Understanding perceptions and practices towards infant mental health within the child welfare system

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The impact of infant mental health interventions on legal decision making within the child welfare system: A systematic review

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Abstract

There is increasing evidence on the use of infant mental health (IMH) interventions in cases of child maltreatment, but the use of interventions within child welfare decision-making systems remains an area of limited study. This systematic review aimed to examine the type of IMH interventions that are being used within the child welfare decision-making system with children aged 0-5, and the outcomes of decisions. Database searching was completed on PsycInfo, Assia, Medline and Web of Science Core Collection in June 2023. The eligibility criteria for studies were (1) peer-reviewed studies; (2) concerning child welfare exposed infants; (3) set in a legal decision-making context; (4) with IMH intervention delivered; (5) involving infants or parents (0-5 years); (6) with outcomes relating to influences on decision making (i.e. parenting capacity assessments, permanency, placement, professionals appraisal of their decisions). Nine eligible studies were included. Quality was appraised using the Crowe Critical Appraisal Tool (CCAT). Findings showed that child-parent-psychotherapy, home-visiting, video-feedback and social support interventions are being used within the context of child welfare decision-making. Some evidence for positive influence on reunification with parents emerged, but overall the quality of the literature limited robust conclusions being drawn, indicating the need for further research attention on this area.

Keywords: child welfare system; infant mental health interventions; decision-making; infants

1.Introduction

Early childhood (0-5years) represents a life-stage with critical and sensitive periods of development (Zeanah & Zeanah, 2019). Infant mental health (IMH) is defined within this period of development as the young child's capacity to experience, regulate and express emotions, form close and secure relationships, and explore their environment (Zeanah & Zeanah, 2001). Insults to development during this time, including maltreatment, environmental stressors (e.g. deprivation), social and emotional difficulties, and lack of nurturing relationships, can have longstanding impacts on development (McLuckie et al., 2019).

Within Scotland, untreated perinatal and infant mental health issues are viewed as a major public health concern (NHS, 2023). The Scottish Government have committed to IMH, with £18 million invested in the development of a range of IMH services (Scottish Government, 2023). This sits alongside striking statistics on children within the Child Welfare System (CWS) in Scotland. In 2022, 48% of children on the child protection register in Scotland were under 5 years (Scottish Government, 2023). Thus, while it is positive to see IMH positioned as a priority through funding across health care professionals, a truly pluralistic approach, that reflects IMH's operational definition as a multidisciplinary field, must reach across health, social care and justice divides (Zeanah & Zeanah, 2019).

Given these statistics and the significant and potentially life-long impact of maltreatment on infants, prevention and treatment are a priority. Intervention for maltreatment (and through this, IMH) is most often provided by members of the CWS and revolves around decisions on placement of children in out of home (OOH) care, reunification with birth parents, or long-term home-based interventions, amongst others. However, research suggests that decision making in the CWS is complex and challenging for professionals (Macdonald et al., 2014). Striking findings report high rates of children returning to care following reunification with their parents: in Scotland two thirds of children in Glasgow who returned home after an episode of maltreatment returned to care at a later point (Minnis, et al., 2010). With the strong research links between IMH interventions and positive outcomes for IMH (Izett et al., 2021), the utility of IMH interventions to decision-making in the CWS must be

considered. The evidence-base for interventions within the CWS is promising, a systematic review of the evidence has provided support for the effectiveness of some IMH interventions (e.g. Attachment and bio-behavioural catch-up - ABC) (Grube & Liming, 2018). However, the suitability of many interventions specifically within the CWS has not been established (Whitcombe-Dobbs & Tarren-Sweeney, 2019), and a recent systematic review highlighted the need for assessment of interventions within specialist populations, such as maltreated children within the CWS (Hare et al., 2023), in light of authors identifying just two IMH interventions of 60 as evidence based for a general population.

