small team, you all end up having the same view. If you're a family engagement worker, you have a very different view." (Clinical psychologist)

Acceptability of IPS and feasibility of delivery: In-depth interviews with participants

One participant was interviewed regarding their experiences with IPS (no SAU participant consented to being interviewed at this time). As this is a single viewpoint on the intervention, findings need to be interpreted extremely tentatively. With this in mind, we were able to capture some initial insights into areas that IPS is working well and where there could be improvements.

What worked well?

The participant was extremely positive about IPS to date, in particular valuing how their involvement with the intervention had been clearly explained, with continual offers of clarification and reassurance. They reported the team being very compassionate, friendly, and approachable.

Regarding the assessment phase, she appreciated the natural observation approach and in particular the discretion of recording the session and was extremely positive about the assessment tools being employed, such as the narrative book.

The parent particularly valued the strengths-based approach that was endorsed, which focused on their family's assets, as opposed to focusing solely on deficits. The participant discussed how they felt the intervention was very much parent-led, and that they were able to take a collaborative role in treatment plans and decisions made.

> "I've been treated, very, very fairly; everything has been led by, I've led, um, they've sort of let me lead everything. They've always gone on what I'm comfortable with, how I feel, what direction I feel is best."

> "When I got the report, everything that she said about my kids and about me, [the psychologist] will send it to me, she'll ask my opinion, um, do I want to amend anything? ... but to be honest, she said wonderful things about me and she said some really wonderful things about my children."

They felt that the practitioners were extremely understanding of her circumstances, fitting appointments around their needs, such as offering flexible appointment times and locations and being nonjudgemental and understanding when appointments needed to be rescheduled. The offering of groceries and provision of Christmas gifts and cards for children was welcomed.

The signposting of other support services was greatly appreciated; for example, financial supports, mental health advice, and information around speech and language support.

> “There’s this tongue exercise that we do at home, it’s a story, but as you tell the story, it’s about a spider … you have to do the actions with your tongue. To help build up the muscles in the tongue so that he [son] can eventually be able to pronounce certain letters … That’s really helping him.”

Finally, the participant was extremely positive about the FEW and how they had supported them throughout her involvement with IPS.

> “Because (FEW) had their own personal experiences with social services in the past, I found, they’re an asset … because they can relate to families in a way that, no offence to (psychologists), they could never relate to me because they’ve never had personal experiences like that.”

What could be improved?

There were several areas that the participant suggested could be improved within IPS. Firstly, they felt they would have benefited from more frequent sessions and of longer duration, as well as offering more face-to-face visits (several meetings were conducted virtually). At times there were delays between appointments, owing to the participant having to manage multiple appointments and the part-time hours of the IPS practitioner, which made it difficult to get a mutually agreed time to meet.

> “I think face-to-face as well and more visits because you can get to know the family a lot more and, I mean, you don’t get a lot of time, you can only say so much and talk about so much in two hours. I’ve not even seen her, because I’ve had so many other appointments, she’s only free on certain days and they always clash. A lot of my contacts is on zoom at the moment or by email.”

Secondly, at times the participant felt the focus was too great on the parent, and the child could have taken more of an active role in answering some of questions during the assessment phase.

> “There could be more interaction with the children as well, not just focusing it on the parents answering questions … It was very parent focused like the questions, but a lot of the questions my son could have answered himself … I mean, asking about his ability, some things did seem inappropriate, like, ‘can [child] throw a ball?’. You could have a session where you don’t actually need to sit and ask any of those questions, you can just assess and evaluate what the kid is able to do, by playing. Because then you’re engaging with the child and you’re getting to know the child as well. Rather than just asking the mum about him.”

Finally, the participant also expressed some frustrations about the pace of the intervention, particularly in implementing support for any needs, such as speech and language therapy, that had been identified during the assessment phase.

> “The roll-out after the assessment is very slow. When they offer, they come to you and they say, right, this is what we’d like to offer you in terms of support around the children and developmental needs … there are other things that have been put on the table that we could do for the children that haven’t started yet … the rolling out the support afterwards is slow.”

Despite these frustrations, the participant was aware of factors contributing to the delay of receiving these services, such as waiting list times, the availability of parents and children, and coordinating with other appointments.

SUMMARY OF STUDY FINDINGS

This study was successful in demonstrating that it is possible to co-produce IPS and that families are willing to be randomly allocated to IPS or SAU and to participate in research assessments. We have summarised the study findings below in relation to each research question (Table 5).

