



Deposited via The University of Sheffield.

White Rose Research Online URL for this paper:

<https://eprints.whiterose.ac.uk/id/eprint/244907/>

Version: Published Version

Article:

Woodrow, N., Holding, E., Arnott, B. et al. (2026) Facilitators and barriers to promotion of and engagement in a parent-infant relationship intervention: a qualitative study. BMC Health Services Research. ISSN: 1472-6963

<https://doi.org/10.1186/s12913-026-15408-y>

Reuse

This article is distributed under the terms of the Creative Commons Attribution (CC BY) licence. This licence allows you to distribute, remix, tweak, and build upon the work, even commercially, as long as you credit the authors for the original work. More information and the full terms of the licence here:

<https://creativecommons.org/licenses/>

Takedown

If you consider content in White Rose Research Online to be in breach of UK law, please notify us by emailing eprints@whiterose.ac.uk including the URL of the record and the reason for the withdrawal request.

Facilitators and barriers to promotion of and engagement in a parent-infant relationship intervention: a qualitative study

Received: 23 July 2024

Accepted: 13 August 2026

Published online: 26 August 2026

Cite this article as: Woodrow N., Holding E., Arnott B. *et al.* Facilitators and barriers to promotion of and engagement in a parent-infant relationship intervention: a qualitative study. *BMC Health Serv Res* (2026). <https://doi.org/10.1186/s12913-026-15408-y>

Nicholas Woodrow, Eleanor Holding, Bronia Arnott, Habiba Aminu, Hannah Fairbrother, Kath Wilkinson, Nai Rui Chng, Helena Cripps, Lisa Wilson, Sarah Betts, Robyn Meadows & Elizabeth Goyder

We are providing an unedited version of this manuscript to give early access to its findings. Before final publication, the manuscript will undergo further editing. Please note there may be errors present which affect the content, and all legal disclaimers apply.

If this paper is publishing under a Transparent Peer Review model then Peer Review reports will publish with the final article.

Facilitators and barriers to promotion of and engagement in a Parent-Infant Relationship

Intervention: a qualitative study

Authors:

Nicholas Woodrow^{1*}, Eleanor Holding¹, Bronia Arnott², Habiba Aminu¹, Hannah Fairbrother³,
Kath Wilkinson⁴, Nai Rui Chng⁵, Helena Cripps⁶, Lisa Wilson⁷, Sarah Betts⁷, Robyn
Meadows⁷, Elizabeth Goyder¹

Authors' institutional affiliations:

1 Sheffield Centre for Health and Related Research (SCHARR), University of Sheffield,
Sheffield, S1 4DA, UK

2 Population Health Sciences Institute, Newcastle University, Newcastle, NE2 4AX, UK

3 Faculty of Health, University of Sheffield, Sheffield, S10 2LA, UK

4 Department of Public Health and Sports Science, University of Exeter Medical School, Exeter,
EX1 2LU

5 MRC/CSO Social and Public Health Sciences Unit, School of Health and Wellbeing, University
of Glasgow, Glasgow, G11 6EW, UK

6 Nottinghamshire County Council, Nottingham, NG2 7QP, UK

7 Nottinghamshire NHS Foundation Trust, Nottingham, NG3 6AA, UK

*corresponding author: Nicholas Woodrow (n.woodrow@sheffield.ac.uk)

Abstract

Background

Parent-infant relationships have a significant impact on children's health outcomes. Despite growing evidence that parenting interventions designed to improve parent-infant relationships can be effective, there is less information about what makes parenting interventions meaningful and helpful to parents, and what barriers and facilitators contribute to service accessibility and engagement. To address this knowledge gap, this paper explores the perspectives of both professionals and service users regarding the valued features of, and the barriers and

facilitators influencing promotion and participation in, the Nottinghamshire (UK) Healthy Families Parent-Infant Relationship intervention (PIRi).

Methods

Primary qualitative data were collected employing purposive sampling. We undertook virtual/phone interviews with nine professional staff involved in the PIRi delivery and fourteen parents who had received support. Data were collected between May and July 2023, and analysed thematically using Nvivo 14.

Results

Several points in the PIRi process acted as barriers and facilitators to engagement and promotion. Health visitors are the key identification and referral route for the PIRi, but they reported lacking detailed knowledge of the specific support provided, impeding their ability to promote the intervention clearly and consistently. This led to misunderstandings around support for parents and concerns about stigma from their referral. Existing capacity challenges within the health visiting service meant limited family contact time, making it difficult to build rapport and identify those who would benefit from the PIRi. Further, confidence around discussing parent-infant relationship difficulties sensitively was reported as a barrier, with concern about relationship breakdown between professionals and families. Awareness of support options and the tailored nature of support were important in encouraging parents' engagement. Parents who accepted PIRi support reported extremely positive experiences and outcomes. Support was seen as accessible, tailored and flexible, and perceived as improving bonding, connection and relationships.

Conclusions

Our study highlights the importance of effectively promoting and embedding knowledge of services, and supporting key referral routes and pathways of care. A clear understanding of service offerings can facilitate more appropriate referrals and better engagement through clear

and consistent messaging about support. Further, ensuring that support is accessible, tailored and flexible is crucial in promoting engagement in parenting programmes.

Keywords: Parent-infant relationship, Parenting intervention, Health visitors, Service evaluation.

Background

The first 1001 days of a child's life, from conception to age two, are a pivotal stage for emotional, physical, mental and neurological development [1,2]. Parent-infant relationships have a significant impact on children's socio-emotional development, health outcomes, educational engagement and attainment, and life chances throughout childhood and into adulthood [3,4,5,6]. Poor parent-infant relationships (characterised as involving inconsistent or disengaged caregiving, a lack of sensitivity to a child's needs, issues consistently recognising and responding to a child's cues) are associated with various negative short- and long-term health outcomes for children, including behavioural problems and mental health concerns [5,7,8]. There is growing evidence that parenting support interventions help improve parenting practices, and health and social outcomes for children [4,9,10], and that parenting interventions show the potential to be cost-effective [11,12,13]. Parenting support interventions can be understood as programmes or services designed to enhance parental knowledge, skills, and confidence. These interventions typically aim to improve parent-child relationships, promote positive parenting practices, and support a child's healthy development. Early intervention to support parent-infant relationships has been identified as a priority in national policy discussions in England [14,15]. The publication of the Early Years Healthy Development Review [16] and a £300m government investment in 75 local areas across England as part of the Family Hubs and Start for Life programme [17] recognises the contribution of the earliest years of life to health and wellbeing. This three-year funding includes £100m dedicated to increasing and developing perinatal mental health and parent-infant relationship support.