Understanding what information influences decisions on maltreatment and resulting implications for outcomes (such as placement type, duration in care etc.), is key to improving the quality of decisions made. A review on which decision-making methods improve decision-making in cases of maltreatment found that decision-making processes (e.g. client satisfaction, adherence) are more often reported on than outcomes (e.g. child safety, OOH placements) (Bartelink et al., 2015). In relation to this, understanding how IMH interventions are being used within legal decision-making settings is an important, and thus far, limited area of understanding. Given the dependence of infants on others, the importance of utilisation of evidence-based decision making by professionals cannot be understated for this group. However, translating evidence and representing it within legal decision-making for infants remains challenging. Lack of training and expertise on IMH principles, difficulties in translating the attachment and relational evidence base into individualised decisions, parental rights and prevailing professional priorities, exist as barriers to IMH informed decision making (Forslund et al., 2021; Miron et al., 2013). Despite the apparent synergy between IMH interventions and the CWS (indeed some authors have asserted that IMH originated within social work (Walsh et al., 2021), there is a paucity of research relating such interventions to decision-making within the CWS and research has found that IMH concepts are often misapplied to inform child removal decisions (Granqvist et al., 2017). Furthermore, it is critical to consider how IMH interventions are being used and assessed in the CWS. As highlighted by a 2019 review on child maltreatment recurrence, outcomes that capture pro-social behaviour change but do

not translate into reduced maltreatment mean continued deleterious experiences for children (Whitcombe-Dobbs & Tarren-Sweeney, 2019). They also found the evidence base reporting on children at *risk* of maltreatment and *exposed* to maltreatment together can conflate interventions that are preventative with those effective for treatment.

The case for IMH inclusion within court-based decision-making has been made for some time (Lederman & Osofsky, 2004). The concept of 'therapeutic jurisprudence,' whereby professionals with roles in the court work in a collaborative way to support substantive legal processes to create therapeutic outcomes for those involved (Lederman et al., 2007). While the inclusion of IMH interventions within court processes is hypothesised to support better outcomes, the lack of critical evaluation of the volume and quality of evidence may limit meaningful advancement and direction of this area of research and practice. A scoping review on how health information impacts on decisions to remove infants from parental care highlighted the limited amount of evidence in this area. They also provided important qualitative insights that the research lacked evidence on what IMH factors informed decision-making (Gregory-Wilson et al., 2022).

A meaningful review and synthesis of existing empirical research investigating the influence of IMH interventions within CWS decision making systems is a justified and important addition to the literature for the development of the field. This review sets out to answer the question: Which infant mental health interventions are being used within child welfare decision making, and what are the outcomes for decisions in relation to child welfare outcomes, such as placement types, parenting capacity assessments, and professionals' appraisals of their decisions. The research aimed to do this by systematically:

1. Examining the quality of the existing research.
2. Examining what decision-making outcomes (e.g. placement types, parenting capacity etc.) for infants are recorded.
3. Examining how IMH interventions are being used within decision making in the CWS.

4. Report on which IMH interventions are being used.

5. When IMH outcomes are reported, examining the outcomes reported.

2. Methods

The systematic review was performed in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) guidance (Page et al., 2021) and was registered on Prospero (CRD42023422059).

2.1 Inclusion criteria

Inclusion criteria were: (1) peer-reviewed studies; (2) concerning CWS exposed infants; (3) set in a legal decision making context (e.g. a court) whereby the intervention was cited as having a decision-making role in terms of the findings informing the decision-making; (4) involving IMH interventions; (5) involving infants (or their parents) aged 0-5 years at the time of intervention; (6) with outcomes relating to influences on decision making (i.e. contact decisions, permanency, placement, professionals appraisal of their decisions).

IMH interventions were defined as interventions targeting emotional, behavioural or social indicators for infants, and/or the infant-parent relationship. Upon screening of articles, the decision was made to expand this to include interventions offering social support to parents by facilitating access to basic services (e.g. financial support, medical services), in light of a research that suggests social support is a crucial element of infant mental health intervention (Minnis et al., 2023, personal communication; Minnis & Forde, 2023).

The legal decision-making context (3) was operationalised by an active relationship between the IMH intervention, and the process of court decisions being made. Outcomes relating to this were necessary for inclusion.

For studies that met all other inclusion criteria but had an age range that included children outside that specified, the decision was made to include them if the majority of the sample fell within the 0-5 category. This applied to one included study (Hazen et al., 2021). While the focus of the review is on court decision outcomes, where IMH outcomes are recorded, they were also extracted and assessed.