It should be highlighted again that the data in this report refers to the early stages of IPS implementation, and, as such, data collection is ongoing. At the time of writing the report, less than 50% of those who completed measures at baseline also completed follow-up measures and no families have started the IPS intervention in Glasgow. There will be a bridging phase between April and June 2024 to build on our previous co-production work, feasibility RCT, and mapping of local service landscapes, to inform a randomised controlled trial (RCT) of Infant Parent Support (IPS), a co-produced, place-based, mental health intervention for struggling families which we are currently awaiting the outcome of a grant application to UKRI (see Appendix D).

Table 5: Summary of findings

Research question	**Findings**
Phase 1 Mapping and co-production of IPS	
Can we co-produce, with parent collaborators, a new intervention, Infant Parent Support (IPS), aiming to improve the mental health of children with a social worker?	Yes. We were able to recruit and retain parent collaborators and co-produce IPS. Its clinical and cost-effectiveness will be tested in the next phase of the study.
Can the project expand to include new partners?	Potentially – although we have not actually expanded to new sites, we plan to hold expression of interest events in London and beyond.
What is the profile of services as usual (SAU) (including infant/adult mental health; social care statutory processes) at each site and can care pathways be improved?	The profile of SAU was carefully mapped (see 'Mapping and modelling of services' and Appendix A) and partnerships between services were created that appear to have improved care pathways.
What are struggling families' experiences of, and barriers/access to, mental health services?	This has been summarised in the 'Mapping and modelling of services' section and Appendix C of the report.
Phase 2 What is the feasibility of an RCT of IPS compared with services as usual?	

Can sufficient numbers of families be recruited and retained such that a full-scale RCT is likely to be feasible?	Yes: 63% of our target recruitment was achieved. Achieving this proportion of our target, alongside our extensive qualitative process evaluation, has allowed us to model future recruitment rates sufficiently accurately to facilitate onward funding to support a definitive RCT.
What outputs and outcomes would families like to see from IPS and can we use this information to develop a 'parent-reported outcome measure' (PROM) and a 'parent-reported experience measure' (PREM)?	PROM and PREM development is still preliminary and will be continued in the next phase. Initial findings suggest families would like to see changes in parent mental health, trauma, addiction, money/financial support, and housing. See Appendix F for draft measure.
How acceptable and feasible are planned outcome measures and study procedures for a definitive RCT trial to parents and professionals?	Parent and child outcome measures were acceptable to parents and professionals and there was little missing data. Slight modifications are needed in the delivery of some measures.
How acceptable and feasible is the IPS intervention to parents and professionals	At this early stage, intervention assessments/interventions were acceptable to parents and professionals.

LIMITATIONS

With regards to our qualitative mapping work, data has been gathered from a modest sample of participants and the perceptions presented here are therefore not necessarily generalisable to other geographical locations. More needs to be understood about pathways out of services, potential 'stuckness' in services and 'bounce' between services from the perspective of parents. So far, this has mainly been considered from a practitioner's perspective.

In relation to the feasibility RCT, we had anticipated that by this stage more collection of 3- and 6-month outcome measures would be complete. Numerous delays to the overall timeline of this project, which has impacted upon the number of families that have been recruited and randomised. In part this was due to delays in receiving ethical approval (initially through NHS, but when this was deemed not possible an ethical approval submission was made to the University of Glasgow ethics). For the Glasgow trial site, there was a lengthy delay in getting the Data Sharing Agreement signed off to enable recruitment to begin. It was finally approved in November 2023. Owing to the very small sample sizes, we are limited in our ability to draw conclusions around the acceptability of IPS, beyond the successes and challenges that have been identified. At point of writing this report, none of the participants will have completed the IPS intervention and so the process evaluation, as well as quantitative data, is focusing on the early roll-out of IPS.

Our findings concur with previous research that has shown that participants from marginalised populations, such as those using social care services, encounter numerous barriers to participating in research, services, and interventions (Mirick, 2016). Within our study, families declined to participate, interventions had to be paused or stopped, and qualitative interviews had to be rescheduled repeatedly. Reasons are multifaceted, relating to concerns over confidentiality, issues of unequal power and stigma, complexities within families' lives (competing priorities and multiple appointments, childcare responsibilities, poverty, and so forth). As a result, our sample size for certain sub-groups was relatively small, which precludes us from drawing firm conclusions about those sub-groups. In addition, these difficulties may contribute to the underrepresentation of some families within our study. For example, our interviews with families demonstrated that they had a particularly good understanding of research and what a feasibility RCT was; it would perhaps not be expected that all families would have such an understanding. In addition, we only managed to recruit mothers into the trial and there is a notable absence of the paternal voice. Although it is usual to have low engagement and high levels of attrition within this population, the information from this study has fed into our recommendations for a definitive RCT as outlined below.