Parenting support interventions: barriers and engagement

Despite a move to increase support, there are many barriers to engaging parents in parenting interventions. These barriers are commonly related to both the accessibility and acceptability of available support. Practical issues such as the location of services, limited availability of local provision, and the time and financial costs associated with attendance (including travel time and public transport expenses) can substantially reduce participation [14,18]. In addition, interventions delivered in settings that feel unfamiliar, formal, or clinical may contribute to perceived stigma, particularly where such environments evoke concerns about being judged as an inadequate parent, alongside a broader lack of trust in professionals and statutory services that some parents perceive [10,14]. Childcare-related challenges also represent an important barrier, as parents may need to arrange and fund childcare in order to attend sessions, which can further limit engagement [10,18]. Parental mental health difficulties may act both as a reason for referral to parent–infant interventions and as a barrier to continued participation, for example where symptoms such as anxiety, low mood, or reduced motivation make attendance more difficult [14,15]. Furthermore, a lack of awareness of available services has been identified as an additional obstacle to engagement in parenting and early intervention programmes [14]. Conversely, previous research suggests that flexibility in delivery and the provision of tailored, individualised support are key facilitators of engagement in parenting interventions [9,18]. Some groups are noted as underserved by parenting support services (e.g., the most socio-economically disadvantaged and minoritised ethnic groups), with an acknowledged discrepancy between families who are in need of support, and those who often access support [8,9,19]. Families living in socioeconomically disadvantaged areas may be at greater risk of experiencing relationship difficulties, due to broader structural pressures. These include financial strain, housing insecurity, reduced access to local support services, limited social support networks, and increased exposure to environmental stressors, all of which can place sustained pressure on family relationships [5,14,18]. However, there is evidence that these families can benefit from

support [3]. This highlights important public health benefits of targeting and ensuring access to support for those in need [20].

In the UK, health visitors (HV) are recognised as being well-placed to identify difficulties in parent-infant relationships [21,22]. HV are specialist community public health nurses, registered midwives or nurses who specialise in working with children from birth to age five to identify and support health needs. The HV workforce undertake five mandated contacts with all babies at key stages of development, including the Health-Promoting Visit at 28 weeks of pregnancy, the New Baby Review at 1 to 2 weeks, the 6 to 8 Week Assessment, the One-Year Assessment at 9 to 12 months, and the Fifth Visit at 2 to 2-and-a-half years [23]. Challenges in identifying parent-infant relationship difficulties have been highlighted by HV, and they have noted the importance of specific training to support this [24,25,26]. Further, the perceived stigma associated with parent-infant relationship difficulties has been noted as a barrier for HV around discussing and referring for support [27,28]. This suggests opportunities to identify families who would benefit from support are being missed.

The Parent-Infant Relationship intervention (PIRi) evaluation

This study reports on an evaluation of the Nottinghamshire Healthy Families Programme Parent-Infant Relationship intervention (PIRi).

Below we describe the PIRi, drawing upon the Template for Intervention Description and Replication checklist and guide [29]. The PIRi was developed as a service to increase capacity and support for parent-infant relationships, due to an identified gap in local provision. The PIRi was developed in Spring 2022, and initially ran for an 18-month pilot period, during which it was evaluated. The PIRi is delivered within the Nottinghamshire Healthy Families Programme (HFP). The PIRi aims to support parents with bonding and connection needs to strengthen their relationship with their baby. It involves the identification of families in need of support by HV within the Nottinghamshire HFP, typically either at the mandatory New Baby Review or 6-8-week assessment. Following completion of the Brazelton New-born Behavioural Observation

(N-BO) tool [30], the N-BO results and professional clinical judgement by HV are used to inform a referral to the PIRi team. Parents are invited to opt-in to the initiative before a referral is made. The PIRi team meet once a week to discuss referrals and cases. If a referral is accepted, the PIRi team carry out their own assessment with the family and discuss what support can be offered. The initiative provides up to six support sessions over 6-12 weeks, across a range of areas of infant development, responsive parenting, parents' emotional health and wellbeing, and parent-infant relationship, depending upon the specific needs of the family. The sessions are individually tailored and co-designed with parents, drawing from a toolkit of interventions of existing resources, including NHS and charity materials (e.g., from the parent-infant foundation), accessible to the PIRi service. Support is primarily delivered face-to-face at parents' homes. One PIRi practitioner delivers support, and sessions can include one or both parents. At the end of the sessions onward referral options are explored with parents. The PIRi is usually delivered to parents with babies under 16 weeks old, but after consultation with the HV, the PIRi team can work with parents with babies up to 12 months old. The PIRi team comprises two full-time specialist public health practitioners and a service manager.

Study aim

This paper presents findings from the qualitative arm of a wider mixed methods evaluation which aimed to explore the perceived feasibility, acceptability, and effectiveness of the PIRi. The evaluation aims, objectives and design were co-developed with Nottinghamshire HFP stakeholders as part of an initial Evaluability Assessment process [31].

Despite growing evidence that parenting interventions can be effective, there is less information about what specifically makes parenting interventions meaningful and helpful to parents, and what barriers and facilitators contribute to service accessibility and engagement [8,10,18]. To address this knowledge gap, this paper explores the perspectives of both professionals and service users regarding valued features of the PIRi, and barriers and facilitators influencing promotion of and participation in the PIRi.

Methods

Sample and recruitment

We employed purposive sampling to capture a range of perspectives from key stakeholders involved in the PIRi. We completed nine interviews with professional staff (a PIRi commissioner, the PIRi service manager, the two PIRi practitioners, and five HV), and fourteen interviews with parents (see Table 1 for parents demographic information – due to the size of the PIRi team (one manager and two practitioners), we did not collect demographics on service providers due to confidentiality concerns)). Professional staff were contacted by our PIRi project partners, and were provided with information sheets and consent forms (see Additional File 1) and invited to contact the research team if they were interested in participating. The inclusion criteria for professional staff were based on their involvement with the PIRi. Specifically, only staff who had some form of involvement with the project were invited to participate. Parents were approached by their PIRi practitioner and initially provided with a verbal description of the study, and if they expressed interest in taking part, were provided with a project information sheet and consent form (see Additional File 1). All parents consented to their contact information being securely transferred to the research team. The research team contacted parents to discuss the research further and then followed up a week later to arrange interviews. The study's inclusion criteria for parents were based on their engagement with PIRi support. Parents were included if they had either completed their support or were nearing its end. We excluded parents who had just started their support to ensure that research participation did not interfere with the initial stages of their PIRi engagement. All participants had time to read the information sheet, and to consider and ask questions about participation. All participants provided written informed consent for their involvement in the research.

Table 1: Parent demographic information

Participant	Age	Gender	Ethnicity	Index of Multiple Deprivation

				Decile (based on postcode). *
Parent 1	37	Female	White British	5
Parent 2	33	Female	White British	10
Parent 3	32	Female	White British	8
Parent 4	35	Female	White British	8
Parent 5	33	Female	White British	7
Parent 6	28	Female	White British	10
Parent 7	26	Female	White British	3
Parent 8	41	Female	Asian Other	1
Parent 9	31	Female	White British	4
Parent 10	29	Female	White British	8
Parent 11	38	Female	White British	5
Parent 12	37	Male	White British	5
Parent 13	36	Female	White British	4
Parent 14	37	Female	White British	1

* The Index of Multiple Deprivation Decile is a measure used in England to rank areas based on their level of deprivation Postcodes are ranked from 1 to 10 - A decile of 1 means the area is among the top 10% most deprived in the country, while a decile of 10 means the area is among the top 10% least deprived in the country.

Data generation

Before data collection, interview topic guides, study information and consent forms were reviewed for comprehension (wording, structure, content) and revised with feedback through engagement and participation work with HFP professionals not directly involved in the PIRi. The interviews followed semi-structured topic guides (Additional File 1). This approach ensured consistency across interviews while allowing for the emergence of participant-led insights. For professional staff, interviews explored topics around facilitators and barriers to delivering the PIRi programme, recruitment/engagement issues and perceived outcomes. For parents, interviews explored understandings of the PIRi, facilitators and barriers to engagement and perceived impacts of support.