Exclusion criteria comprised of studies (1) not published in English; (2) unpublished articles or articles not from peer-reviewed journals; (3) outcome data not

quantitatively reported; (4) non-interventional papers; (5) articles not available at full-text.

2.2 Search Strategy

Electronic databases (PsycINFO, Assia, Medline & Web of Science Core Collection (WoS)) were last searched on 01/06/2023 with no restrictions on date. A search strategy was developed by the researcher with support from a specialist librarian, and peer-reviewed by a specialist librarian. To identify relevant search terms, subject headings were explored, and relevant terms added to the search strategy to ensure a comprehensive search resulted. The search strategy was initially piloted on PsycInfo and further developed and refined for final searching. The search strategy included search terms based on two concepts; (1) infants in the child welfare system; (2) IMH interventions.

To structure the search, IMH interventions were included if they had been identified as evidenced-based by a recent systematic review (namely Attachment and Biobehavioural Catch-Up -ABC, and Video-feedback Intervention Parenting Program - VIPP) (Hare et al., 2023), or were interventions recommended for the target population by the Psychological Therapies 'Matrix', which provides a guide for evidence-based therapeutic provision to NHS Boards in Scotland (The Scottish Government, 2014), and is currently undergoing review. The search also included an open-ended line which did not specify type of IMH intervention to allow for a wider breath of interventions to be returned, reflecting the transitionary phase the Matrix is in and the wide scope of potential IMH interventions. Full search strategies for each database are available in Appendix 1.

Reference list hand searching was completed on articles identified for inclusion.

2.3 Data extraction and synthesis

The researcher completed data extraction across articles. Data were extracted on study and sample characteristics, interventions and delivery method, what and how outcomes were measured, data analysis and key findings relevant to the current reviews aims. To ensure systematic data extraction, a tool was developed (Appendix 2). Data were synthesised in line with the aims of the research questions and any

areas of ambiguity were reviewed via supervision. In cases where data was not available, authors were contacted to obtain information (see Figure 1).

In cases where effect sizes were not reported and data were available to do so, Cohen's *d* was calculated to allow for standardised comparison. Previous research reports this as suitable measure for between groups designs with a sample > 20 (Goulet-Pelletier & Cousineau, 2018). The mean age of infants was calculated if not reported and data were available to do so. In light of the variable nature of studies included and heterogeneity of data therein, a meta-analysis was not deemed possible.