In addition, parent collaborators are key to the co-production of the research design and delivery but due to their lived experience it is vital that engagement work is taken at a slow pace and uses a trauma-informed approach. There was an underestimation of the time resource required to work and engage with parent collaborators to pilot research tools such as the PREMS and PROMS. In addition, although every effort was made to reach both male and female parents and a range of ethnic groups, all our parent collaborators were white and female.

There are complexities in recruiting Family Engagement Workers which impact on the time attributed to this and the subsequent impact this can have on delivering IPS intervention. Delays around CRB checks and complexities with the DBS/PVG forms meant that staff were not able to start in roles as early as we anticipated (although this is not confined to FEWs but also affects new employees across the service). Importantly, we only had one FEW and so it is hard to disentangle whether it was the family engagement role that was empowering or if it was due to the particular person we had in post.

Finally, the IPS teams are highly skilled specialists in infant mental health and social care; however, in the next phase of our research greater attention needs to be given to capturing the voice of the child in relation to both research and service delivery (McFadyen et al., 2023).

RECOMMENDATIONS AND NEXT STEPS

Policy and/or practice recommendations and next steps

Through working with our families in the current trial in both the mapping and co-production phases, as well as intervention delivery, we have demonstrated that understanding and responding to families as a whole, and providing holistic support that considers the impacts of poverty, NDCs, and trauma on their material and psychological wellbeing needs is central to making a difference for families with multiple and complex needs. The involvement of expert-by-experience professionals in the team was also innovative and transformative. This learning needs to continue to be shared across services to improve families' overall experiences.

Even at this early stage of intervention roll-out, there is evidence of changes in access to services for children and their families, with conversations taking place between services which have been historically perceived as siloed. IPS teams are in an excellent position to refer into other services and build partnerships to offer holistic support to families. Changes within organisations, such as the NSPCC, were also evident. For example, changes to how expenses were paid to participants and embedding lived experience roles within their teams.

However, initial findings from the feasibility study suggest that families who have an allocated social worker are presenting with a complexity of need that may not be appropriately met with a therapeutic intervention at this point in their journey within the statutory system. We need to consider participants' readiness for change and the timing of referrals in terms of where a family is at. When families have competing priorities, this can also create circumstances whereby there is a split in where that priority needs to be; safeguarding is always prioritised. This caused some difficulties in achieving our original vision of IPS, which was to move the focus from a child protection risk management perspective (as seen with IFT) to one that strives to promote and increase client/parent autonomy. Therefore, the challenge we face as we move towards a definitive RCT is how to target families with sufficiently low levels of need to benefit fully from IPS. This is discussed further in research recommendations and next steps below.

Our findings also highlight the ongoing challenges of child protection thresholds. It was envisaged that IPS would target families at the first signs of struggle, and, as such, the target population was families whose children are 'in need'. As shown in Figure 4, most of our participants were sitting at what we termed 'unidentified child protection' level, or as other researchers have called a 'Complex Child in Need' level (Kirk & Duschinsky, 2016). These are families that were deemed below child protection thresholds but at the upper ends of children in need. It was only through examining these cases methodically, as the IPS teams did, that the individual needs and risk for each family emerged. Families can very quickly go into crisis (moving between the layers illustrated in Figure 4) and at the time IPS became involved, it became apparent that they were no longer consistent with a child in need categorisation. As such, greater partnership is needed between early services, in identifying the need for these families on the cusp of child in need and child protection and working together to improve outcomes. These families require services more akin to those provided with statutory child protection categories and “beyond the low-resource and low-oversight model that generally accompanies a child in need categorisation” (Kirk & Duschinsky, 2016:963).

For Partnership for Change, this calls for recruiting families through early service providers, health visitors, as well as social work. Thinking more widely, Minnis and colleagues have called for a greater cross-governmental focus on babies and children under the age 5 years, necessitating a joined-up approach between governments, NHS, and local authorities to improve child health (Minnis et al., 2024).