All interviews were conducted by NW or HA via telephone call or an online video call between May and July 2023, and lasted 30-60 minutes (mean length 54 minutes). Participants

participated from private home/office spaces. Interviews were audio recorded only, using an encrypted recorder. All interviews were transcribed verbatim by a university department transcription service, and anonymised at the point of transcription.

Data analysis

The analysis was conducted by a multidisciplinary research team with research perspectives and practice experience spanning health inequalities, substance misuse, youth offending, and child and adolescent mental health. Interview data were analysed by NW, HA and EH, drawing on a thematic analysis approach [32]. To ensure the trustworthiness and credibility of the findings, several measures were employed. A coding framework was applied to the transcripts (see Figure 1). The development of the coding framework was both inductive and deductive, with an initial scaffolding being used, developed from the RE-AIM evaluation framework [33]. The RE-AIM framework is a widely used tool in public health and implementation science to plan and evaluate interventions across five key dimensions: Reach, Effectiveness, Adoption, Implementation, and Maintenance (see [33] for more detail). The RE-AIM framework was chosen as the key dimensions of the framework map well onto the aims of the evaluation. The five key dimensions of the RE-AIM framework were amended and defined based on the evaluation aims and initial reading of a selection of interview data by NW, HA, and EH (five different transcripts each). NW, HA, and EH engaged in regular peer debriefing sessions to discuss initial thoughts and codes and the dimensions were amended to: Access (are people able to engage/participate); Accommodation (how the service is organised to suit the service user's ability to engage); Effectiveness (perceptions of effectiveness); Implementation (the extent to which a programme is delivered as intended); Maintenance (considerations for continued use/implementation).

All transcripts were shared, read and coded by NW, HA and EH, with codes amended and developed based on reading the interview transcripts. The coding framework was added to and revised in research team meetings, with codes grouped under the main code headings and

arranged into sub-codes (see Figure 1 for more information). The coding framework was then applied to a selection of transcripts (six transcripts, two each for NW, HA, EH), which were double-coded to check for coding consistency and to mitigate individual researcher bias. This involved each author coding two transcripts, with each being coded by one other researcher. These were then checked in consensus meetings. The remaining seventeen transcripts were then split and allocated between NW, HA and EH, and coded. Once all transcripts were fully coded, we organised and grouped related codes into overarching themes through an iterative process. Through the analysis, during analysis and wider team discussions, key themes around the different barriers and facilitators to PIRi engagement were generated and developed. NW, HA, and EH reviewed the themes, ensuring they were well-supported by rich verbatim excerpts from the transcripts, maintaining a clear audit trail from the data to the final interpretation, and confirming that similar perspectives were consistently present in the professional staff and service users' accounts. The multidisciplinary composition of the wider research team around the fields of public health and parent-infant relationship interventions, informed both the project development and the interpretation and implications of our findings. These varied professional and research perspectives supported reflexive discussion throughout the analytic process and helped ensure that interpretations were critically examined and grounded in the data.

A larger and more diverse sample may have produced different findings, but drawing on a relatively new and small service, and managing the challenges of recruitment in healthcare settings [34,35], our sample appeared sufficient enough to provide valuable insights [36].

Transcripts were coded using the qualitative data management software system NVivo 14.

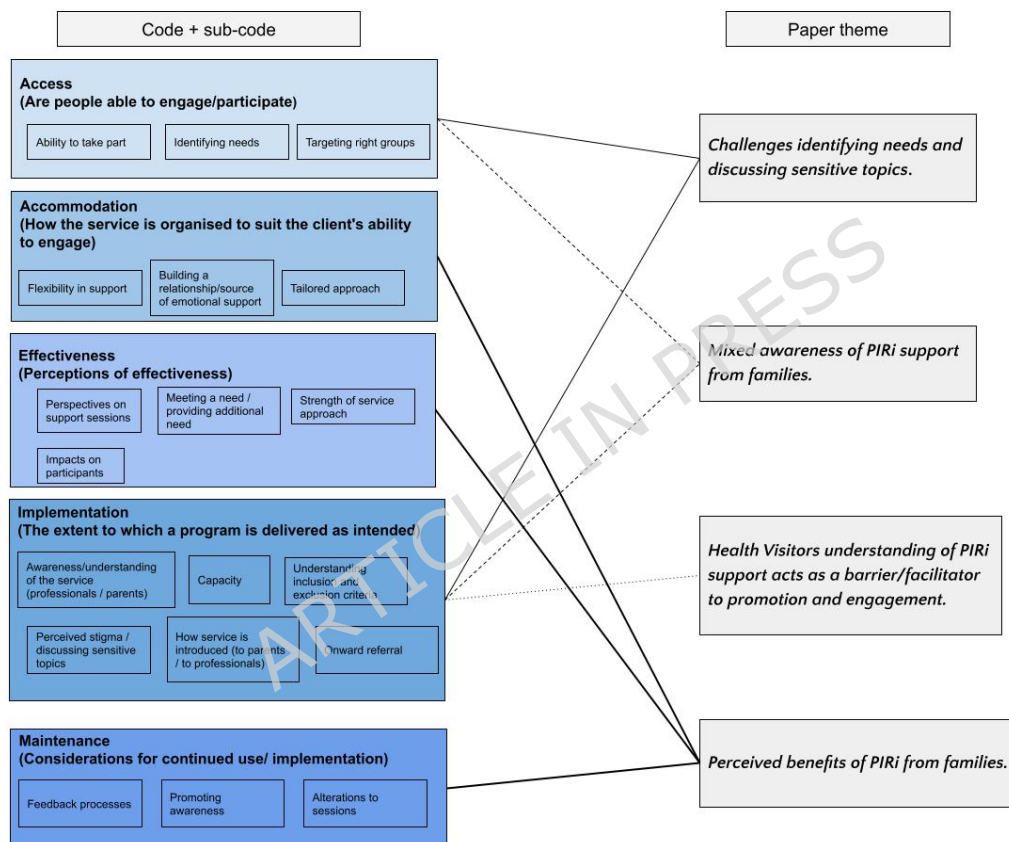
Ethics

Ethical approval for the study was granted by the Sheffield Centre for Health and Related Research (SCHARR) ethics committee at the University of Sheffield, application reference number: 051579.

Results

Four main themes were generated from the analysis: (1) Challenges identifying needs and discussing sensitive topics, (2) Health Visitors understanding of PIRi support acts as a barrier/facilitator to promotion and engagement, (3) Mixed awareness of PIRi support from families, (4) Perceived benefits of PIRi from families. Figure 1 describes the development of the themes.

Figure 1: Coding framework and theme development



Our findings highlight how barriers and facilitators to the delivery of the PIRi existed at different time points in the identification and referral process. There were issues around engaging parents, but before this, challenges around identifying difficulties, and issues of knowledge, awareness and promotion from HV (the key referral route) were identified. When parents engaged in the PIRi, support was reported to improve parenting knowledge and skills, as well as bonding and relationships with babies.