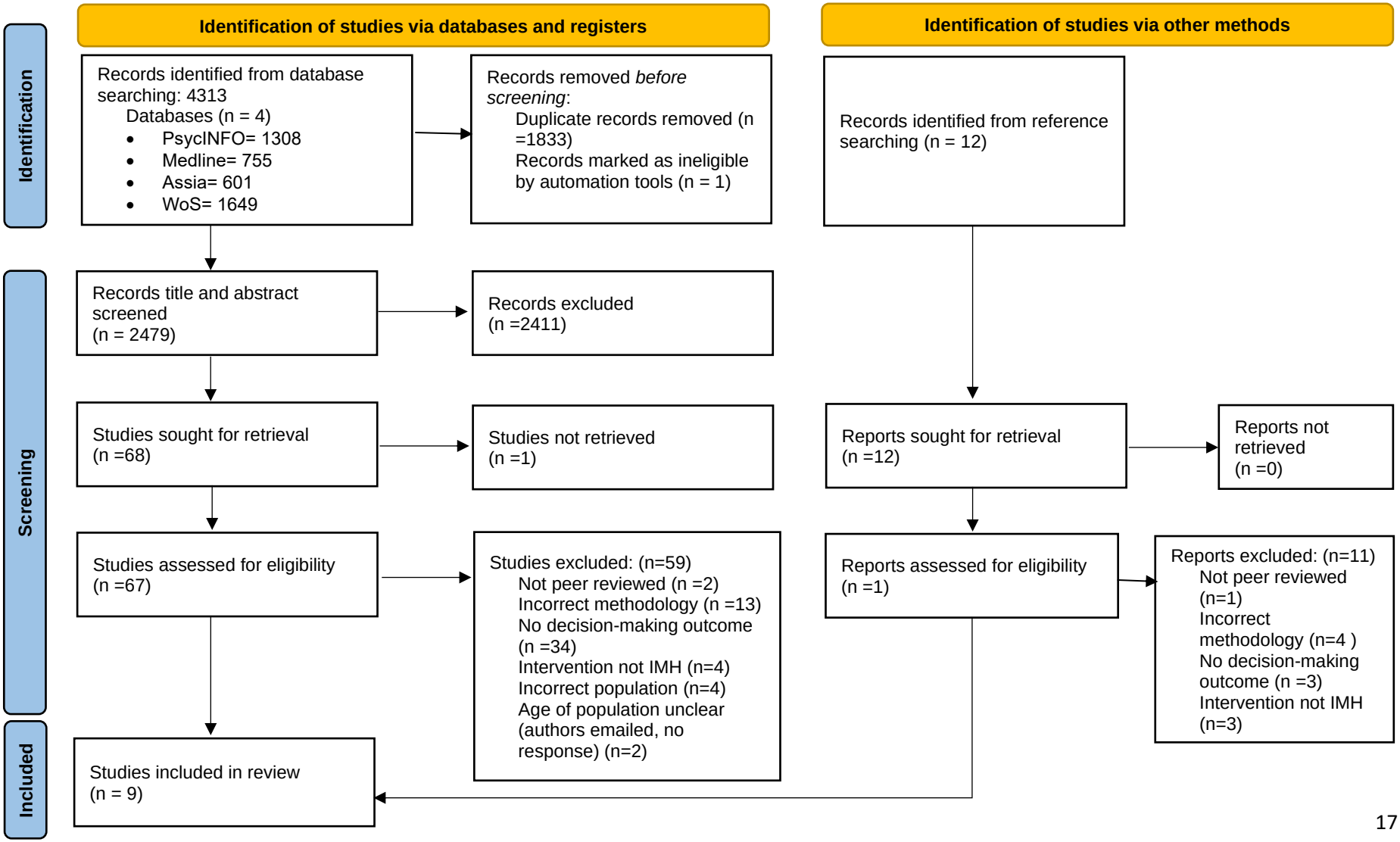
2.4 Quality appraisal

The Crowe Critical Appraisal Tool (CCAT) (Crowe & Sheppard, 2011) was used to appraise included studies. The CCAT can be utilised for appraisal across multiple research designs, with good interrater reliability previously found (Crowe et al., 2012), and was thus deemed suitable to the aims of the current study. Of included studies, a random sample of 50% were independently appraised by a second appraiser using the CCAT. A high level of agreement was present (80%), and areas of disagreement were reviewed and discussed until consensus was reached. In line with the aims to understand the quality of the evidence base, total scores on the CCAT were classified into three categories: low (35-49%), medium (50-74%) and high (above 75%). Reflecting CCAT guidelines, where appraisers are prompted to reflect on if it is worth of continuing, it was decided that should studies fall below 35% (14 points) they would not be included in the narrative synthesis. The CCAT notes that total scores can obscure important elements of quality contained in different sections, therefore the individual scores of the CCAT are reported in Table 1.

3. Results

A total of 4,313 articles were returned from database searching. Following de-duplication, 2,479 articles remained for screening and review. The author completed title and abstract screening and 68 articles remained. A random selection of 10% of the title and abstract search results were independently screened by a second reviewer. There were no disagreements regarding exclusions. Of the 68 articles remaining, 67 were accessible and were assessed at full text against the eligibility criteria. Articles that were ambiguous to the author were discussed until agreement was reached via supervision with the research supervisor. One article was identified from reference searching. The ages of children in two studies were not clear, corresponding authors were contacted but no reply was received, they were thus excluded. Nine studies published between 2010 and 2022 were included, with a total sample of 1,363 participants. Results are categorised into quality assessment, study characteristics and (by quality) intervention characteristics and effects and outcomes. Further description on the types of IMH interventions used by authors is available in Appendix 12.