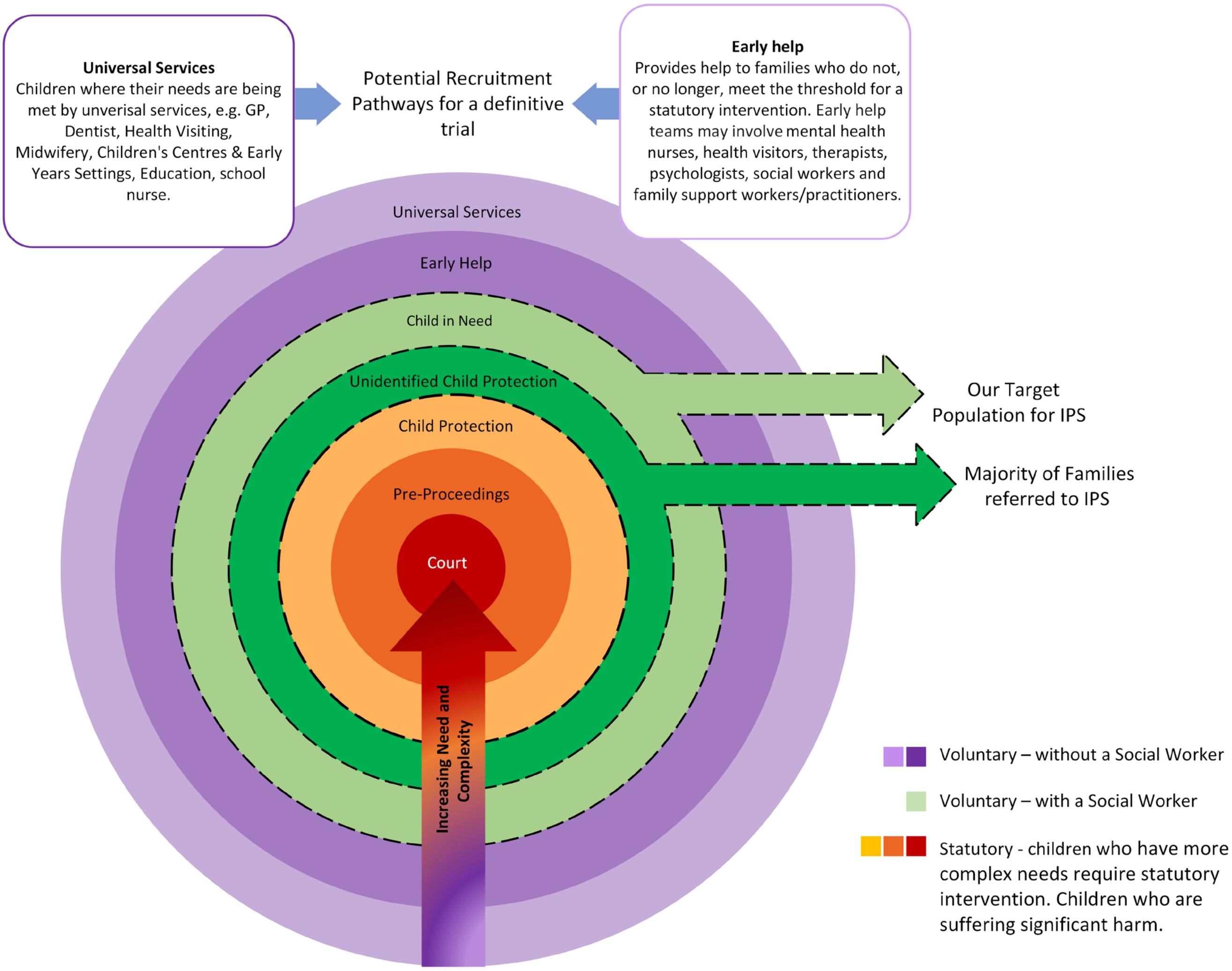
Research recommendations and next steps

Co-producing complex interventions

With regard to co-production, one of the most profound changes that practitioners discussed as a result of working alongside parent collaborators was personal growth and challenging their own ways of thinking. They valued the opportunity to hear individual’s experiences and care journeys, which created more empathy towards their circumstances, as well as being mindful of stigma towards people living in poverty, and challenging discriminatory language, terminology, and viewpoints. It also broadened their mindset towards the involvement of lived experience in service development, questioning how services could or should be developed without the involvement of lived experience. Nonetheless, there has been considerable learning as we take Partnership for Change to the next stage:

- The parent collaborator lead was fundamental in co-ordinating, supporting, and engaging the parent collaborators. Similar projects would benefit from the parent collaborator lead being employed full-time in order to support greater parent collaborator involvement in co-production.
- A better balance of parent collaborators and practitioners is needed in decision-making meetings to ensure that parent collaborators’ voices are not drowned out. To adjust for the strong voices of the professionals, a greater parent collaborator to practitioners ratio is needed, which could also prevent issues of non-attendance and attrition.
- Having a shared understanding of co-production and associated goals is fundamental to the success of a project. This necessitates involving all stakeholders right at the conception of the project.
- Ethical processes should regard parent collaborators as professionals so that they can be interviewed equitably along with other professionals and therefore have equal voices.
- A shared framework for decision-making and feedback is needed to allow all stakeholders to be kept up to date with actions and outcomes and for all stakeholders to feel that they are genuinely contributing to intervention development.

Figure 4: Visual representation of referrals into IPS (go to accessibility text)



Moving forward from the feasibility RCT

Although the data presented in this report refers to the early stages of IPS implementation, we were able to recruit and retain a high proportion of our target families. This, alongside our extensive qualitative process evaluation, has allowed us to model future recruitment rates sufficiently accurately to facilitate onward funding to support a definitive RCT. In both sites, large numbers of potential recruits were identified, but we had ongoing problems targeting families with sufficiently low levels of need to benefit fully from IPS, especially in Glasgow. The study has revealed ways to overcome this (e.g. recruitment through health visitors or early intervention services) that we will implement in the next phase.