Challenges identifying needs and discussing sensitive topics

HV discussed their capacity and the scope and frequency of their contact with families as being key challenges to identifying parent-infant relationship difficulties. This was due to a combination of the limited number of contacts and the large number of tasks that HV must deliver during each contact, the number of other services they need to be aware of, and the lack of time they have to build rapport with a family. Indeed, the HV discussed how the New Baby Review was often too 'hectic' for identification of parent-infant relationship difficulties, leaving a limited opportunity for the HV to observe interactions and discuss the PIRi at the 6-8 Week Visit:

'The birth visit is often just, parents need time we often go out and the parents are struggling to get to grips with everything, and when you've just had a baby, it's a massive life-changing event, and the hormones are all over the place, they're sleep deprived, there's a lot going on with a two weeks old, so it's very difficult to identify a problem with a relationship then.' (Health visitor 5)

Further, HV and PIRi practitioners referred to how a lack of confidence and knowledge in approaching or discussing issues around parent-infant relationships may hinder the identification of need, and impact referrals. Highlighting a common challenged experience by HV, a PIRi practitioner discussed how HV often reported feeling like they are navigating stigmatising topics, and are worried about potentially making parents feel judged:

A lot [of HV] come back and say they find it quite difficult to talk to parents about the service and infant relationships, and that parents feel like they are being judged.' (PIRi practitioner 2)

HV described how they were not 'scared' to have such conversations, but expressed concerns around how to effectively do this. A common concern about approaching such topics was

around relationship breakdown between staff and families. Here a HV highlighted the challenges of raising potential issues around parent-infant relationships with parents who may not be aware of any issues, and the damage and upset this can cause:

'Obviously it's quite a sensitive topic, especially going in at the birth visit when the baby is two weeks old, and you're saying you've identified that there could be improvements in the relationship, especially for those families that aren't identifying it themselves, it's fine if a mum has given birth and is open about saying it...they may say they never want you to go back, and then you're never going to see them anymore.' (Health visitor 3)

Strategies HV used to identify needs included; assessing if issues came up in natural conversations, following up if parents self-identified challenges, and discussing any identified need from the health visiting checklists and assessments they complete (e.g., the N-BO). Crucially, language and framing from professionals were seen as important in ameliorating potential concerns. However, stigma and the threat of stigma, were continually highlighted by HV:

'There is a stigma around it, but again, I think it's about how you deliver it.' (Health visitor 4)

Health Visitors understanding of PIRi support acts as a barrier/facilitator to promotion and engagement

Whilst all HV we interviewed were aware of the PIRi, there was mixed awareness around understanding of the specific support offered (including the programmes content, its flexibility and tailored support) and of the referral criteria:

'People will say to you, well what kind of things do they do?...What I don't have a good understanding now is what's delivered sort of week by week...it would be good to just have a general overview of the sessions. I would like a, maybe a booklet with the contents of the programme so that I'm giving more information about what's actually

involved in the programme. I don't really know much about the contents of it.' (Health visitor 1)

Indeed, many noted that they and other HV in their team needed further information, especially around the specifics of the support and sessions provided:

'No, I don't think I do [have a good understanding of the PIRi] as much as I'd like to.

So, I think from our perspective within the [health visiting] team we could do with having more information on that so we, that we can understand it a little bit more.' (Health visitor 4)

Some HV noted how their understanding of the PIRi helped them explain the support and promote engagement. For others, a greater understanding was noted as needed to aid promotion to parents. One HV spoke about how having a better understanding of the PIRi can be used to avoid notions of stigma, and help highlight specific support that can be offered:

'If we can have that greater understanding [of the PIRi] and things we can explain it to them a little bit more and say no, no, no this is about support and explaining to them that this isn't anything to be ashamed of.' (Health visitor 3)

The PIRi practitioners reported how they had spent time promoting and publicising the support (e.g., attending HV meetings to increase awareness of the service). Whilst this worked in the short term, it was noted as time and resource-intensive and did not have a lasting effect:

'Going to the face-to-face [health visiting team] meetings has been useful, and following them we do seem to get an increase in referrals from those areas, then the drop again and we do a refresher and they go back up.' (PIRi practitioner 1).

This highlighted the wider challenge of embedding knowledge of new services into HV practices. One HV spoke of how the lack of familiarity with the PIRi could result in a lack of use and promotion due to them reflexively referring to established support options:

'It's like any new service, it's not the first thing that people think about, because you're so used to referring onto something else like the children's centre.' (Health visitor 2)

Others spoke of how there were many community, health and mental health services for parents to be referred to for a variety of needs, and it was difficult for HV to keep track of new services:

'There's so much support now that we can refer to and have to be aware of, so it's just hard to keep up with new ones, and to remember 'oh there's this for parent infant relationships now.' (Health visitor 1)

Mixed awareness of PIRi support from families

Parents noted mixed initial awareness of the PIRi:

'I thought it sounded amazing, as soon as she [HV] told me about it, I thought that sounds like it will be so good for us, like it would help so much.' (Parent 2)

'To be honest I didn't really know what they [PIRi] did, I'd forgot what I'd been told after I'd been referred over. But [PIRi practitioner] came out and explained what it was.' (Parent 7).

Several parents noted that initially, they had a limited understanding of the PIRi service and support based on the description and information provided to them by their HV. This resulted in anxiety for some parents during initial discussions. Due to preexisting perceptions around parenting support programmes, some parents noted that they had concerns about being judged as a parent when the PIRi was first presented, which acted as a barrier to participation. As an example, this parent discusses perceptions of stigma around help-seeking and parenting, and how these can be mitigated by clear and supporting interactions with professionals:

'My first thought was, are they going to report me to social care because I'm not coping, is that a red flag against my name like I can't look after my baby or something. So it does feel like there is a bit of a stigma around asking for help, but I kind of realised that wasn't the case. [PIRi practitioner] was very supportive, she made it clear straight away I'd done the right thing.' (Parent 1)

Indeed, concerns around stigma and judgment were reassured either through a clearer explanation by a HV, or during initial meetings with PIRi practitioners where they could explain the PIRi and the support that could be offered:

'There was apprehension at the beginning because there was not a lot of information around exactly what they can offer, so it wasn't until [PIRi practitioner] came out and explained everything in detail that we realised what we could get.' (Parent 5)

A number of parents reported they needed general support around their mental health as well as parent-infant relationship difficulties, and thus accepted the PIRi referral without full appreciation of what support could be provided:

'It probably wasn't so much about the benefits or what the service was going to be because that information wasn't available at the time... I just wanted all the help I could get.' (Parent 12).

While this could be beneficial in terms of engaging and supporting families, it sometimes created unnecessary appointments for the PIRi practitioners. The importance of HV having a clear understanding of support was vital, for both parent's awareness and ensuring the PIRi practitioner's time was not wasted:

'Occasionally you go to them and they have no idea, and I think they're the only ones who say, "I didn't realise that's what you did", and they're the ones who will come back to you and say they don't need the support, and a lot of that is about the health visitors and how they are explaining the service.' (PIRi practitioner 2)

Perceived benefits of PIRi from families

Despite the identified challenges around identification and referral, parents who engaged in the PIRi spoke extremely positively about the support. All parents we interviewed reported positive impacts on their overall health and wellbeing, particularly their mental health. Parents noted improvements in their parenting knowledge and skills, and crucially for many parents, improvement in confidence around parenting:

'It's [PiRi] been tremendously useful for building my relationships with [baby name], it's given me a lot more confidence than I set off with.' (Parent 8)

Parents felt the PIRi support improved bonding, and connection, and increased their awareness and ability to identify their babies' needs, ultimately strengthening their relationships. In speaking about their learning through PIRi support, one parent spoke about gaining 'understanding', and how this made them 'more comfortable' being with their baby:

'I felt more comfortable with being around her, [baby], with understanding her needs, I felt like I'd learnt something new every time that we had a session.' (Parent 4)

Parents described the PIRi support as accessible (predominantly due to it being delivered in their own homes). Home support was invaluable for some parents, enabling their engagement at both practical and personal levels. The below quote highlights how support being delivered at home made this parent's engagement possible by reducing logistical and mental health barriers around participation, with this allowing them to be 'relaxed', enabling them to focus on the support sessions:

'We wouldn't have done it, if we had to go out, we wouldn't have done it, not with my anxiety around leaving the house. So because they were coming to us, was another reason we kept the sessions. Even now it's such a mammoth task to go to a play group or something, so having [PIRi practitioner] come here, it helped to make the sessions feel calmer and relaxed, I wasn't having to rush round to get bottles ready and stuff, all that stuff, it just meant all I needed to go was be at home, and then I could concentrate on what [name] was saying... doing it at home helped with my anxiety, so this made sure I didn't miss out' (Parent 11)

As well as home support, the consistency of having the same PIRi practitioner was a key benefit to many parents. This helped build rapport and relationships which led to developing 'trust' – this not only improved engagement, but also reduced perceived stigma allowing things such as 'shame' to be overcome:

'But I did think this was really good, that it was consistent and that you could build a relationship. I think you're building up a relationship through it, and you open up to them more and you trust them more, you don't feel ashamed to say things... I wouldn't have shared as much as I did if it kept being someone different' (Parent 9)

Parents highlighted the flexible and tailored nature of the PIRi support as crucial. This was also described as a key component of the PIRi programme by the HV and PIRi practitioners:

'We have a menu of interventions we work from...we agenda match, so we only do what the families need, and we establish that in our initial visit, and we are looking at that all the time.' (PIRi practitioner 1)

This continued focus on a collaborative approach by the PIRi team, created a perception that support was designed around the family's needs. Parents spoke about how support was perceived to be responsive to issues experienced during the babies' development:

'I appreciated how they moved things, and ran the session based on how we both felt was appropriate...It was like we'd have a session and then see what was needed next. And having that time for a general conversation about how things were, would shape what we did next.' (Parent 13)

This flexibility was described as feeling like support was personalised and 'tailored'. This was seen as a key aspect of the PIRi, and played a role in continued engagement in support,

'The person I had was very good at looking at what actually I did need, and not just following a programme just because, so it really tailored it, so we did weening, things like having difficulties with teething and things like that, and she just gave really helpful advice and things like that, and that to help with my anxieties...That really helped me, I wanted to keep working with them because I was getting support for new things that was coming up' (Parent 3)

Discussion

Our findings identify several key points in the PIRi referral process which acted as barriers and facilitators to engagement and promotion of the PIRi. HV limited contact with families was noted as a barrier to identifying need, as this made it challenging to build rapport and effectively identify parent-infant relationship difficulties. Further, HV highlighted challenges in discussing topics around parent-infant relationships, and a lack of confidence and concern around relationship breakdown between professionals and families. The HV reported lacking understanding of the specific support the PIRi offered, with this limiting their abilities to clearly and consistently promote the PIRi to families. Parents' initial awareness of the programme varied based on the HV explanations. This resulted in some parents expressing concerns about stigma and judgement, with a clearer explanation reducing such concerns. For parents who engaged in support, the PIRi was seen as extremely positive and provided valued support to parents around improving bonding, connection and relationships with babies. Awareness of support options and the flexible and tailored nature of support was important in encouraging engagement for parents. The perceived positive impacts of the PIRi supports the growing evidence around the benefits of parenting support interventions [4,9,10,18]. The emphasis on flexibility and tailored support also echoes wider literature around what features of parenting interventions encourage engagement [18,37,38].

It has been suggested that up to a third (32%) of UK mothers may experience difficulties around bonding with their babies [39]. Our evaluation supports evidence that HV are well placed to identify such parent-infant relationship difficulties [22]. However, it crucially highlights challenges for HV in identifying need [24,25,26], due to limited understanding of support, confidence in talking to families about parent-infant relationships, and capacity issues. A key barrier to the effective promotion of the PIRi was HV awareness of the specific support offered and the flexible and tailored nature of support. These were particularly important in promoting the PIRi and benefits of engagement to parents, and overcoming initial concerns of stigma and judgement [27,28]. Our study highlighted how initial concerns during referral, due to an unclear

description of the PIRi, could be mitigated through a clear explanation by a HV or PIRi practitioner. The concerns identified by our participants around stigma and judgement associated with participation suggest potential barriers to engagement. While these concerns were expressed within our sample, existing literature suggests that such issues may be particularly salient for more vulnerable families, who may experience more frequent or mandatory contact with services and perceive a greater risk of professional scrutiny or formal consequences. This can contribute to heightened concerns about service involvement and perceptions of 'surveillance' by professionals [40,41,42]. Where parents do not clearly understand the nature of the support being offered or its potential benefits, these concerns may lead to declining referrals or reduced engagement.

Reflecting the wider literature [24,43] HV noted that they are using a range of approaches to identify and discuss parent-infant relationship difficulties, but often have to rely on clinical judgement/experience rather than formal training or validated assessment tools. Confidence in approaching and discussing parent-infant relationship difficulties was noted as a key barrier for HV in discussing the PIRi. This supports existing evidence around how HV perceived challenges discussing sensitive topics [43,44,45,46]. Our study adds to calls for further training and support around the importance of parent-infant relationships, and how to approach discussions around parent-infant relationship difficulties [24,25,26,43]. The UK Government has recently published guidance for frontline practitioners on how to explore parent-infant relationship difficulties, including prompts for starting conversations [47]. Developing this, alongside increasing awareness of parent-infant relationship support services, may help better identify unmet need for families. However, it will be important to robustly evaluate the implementation of the conversation prompts.

The HV participants in our study noted how their workloads and the limited amount of time they had to spend with families, impacted their abilities to identify needs. This reflects workload and

caseload issues of HV more widely [48] with HV numbers decreasing by over a third (37%) since 2015 [49] in part due to reductions in The Public Health Grant (£4.2 bn in 2015-16, £3.3 bn in 2021-22) [50]. This highlights how capacity and workload issues can impact the identification of needs through limited contact time with families. Thus, whilst HV may be well placed to identify need, our study highlights how there are considerable barriers in place around knowledge, confidence and capacity.

Implications for practice

Our findings highlight the importance of key referral sources being knowledgeable and informed about services and the specific support they offer to identify need and promote engagement. Providing parents with a clear understanding of available support during the initial presentation of services may facilitate uptake and reduce wasted referrals and initial assessments. Further, highlighting features of support seen as key components (e.g., flexible support, tailored support, consistency in staff, one-to-one and home delivery of support) may encourage engagement. Indeed, developing trusting relationships between practitioners and parents through consistency in staff has been noted as crucial in fostering parent engagement and ensuring the effective implementation of programmes [38, 40, 42]. Further, home delivery of support can help address many barriers around accessibility (e.g., eliminating travel and childcare costs) and can reduce anxiety and stress, which is especially beneficial for people with mental health concerns. However, it is also important to acknowledge that home-visiting may not be experienced uniformly across families. For some, particularly where there are pre-existing concerns about professional involvement, judgement, or formal service scrutiny, receiving support within the home environment may evoke feelings of being monitored [40,41,42]. In these contexts, home-visiting could potentially heighten anxiety or reduce willingness to engage, suggesting that the perceived benefits of this mode of delivery may depend on how the intervention is introduced, explained, and collaboratively negotiated with families.