To capture families at the point when they first engage with services – that is, when they first display signs of struggling or need – we may need to rethink referral pathways in the study. This may mean altering the referral criteria so that the family does not have to have a named social worker, and moving towards families who have family support services.

It is acknowledged that there will be a lot of complexity even when recruiting families in this manner, and foundational work is needed to develop partnerships between services and referral pathways into the next phase of IPS.

- Mapping of services will identify if there is an overlap with existing services, as well as identifying new, potential referral routes into IPS.
- Further work is needed to understand how IPS sits alongside these existing services in targeting families who need more early intensive specialist interventions/therapeutic work. IPS is unique, offering a holistic, poverty-, trauma-, and neurodiversity-aware intervention. Yet there is some overlap with existing local authority and third sector services, although these do not include an offer of evidence-based relationship-focused therapeutic interventions as are offered routinely in IPS. Again, this will be explored further in our bridging phase.
- Our mapping work has highlighted another challenge: children under 5 may not be visible to any service or support, particularly if they have refused efforts to liaise with health visiting services and if they are not engaged with nurseries. Further exploration is needed around how we will identify these families. A key difference between the previous IFT intervention and IPS is that the former was mandated by the judiciary, and as such there is more pressure to engage and keep appointments. IPS, on the other hand is a voluntary service and as such carries with it fewer pressures. This needs to be built in when thinking about engagement and retention in the next trial.
- We need to give adequate attention to the principles of equity, diversity, and inclusion. How do we ensure that we target a diverse range of families, in terms of ethnicity, gender, age, disability, and socioeconomic status? Do our trial teams (researcher, practitioner, lived experience practitioner, and parent collaborator) also mirror this diversity? In addition, although it wasn’t planned, all our participants were mothers. Fathers are commonly underrepresented in research, and future research could focus on strategies to promote recruitment and retention for this population.
- We will continue to map key differences in the social services and legal contexts in Glasgow and Bromley, to best understand how we can embed IPS within their local community/service context and target the families likely to most benefit. Place-based inequalities are a key focus of our grant application to UKRI (see Appendix D).

Referrals, recruitment, and retention into research trials and interventions

Overall, we were successful in collecting data on parent and child outcome measures in relation to mental health, although there is still some piloting work to be done around the BCAPI and the PREM/PROMs before we move to a full randomised controlled trial. Largely, participants were positive about their research experiences, including the acceptability of measures and study procedures. With regards to health economic data, if moving forward to a full randomised trial, we would need to put in place an appropriate mechanism to ensure that SAU data collection is implemented. We know from previous experience that it is feasible to do it; however, for this project we were not able to show evidence that collecting this data is feasible and acceptable.

Effective recruitment and retention strategies are needed to ensure that hard to reach families can participate in, and remain in, research and complex interventions. Although the number of participants in our follow-up assessments is still low, our findings contribute to the discussions around improving practice in this area, as well as feeding into recommendations for definitive RCT. Our findings contribute the discussions around improving practice in this area, as well as feeding into recommendations for definitive RCT.

Participants expressed a great deal of hope and enthusiasm for potentially being randomised to the treatment arm of the trial (IPS). As we are working with vulnerable families, who are perhaps seizing any opportunity to improve their families' situations, we need to make sure we are supporting all families.

- Our findings highlight the crucial role of the recruitment co-ordinator in enhancing the informed consent process, permitting extended informed consent discussions between her and the participant. They could also improve participant trust of researchers by brokering relationships between their clients and the research team.
- We need to explore other avenues to providing study information and obtaining meaningful informed consent from participants with diverse needs (e.g. levels of literacy, sociocultural backgrounds, neurodiversity, etc.). This should include printed materials, recruitment decision aids, and audio-visual presentations.
- People with lived experience (i.e. parent collaborators) have a role to play in supporting SAU families. Parent collaborators could alleviate some of the parent's uncertainty around research processes/pathways by checking in with them at strategic time points and maintaining contact between appointments.
- Relationships are crucial for effective engagement with service users and good outcomes. Lived experience (PC/FEW) can help establish collaborative relationships, particularly when factoring in the pressures on practitioners/services to do this. This role should not be underestimated.
- Parent collaborators could emphasise equipoise (a state of genuine uncertainty on the part of the investigators regarding which arm of the trial is more beneficial) exists for IPS and SAU to alleviate some of the disappointment around not being selected for the treatment arm. This was particularly important for our families, as our early work highlighted that current services did not always meet their needs.
- Remuneration is a strong incentive to research involvement, particularly if distributed immediately after participation.
- We need to develop strategies to minimise burden on families attending appointments. Remaining cognisant of practical barriers to attending services (money to travel, ability to travel, lack of childcare, centralised rather than locally situated services, parental

commitments such as school runs, inappropriate appointment times, multiple appointments with multiple services clashing).
- Families experiencing vulnerability frequently need to reschedule appointments. This needs to be built into study timelines, particularly when conducting multiple assessments (qualitative interviews, questionnaire data). Participants in our study appreciated nonjudgemental, understanding research teams in respect to last-minute cancellations.

Lessons learned

The role of lived experience

Our lived experience practitioner was viewed as a respected and essential part of the IPS team. The FEW role was novel and as such it has continued to be developed and refined. We have identified several recommendations and challenges for the development of this role in the future, which can be applied to other lived experience roles.

- Establishing FEWs role and responsibilities within the project is critical if posts are to be sustainable. Inadequate preparation can lead to FEWs experiencing an 'underload' of work; that is, feeling under-stimulated, with too few responsibilities and challenges. This can lead to workers feeling undervalued, which has repercussions for retention of FEWs.
- It is essential to the success of the lived experience posts that they have adequate support and supervision. This is important to manage and execute work objectives, motivate and support practitioners, as well as to help manage any challenges that arise.
- Having a line manager with lived experience (our Family Engagement Lead) was crucial to the success of the FEW post. The line manager was available to discuss issues relating to lived experience that other workers may have not been able to, for example if the worker was triggered by a past event. This was particularly important as our FEW was the only lived experience worker in IPS.
- To foster collegial interaction, FEWs need to be embedded with the team – for example, having more opportunities to be co-located with other team members.
- Services would benefit from the embedding of FEW in the community, where families could drop in as needed for support. This was also raised as important to families, for whom having scheduled appointments are not always feasible. This would also increase the presence of IPS within the community and allowing for a partnership with other organisations to be developed.
- Opportunities for additional training should be provided for FEW, particularly around NDC assessments (i.e. ASQ, ESSENCE). Lived experience practitioners are able to empathise with people currently experiencing multiple disadvantage; therefore, they are more likely to elicit honest responses from families, which helps to gather information that might be missed from other practitioners.
- We need to consider availability of accredited training courses for lived experience to develop their educational and skills attainment, improve their employment outcomes,

providing an opportunity to progress. Making such posts attractive will help with recruitment and retention in posts. Examples of these are already in existence (Basset et al., 2010).

- Understanding of lived experience roles across services and the associated benefits needs to be promoted. For example, our early mapping work uncovered professionals' concerns around lived experience practitioners being able to maintain boundaries with the families they work with, and fear of inappropriately disclosing information.
- Practitioners also described their frustration at not being able to fully support or intervene with older children in the family, as the remit of IPS was to work with the under-5s. Further work is needed here to help practitioners understand that through working with one child, the relationships with others in the family or subsequent children can also be improved (Zeanah, 2001) and that the improved liaison between IPS and other services (such as CAMHS) is likely to be helpful for older children.

CONCLUSION

In this study we have demonstrated the feasibility and acceptability of parent and child outcome measures to be used in a definitive RCT, and will take forward the lessons learned, and modifications needed in the setting up and planning phase before beginning recruitment in a definitive RCT.

We have highlighted additional modifications needed in the delivery of some measures, particularly owing to the sensitive content being probed. We have also highlighted the difficulties in recruiting and retaining families with vulnerability, both in research studies and in interventions. This will necessitate some further piloting of measures, most notably in relation to child mental health and the PROM/PREMS, before commencing the definitive RCT.

We have also demonstrated that data collection for an economic analysis is feasible and acceptable. We were able to collect data on preference-based wellbeing for parents using ICECAP, and on HRQoL for children using PedsQL, which can be transformed into a utility measure and used in an economic evaluation. However, attention needs to be paid to data collection for younger children (in the 0–2 age range) where we had some missing data. We have also evidenced that we can capture service use from a patient perspective to inform a trial model.

The importance of adopting a whole-family approach to children's mental health, as well as providing holistic support that recognises the impacts of poverty, NDCs, and trauma has been reiterated throughout this project. To achieve this demands greater partnership working in health and social care: it demands a **Partnership for Change**.