Information resources provided to parents early on (e.g., leaflet/website detailing service information and specific support offered) may help provide clarity and consistency regarding support, potentially stimulating parents to identify and bring up parent-infant relationship difficulties themselves outside of mandatory HV contacts. Due to the identified challenges from HV around identification and referral (awareness of the PIRi, limited HV capacity), multiple referral routes may enable more effective identification of families who might not be reached through the single pathway of HV referral. Indeed, providing multiple service access routes has been noted as a key feature of effective engagement and access [51].

Embedding PIRi workers into health visiting teams may support awareness of the availability of parent-infant relationship support and encourage referral and discussion of issues. More generally, HV may benefit from further training and support in the importance of parent-infant relationships and how to have discussions around parent-infant relationship difficulties (building on recent Government guidance) [47]. Our findings show how parents' initial anxieties and perceptions of stigma may be reduced by providing clearer information about support, using appropriate language and framing when discussing services and support, highlighting benefits to the baby and parent's wellbeing, and emphasising that support is not a reflection of parenting abilities.

Generally, clear information about services and support may encourage promotion from professionals, encourage engagement for families by overcoming reticence or concerns about stigma, and result in the identification of more appropriate referrals for those in need.

Study Limitations

Due to the relatively small-scale nature of the PIRi and the restricted time we had for data collection, we had a limited sample of both professional practitioners (including HV) and parents to draw on. For parents in particular, interviewing service users during their initial or main

treatment was not appropriate, and contacting those who had historically completed and been discharged from treatment was deemed challenging due to informed consent and data protection issues. This resulted in a small pool of potential participants. Thus, recruitment was ultimately limited to those referred to and receiving support from the PIRi team during the data collection period.

Despite our efforts to recruit a broad sample (this included active recruitment from our practice partners and offering flexibility in interview scheduling), this resulted in a sample which did not have substantial diversity in terms of gender or ethnicity (see Table 1), resulting in potentially missed perspectives and insights from some populations. Had we been able to include these perspectives, our findings may have provided insights into different social pressures or barriers to engagement that are unique to gendered experiences, and insights into the role of culturally specific stigma or systemic inequities in accessing and navigating support services. Future work could take a health equity approach, including engaging diverse community stakeholders to co-design research projects, and targeting recruitment strategies to reach a wider range of participants, including those from different socioeconomic, cultural, and geographic backgrounds.

As we were only able to speak to parents who were close to programme completion or had recently completed their support, those who did not engage or dropped out of PIRi support were not sampled. This may have contributed to the parents having more positive views of the programme, as they had remained engaged. Further, we do not know whether non-engagement or dropout was related to the barriers that we identified (e.g., not understanding the service due to a lack of information) or other issues. Exploring such perspectives would have allowed more insight into parents' awareness of PIRi support, and to see if referrals were appropriate. Additionally, the HV who agreed to take part in the PIRi evaluation may have had greater knowledge of the PIRi than their peers. Sampling more HV may have allowed greater insights

into their awareness of the PIRi, their confidence in discussing parent-infant relationship topics, and other barriers/facilitators around referral and engaging parents.

Finally, we did not collect detailed demographic information from service staff, such as their professional background or years of experience. This prevents an appreciation of how this could have shaped their perspectives. Given the small scale of the PIRi team, collecting such data would have risked identifying the service providers. Similarly, the demographic information gathered from families was limited to basic characteristics. A more comprehensive understanding of family dynamics, including the number of children in the household or primary languages spoken, would have provided a more nuanced context for our findings.

Conclusion

A clear understanding of service offerings at all levels may enable more appropriate referrals and better promotion and engagement through clear and consistent messaging about support. Further, ensuring that support is accessible, tailored and flexible appears crucial to promoting engagement in parenting support programmes. Overall, our study highlights the importance of effectively promoting and embedding knowledge of services and support in key referral routes and care pathways.

List of abbreviations

Brazelton New-born Behavioural Observation (N-BO)

Health visitors (HV)

Healthy Families Programme (HFP)

National Institute of Health and Care Research (NIHR)

Parent-Infant Relationship intervention (PIRi)

Public Health Intervention Responsive Studies Teams (PHIRST)

Declarations

Ethics approval and consent to participate

The study was conducted in accordance with the Declaration of Helsinki and the University of Sheffield Research Ethics Policy Governing Research Involving Human Participants, Personal Data and Human Tissue. Ethical approval for the study was granted by the Sheffield Centre for Health and Related Research (SCHARR) ethics committee at the University of Sheffield, application reference number: 051579.

Informed consent to participate in the study was obtained from all participants. All participants provided written informed consent for their involvement in the study which was electronically signed.

Consent for publication

Written informed consent included consent for publication of the findings and the use of anonymised quotations in publications.

Availability of data and materials

The qualitative datasets generated and/or analysed during this study are available from the corresponding author on reasonable request, and subject to approval from the Sheffield Centre for Health and Related Research (SCHARR) ethics committee at The University of Sheffield.

Competing interests

NW, EH, HA, BA, HF, KW, NRC, EG do not have any conflicts of interest.

HC is employed at Nottinghamshire County Council, and LW, SB, RM are employed at Nottinghamshire NHS Foundation Trust.

This study has been co-produced with our Nottinghamshire Healthy Families Programme practice partners. All involved are committed to helping to facilitate a robust evaluation of the PIRi service in order to inform potential changes and adaptations. There has been no pressure or influence to modify, restate, weaken, omit or frame findings, conclusions and recommendations from any team member.

Funding

This project is funded by the National Institute of Health and Care Research (NIHR) [Public Health Research Programme (NIHR135460/PHIRST)]. The views expressed are those of the authors and not necessarily those of the NIHR or the Department of Health and Social Care.

Authors' contributions

Conceptualization: NW, HF, HC, LW, EG

Methodology: NW, HA, NRC

Formal analysis: NW, HA, EH

Resources: HC, LW, SB, RM

Writing - Original Draft: NW, EH, HA, BA

Writing - Review & Editing: NW, EH, HA, BA, KW, NRC, HC, LW, SB, RM, EG

Supervision: EG

Project administration: NW

Funding acquisition: EG

Acknowledgements

We are extremely grateful to the staff and service user participants who took part in interviews for this study, and those who provided help in recruiting them. We would also like to thank those involved in our public involvement, engagement and participation work for commenting on our study documents.

References

1. Leadsom A, Field F, Burstow P, Lucas C. 1001 Critical Days: The Importance of the Conception to Age Two Period. 2018. <https://www.wavetrust.org/1001-critical-days-the-importance-of-the-conception-to-age-two-period>
2. Benoit D. Infant-parent attachment: Definition, types, antecedents, measurement and outcome. *Paediatrics & Child Health*. 2004;1;9(8):541–5.