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APPENDICES

Appendix A: Dalgarno, L., Graham, S., Crawford, K., Fisher, J., Pownall, J. & Minnis, H. (2023) *Partnership for Change: Phase 1 findings*. University of Glasgow. https://foundations.org.uk/wp-content/uploads/2025/08/Appendix-A_Partnership-for-Change-–-Phase-1-findings-.pdf

Appendix B: Pownall, J., Crawford, K., Dalgarno, L., Fisher, J., Graham, S., Turner, F., Boyd, K., Seyahian, A., McConnachie, A., Cosgrave, N., Donaldson, J., Forde, M., Atkinson, C., McCullough, J., Sayal, K., Ougrin, D. & Minnis, H. (2024) Infant Parent Support (IPS): A multidisciplinary intervention to improve the mental health of children with a social worker. A study protocol for a feasibility randomised control trial with embedded process evaluation. Pilot and Feasibility Studies (under review). https://foundations.org.uk/wp-content/uploads/2025/08/Appendix-B-Pownall-J-Infant-Parent-Support.pdf

Appendix C: DRAFT: An extract from interim process evaluation report: Fundings from Families regarding experiences with social work. https://foundations.org.uk/wp-content/uploads/2025/08/Appendix-C-An-extract-from-interim-process-evaluation.pdf

Appendix D: Partnership for Change: RCT of Infant Parent Support teams to address place-based inequalities for struggling families. Grant application submitted to UKRI. 10.10/2023. https://foundations.org.uk/wp-content/uploads/2025/08/Appendix-D-Application-overview-UKRI-Funding-Service.pdf

Appendix E: IPS Clincs Powerpoint. https://foundations.org.uk/wp-content/uploads/2025/08/Appendix-E-IPS-Clinics.pdf

Appendix F: Participant Reported Outcome Measure (PROM) & Participant Reported Experience Measure (PREM). https://foundations.org.uk/wp-content/uploads/2025/08/Appendix-F-PREM-PROM-Measure.pdf

ACCESSIBILITY TEXT

Figure 1: Overview of the Partnership for Change study

The image is a structured flowchart outlining the design of a research study. It is divided into three main vertical sections:

Quantitative evaluation (left section)

- Begins with baseline outcome measures involving 30 participants.
- Followed by follow-up measures taken 3 to 6 months later, again with 30 participants.
- Followed by quantitative feasibility measures
- This feeds into the overall analysis and synthesis of findings.

Trial (central section)

- Starts with a mapping and modelling phase.
- Followed by the development of IPS
- Then baseline data collection is conducted (which links to baseline outcome measures in the quantitative evaluation strand)
- Participants go through consent and randomisation, being assigned to either:
    - SAU (Service as Usual)
    - IPS, which includes: Assessment, IPS intervention and closure
    - After SAU or IPS steps both have 3-to-6-month post-randomisation data collection carried out (which links to follow-up measures at 3-6 months and quantitative feasibility measures in quantitative evaluation)
- This feeds into the overall analysis and synthesis of findings.

Process evaluation (right section)

- Phase 1 qualitative work (which is linked to mapping and modelling phase in trial):
- Exploring experiences of co-production (linked to development of IPS in the trial column) from:
    - Parent collaborators
    - Research team
    - IPS team
- Parent interviews (6 to 8 participants) (linked to baseline data collection in the trial column) covering:
    - Experience of and access to services
    - Expectations of participating in the research
- Parent collaborators capture key issues around recruitment, retention, assessments, and intervention delivery (linked to SAU, and IPS, assessment, IPS intervention, and closure in the trial column).

- Focus groups with IPS and SAU teams (linked to closure of IPS in the trial column).
- Parent interviews (linked to 3-to-6-month post-randomisation data collection in the trial column) to assess:
    - Acceptability and feasibility of research measures and processes
- Experiences of co-production (linked to 3-to-6-month post-randomisation data collection in the trial column) involving:
    - Parent collaborators
    - Research Team
    - IPS Team
- Emergent issues – method and frequency as required

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Figure 2: Working group composition and terms of reference

The image is a flowchart describing the three working groups composition, and highlighting the key themes that run through all the groups as well as the specific purposes and structure for each group.

Top Section: Key themes running through all working groups

- Infant mental health
- The voice of the infant
- The role of people with lived experience
- Communication with the Parent Collaborator Group

Middle section: working groups

This section is split into 3 boxes representing the three different working groups, with arrows between the three to represent the process of feedback and reflection between all groups.

Poverty awareness - Total participants: 7 (including 2 Parent Collaborators)

- What supports IPS can or cannot offer around poverty and material deprivation, including developing new partnerships
- Proposed assessments or tools for collecting information on poverty and material deprivation
- How IPS service can be made more poverty-aware in terms of assessments, content, and delivery

Neurodiversity in struggling families - Total participants: 9 (including 2 Parent Collaborators)

- Proposed assessments and interventions for neurodevelopmental conditions

Assessment & intervention - Total participants: 10 (including 1 Parent Collaborator)

- Developing the toolkit of interventions and assessments that would be used in the IPS service

Bottom section: Key techniques used in working groups

- Clear agenda; purpose and actions for meetings
- Encouraging participation and respect for everyone and their views, including active listening
- Sharing relevant knowledge and experience
- Use of open questions to access views
- Ensuring parent collaborators had involvement in decisions and involvement in all outputs

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Figure 3: IPS logic model

A diagram illustrating the IPS logic model, organised into five vertical columns, labelled A to E, each representing a stage in the process. The model also emphasizes the importance of recognising the outcomes and outputs prioritised by families themselves

Column A: Initial problems

Parent-related

- Parent(s)' experience of maltreatment – increased risk of mental illness and/or Addictions (double jeopardy)
- Parent neurodevelopmental conditions (NDC)
- Structural inequalities acting on parent e.g. poverty, racism, classism, housing and benefits insecurity

Child-related

- Child's experience of maltreatment – increased risk of mental illness and/or behaviour problems (double jeopardy)
- Child neurodevelopmental conditions
- Structural inequalities acting on child e.g. poverty, racism, classism, school stigma, neighbourhood threats/bullying

Column B: Mechanisms of problem development

This column shows three boxes with a double headed arrow between, ‘Increasing parental stress’ and, ‘Increasing child stress’, boxes contain:

- Shame, leading to a sense of powerlessness
- Trust issues, tendency to perceive rejection
- Severe relationship dysfunction

Below ‘Increasing child stress’ is three small double headed arrows making a circle, connected to ‘Increasing child behaviour problems’.

Column C: Inputs delivered via IPS and mechanisms of change

Central box contains, “Relationship focussed treatment (e.g. child-parent psychotherapy)”, and there are 5 boxes around this with arrows pointing to this box. There 5 boxes contain:

- Parent understanding of own NDC and maltreatment profile, and their links with additional mental illness/substance misuse reduces self-blame and stress
- Specific psychiatric treatments if required
- Parental receives respectful support (including therapist acknowledgement of structural inequalities) in addressing current material circumstances reducing stress
- Parent understanding of how own NDD profile and child NDD profile interact, reduces parent self-blame, child blame and reduced parent and child stress
- Child and parent understanding of child NDD symptoms reduces child stress and behaviour problems

There is also a seventh box with a bold outline that reads ‘reducing stigma and shame’.

Column D: Outputs

- ‘Reduced relationship dysfunction’ is the middle box of three with an arrow from this box pointing to these two boxes above and below:
    - Improved parental mental health and material circumstances
    - Improved child mental health and material circumstances

‘Reduced relationship dysfunction’ also has an arrow pointing to the middle box in Column E: Outcomes.

Column E: Outcomes

- ‘Avoidance of need for social care’ is the middle box of three with an arrow from this box pointing to these two boxes above and below:
    - Continued good parental mental health and material circumstances
    - Continued good child mental health and material circumstances

At the bottom of the 6 boxes in columns D and E there is also a box containing: 'What do parents want to see as tangible outputs and outcomes? Can we codesign, with parents, a quantitative person centred outcome measure for use in a future definitive RCT?'

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Figure 4: Visual representation of referrals into IPS

The diagram consists of seven concentric circles, illustrating how children's services engage with families based on their level of need. As the circles move inward, they represent increasing levels of intervention. The outer purple circles indicate voluntary services without social worker involvement, while the green circles represent voluntary services that include a social worker. The innermost orange and red circles signify statutory services for families with the highest levels of need. Children who are suffering significant harm.

The diagram also highlights where most families recruited for the trial were positioned and identifies potential new referral pathways for future studies.

Above the concentric circles is text reading 'Potential recruitment pathways for a definitive trial' and two boxes either side with arrows pointing towards this text:

- Universal services – children where their needs are being met by universal services, e.g. GP, Dentist, Health Visiting, Midwifery, Children's Centres & Eary Years Settings, Education, school nurse.
- Early help – provides help to families who do not, or no loner, meet the threshold for a statutory intervention. Early help teams may involve mental health nurses, health visitors, therapists, psychologists, social workers, and family support workers/practitioners.

The seven concentric circles are from outside in are:

1. Universal Services (purple) - Labelled as voluntary without a social worker.
2. Early Help (light purple) - Labelled as voluntary without a social worker.
3. Child in Need (green) – Labelled as voluntary with a social worker; has an arrow labelling this as the 'Our target population for IPS'
4. Unidentified Child Protection (darker green) – Labelled as voluntary with a social worker; has an arrow labelling this as the 'Majority of families referred to IPS'
5. Child Protection (yellow-green)
6. Pre-Proceedings (orange)
7. Court (red)

There is an arrow point from the outer circle to the inner circle labelled "Increasing need and complexity"

Click here to return to main report.