3. Sleet M, Li ET, Vainieri I, Midgley N. The Evidence-Base for Psychodynamic Interventions with Children Under 5 Years of Age and Their Caregivers: A Systematic Review and Meta-Analysis. *Journal of Infant, Child, and Adolescent Psychotherapy*. 2023;3;22(3):179–214.
4. Barlow J, Coren E. The Effectiveness of Parenting Programs: A Review of Campbell Reviews. *Research on Social Work Practice*. 2018;1;28(1):99–102.
5. Harold G, Acquah D, Sellers R. What works to enhance inter-parental relationships and improve outcomes for children. Early Intervention Foundation. 2016.
<https://www.eif.org.uk/report/what-works-to-enhance-interparental-relationships-and-improve-outcomes-for-children>
6. NICE. Social and emotional wellbeing: early years. NICE. 2012.
<https://www.nice.org.uk/Guidance/PH40>
7. Cramphorn K. Engaging parents in community-based support to develop co-parental relationships that positively impact on their children: a voluntary sector perspective. *Voluntary Sector Review*. 2020;1;11(3):373–81.
8. Doubell L, Stock L, Acquah D. Inter-parental relationship support services available in the UK: rapid review of evidence. Early Intervention Foundation. 2017.
<https://www.eif.org.uk/report/interparental-relationship-support-services-available-in-the-uk-rapid-review-of-evidence>
9. Gonzalez C, Morawska A, Haslam DM. Enhancing Initial Parental Engagement in Interventions for Parents of Young Children: A Systematic Review of Experimental Studies. *Clin Child Fam Psychol Rev*. 2018;1;21(3):415–32.
10. Kane GA, Wood VA, Barlow J. Parenting programmes: a systematic review and synthesis of qualitative research. *Child: Care, Health and Development*. 2007;33(6):784–93.
11. Sampaio F, Nystrand C, Feldman I, Mihalopoulos C. Evidence for investing in parenting interventions aiming to improve child health: a systematic review of economic evaluations. *Eur Child Adolesc Psychiatry*. 2024;1;33(2):323–55.

12. Department of Health. Future in mind - Promoting, protecting and improving our children and young people's mental health and wellbeing. Department of Health. 2015.

https://assets.publishing.service.gov.uk/media/5a80b26bed915d74e33fbe3c/Childrens_Mental_Health.pdf

13. Crealey GE, Hickey G, McGilloway S. A cost-effectiveness analysis of a universal, preventative-focused, parent and infant programme. BMC Health Services Research. 2024;8;24(1):176.

14. Pote I, Doubell L, Brims L, Larbie J, Stock L, Lewing B. Engaging disadvantaged and vulnerable parents An evidence review. Early Intervention Foundation. 2019.

<https://www.eif.org.uk/report/engaging-disadvantaged-and-vulnerable-parents-an-evidence-review>

15. Public Health England. Early years high impact area 2: Supporting maternal and family mental health. Public Health England 2020.

<https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children/early-years-high-impact-area-2-supporting-maternal-and-family-mental-health>

16. HM Government. The best start for life: a vision for the 1,001 critical days. HM Government. 2021.

https://assets.publishing.service.gov.uk/media/605c5e61d3bf7f2f0d94183a/The_best_start_for_life_a_vision_for_the_1_001_critical_days.pdf

17. Family Hubs and Start for Life – everything you need to know – Department of Health and Social Care Media Centre. 2024. <https://healthmedia.blog.gov.uk/2024/05/02/start-for-life-and-family-hubs-everything-you-need-to-know/>

18. Mytton J, Ingram J, Manns S, Thomas J. Facilitators and Barriers to Engagement in Parenting Programs. 2014;41(2):127–37.

19. Hackworth NJ, Matthews J, Westrupp EM, Nguyen C, Phan T, Scicluna A, et al. What Influences Parental Engagement in Early Intervention? Parent, Program and Community Predictors of Enrolment, Retention and Involvement. *Prev Sci*. 2018;1;19(7):880–93.
20. Raouna A, Malcolm R, Ibrahim R, MacBeth A. Promoting sensitive parenting in ‘at-risk’ mothers and fathers: A UK outcome study of Mellow Babies, a group-based early intervention program for parents and their babies. *PLoS ONE*. 2021;16(2):e0245226.
21. Public Health England. Best start in life and beyond Improving public health outcomes for children, young people and families. 2021.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/960708/Commissioning_guide_2.pdf
22. Elmer JRS, O’Shaughnessy R, Bramwell R, Dickson JM. Exploring health visiting professionals’ evaluations of early parent-infant interactions. *Journal of Reproductive and Infant Psychology*. 2019;20;37(5):554–65.
23. Public Health England. Health visiting and school nursing service delivery model. 2021.
<https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children/health-visiting-and-school-nursing-service-delivery-model>
24. Wilson P, Thompson L, Puckering C, McConnachie A, Holden C, Cassidy C, et al. Parent-child relationships: are health visitors’ judgements reliable? *Community Practitioner*. 2010;83(5):22–5.
25. Appleton JV, Harris M, Oates J, Kelly C. Evaluating health visitor assessments of mother–infant interactions: A mixed methods study. *International Journal of Nursing Studies*. 2013;1;50(1):5–15.
26. Kristensen IH, Trillingsgaard T, Simonsen M, Kronborg H. Are Health Visitors’ Observations of Early Parent–Infant Interactions Reliable? A Cross-Sectional Design. *Infant Mental Health Journal*. 2017;38(2):276–88.

27. Bateson K, Sercombe M, Hamilton W. Securing Healthy Lives. 2021. Available from: <https://parentinfantfoundation.org.uk/securinghealthylives/>
28. Briscoe L, Marsland L, Doyle C, Docherty G, Flynn A, Gichuru P. A mixed method study to explore the maternal impact and outcomes of a specialist Building Attachment and Bonds Service (The BABS Study). *Health Care for Women International*. 2022;0(0):1–22.
29. Hoffmann TC, Glasziou PP, Boutron I, Milne R, Perera R, Moher D, et al. Better reporting of interventions: template for intervention description and replication (TIDieR) checklist and guide. *BMJ*. 2014;7;348:g1687.
30. Brazelton Center UK. The NBO & NBAS for Parents. 2024. <https://www.brazelton.co.uk/parents/the-nbo-and-nbas-for-parents/>
31. Leviton LC, Khan LK, Rog D, Dawkins N, Cotton D. Evaluability Assessment to Improve Public Health Policies, Programs, and Practices. *Annual Review of Public Health*. 2010;21;31:213–33.
32. Braun V, Clarke V. Using thematic analysis in psychology. *Qualitative Research in Psychology*. 2006;1;3(2):77–101.
33. Glasgow RE, Vogt TM, Boles SM. Evaluating the public health impact of health promotion interventions: the RE-AIM framework. *Am J Public Health*. 1999;89(9):1322–7.
34. Campbell S, Greenwood M, Prior S, Shearer T, Walkem K, Young S, et al. Purposive sampling: complex or simple? Research case examples. *Journal of Research in Nursing*. 2020;1;25(8):652–61.
35. Etikan I, Musa SA, Alkassim RS. Comparison of Convenience Sampling and Purposive Sampling. *American Journal of Theoretical and Applied Statistics*. 2016;5(1):1–4.
36. Malterud K, Siersma VD, Guassora AD. Sample Size in Qualitative Interview Studies: Guided by Information Power. 2016;26(13):1753–60.
37. Vseteckova J, Boyle S, Higgins M. A systematic review of parenting interventions used by social workers to support vulnerable children. *Journal of Social Work*. 2022;1;22(4):992–1030.

38. Hogg S. Rare Jewels: Specialised parent-infant relationship teams in the UK. Parent Infant Partnership UK; 2019: <https://parentinfantfoundation.org.uk/wp-content/uploads/2019/09/PIPUK-Rare-Jewels-FINAL.pdf>
39. National Childbirth Trust. Difficulties with baby bonding affect a third of UK mums. NCT (National Childbirth Trust). 2016. <https://www.nct.org.uk/about-us/media/news/difficulties-baby-bonding-affect-third-uk-mums>
40. Reardon T, Harvey K, Baranowska M, O'Brien D, Smith L, Creswell C. What do parents perceive are the barriers and facilitators to accessing psychological treatment for mental health problems in children and adolescents? A systematic review of qualitative and quantitative studies. *Eur Child Adolesc Psychiatry*. 2017;1;26(6):623–47.
41. Sayal K, Tischler V, Coope C, Robotham S, Ashworth M, Day C, et al. Parental help-seeking in primary care for child and adolescent mental health concerns: qualitative study. *The British Journal of Psychiatry*. 2010;197(6):476–81.
42. Hansen AS, Tell  us GK, Mohr-Jensen C, Lauritsen MB. Parent-perceived barriers to accessing services for their child's mental health problems. *Child Adolesc Psychiatry Ment Health*. 2021;29;15(1):4.
43. McAtamney R. Health visitors' perceptions of their role in assessing parent-infant relationships. *Community Practitioner*. 2011;84(8):33–7.
44. Kouvaras S, Hassett A, Lumsden V. Health visitors' experiences talking about difficulties with the parent–infant relationship. *Journal of Health Visiting*. 2022;2;10(7):292–302.
45. Cowley S, Whittaker K, A G, et al. Why Health Visiting? A Review of the Literature about Key Health Visitor Interventions, Processes and Outcomes for Children and Families. Department of Health Policy Research Programme. 2013. <http://www.kcl.ac.uk/nursing/research/nnru/publications/index.aspx>
46. Rowan C, McCourt C, Bick D. Provision of perinatal mental health services in two English strategic health authorities: views and perspectives of the multi-professional team. 2010;8(3):98-

106. <https://www.rcm.org.uk/media/2758/evidence-based-midwifery-september-2010.pdf#page=26>

47. Department of Health and Social Care. Parent-infant relationships: starting conversations (practitioner guide). 2024 . Available from: <https://www.gov.uk/government/publications/parent-infant-relationships-starting-conversations-practitioner-guide>

48. Institute of Health Visiting. State of Health Visiting in England. 2020. Available from: <https://ihv.org.uk/wp-content/uploads/2020/12/State-of-Health-Visiting-survey-2020-FINAL-VERSION-18.12.20.pdf>

49. Institute of Health Visiting. Health visitor workforce numbers in England reach an all-time low [Internet]. IHV. 2022. Available from: <https://ihv.org.uk/news-and-views/news/health-visitor-workforce-numbers-in-england-reach-an-all-time-low/>

50. The Health Foundation. Public health grant allocations represent a 24% (£1bn) real terms cut compared to 2015/16. 2021. Available from: <https://www.health.org.uk/news-and-comment/news/public-health-grant-allocations-represent-a-24-percent-1bn-cut>

51. Moran P, Ghatge D, Van Der Merwe A, Policy Research Bureau. 2004. What works in parenting support?: A review of the international evidence. London: DfES Publications.

Figure 1. Coding framework and theme development

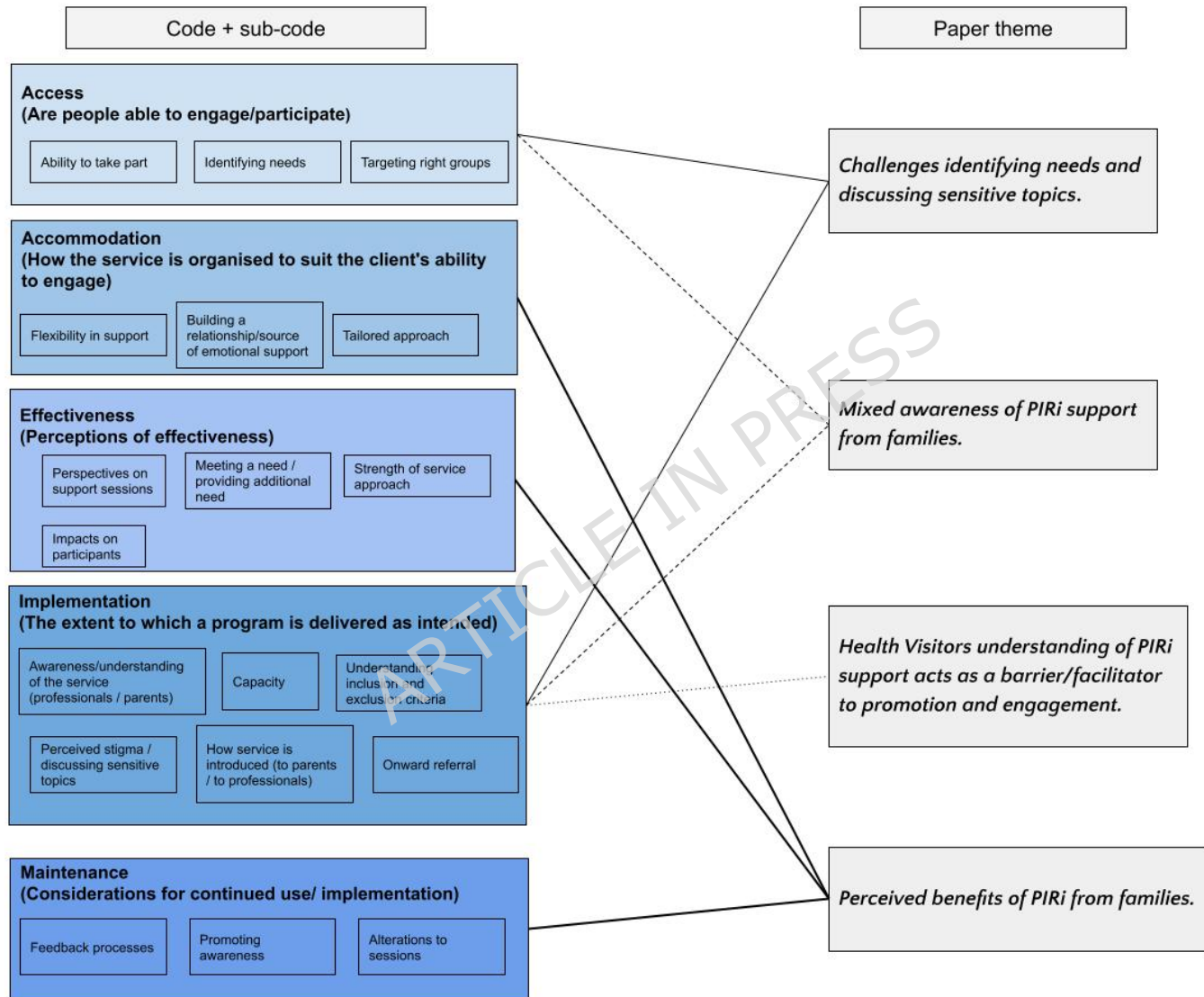


Table 1: Parent demographic information

Participant	Age	Gender	Ethnicity	Index of Multiple Deprivation Decile (based on postcode). *
Parent 1	37	Female	White British	5
Parent 2	33	Female	White British	10
Parent 3	32	Female	White British	8
Parent 4	35	Female	White British	8
Parent 5	33	Female	White British	7
Parent 6	28	Female	White British	10
Parent 7	26	Female	White British	3
Parent 8	41	Female	Asian Other	1
Parent 9	31	Female	White British	4
Parent 10	29	Female	White British	8
Parent 11	38	Female	White British	5
Parent 12	37	Male	White British	5
Parent 13	36	Female	White British	4
Parent 14	37	Female	White British	1

* The Index of Multiple Deprivation Decile is a measure used in England to rank areas based on their level of deprivation Postcodes are ranked from 1 to 10 - A decile of 1 means the area is among the top 10% most deprived in the country, while a decile of 10 means the area is among the top 10% least deprived in the country.