Figure 1:
Prisma Flow chart



3.1 Quality assessment

Overall, three (34%) studies were deemed to be of good quality (Cyr et al., 2022; Stacks et al., 2020; van der Asdonk et al., 2020), with a score above 75% on the CCAT. Four (44%) were medium quality (overall score 50-74%) (Casanueva et al., 2013; Hazen et al., 2021; Twomey et al., 2010; van der Asdonk et al., 2019), and two (22%) were low quality (overall score 35-49%) (Casanueva et al., 2019; Chinitz et al., 2017). No studies appraised fell below these thresholds. The breakdown of results across each category is available in Table 1.

Methodological limitations of all studies related to unclear design and data collection, where replicability was undermined, and biases (e.g. selection bias) were present and unaddressed. As regards design, information was lacking in many studies relating to the detail of interventions provided. For example seven studies provided treatment interventions (Table 2), of which four reported number of sessions delivered (Casanueva et al., 2013; Chinitz et al., 2017; Cyr et al., 2022; van der Asdonk et al., 2020). Variability on design was therefore likely introduced across studies, and left unrecognised in analysis.

For studies of low quality, clear issues were evident in analysis methods chosen; in-text reporting of results lacked conformity with standardised reporting guidelines (e.g., American Psychological Society, 2022); and description of outlying data or unexpected results were absent. There were also limitations in both low and medium quality regarding interpretability of results due to lack of sufficient detail, e.g., details of statistical methods used to obtain results not clearly stated (Casanueva et al., 2013). Limitations in studies handling of attrition within design and data-analysis was also evident in low and medium studies. Attrition was high across all interventional studies (see Table 2). Four studies reported pre- and post-test sample sizes, differences in analysed sample size were not explained by Casanueva et al. (2019), and attrition was not reported by Casanueva et al. (2013). Management of non-participation was discussed in just two of the four studies with time between pre and post-test data collection – Asdonk et al. (2020) and Cyr et al. (2021).

Table 1:

Quality appraisal using CCAT

Article	Preliminaries	Introduction	Design	Sampling	Data collection	Ethical matters	Results	Discussion	Total
(Stacks et al., 2020)	4	5	3	3	3	4	4	4	30 (75%)
(Chinitz et al., 2017)	2	3	3	2	3	3	1	1	18 (45%)
(van der Asdonk et al., 2020)	4	5	2	4	4	4	4	4	31 (78%)
(van der Asdonk et al., 2019)	4	5	3	3	3	4	4	3	29 (73%)
(Casanueva et al., 2019)	2	3	2	2	2	3	1	3	18 (45%)
(Casanueva et al., 2013)	3	3	3	4	3	3	1	3	23 (58%)
(Hazen et al., 2021)	3	4	3	4	4	2	3	4	27 (68%)
(Cyr et al., 2022)	5	4	3	3	4	4	4	4	31 (78%)
(Twomey et al., 2010)	4	3	4	3	3	2	3	3	25 (63%)

3.2 Study characteristics

Table 2 contains details of study and sample characteristics. Two studies were conducted within the Netherlands, one in Canada, and the remaining six in the USA. Two studies were randomised controlled trials (RCT), four studies were uncontrolled trials with pre and post measures, one was a between groups cross-sectional study, and two were observational.

All studies were set within the context of decision-making about child welfare involved infants. Participants for eight studies were infants or parent-infant dyads, while for one study (van der Asdonk et a., 2019) participants were professionals involved in decision-making for maltreated infants.

When reported, the average duration of studies (i.e. time to follow up) was 10.75 months (n=4), with one study reporting the average number of Child Parent Psychotherapy (CPP) sessions as 25, rather than a time to follow up (Casaneuva et al., 2013).

Biological sex of parents included in samples were mainly female (52-93%) and was reported by six studies (Chinitz et al., 2017; Cyr et al., 2022; Hazen et al., 2021; Stacks et al., 2020; Twomey et al., 2010; van der Asdonk et al., 2020). Five studies reported on ethnicity; regarding majority ethnicity two samples were 55% and 58% black respectively (Chinitz et al., 2017; Casaneuva et al., 2013), two samples 61% and 50% white (Hazen et al., 2021; Casaneuva et al., 2019) and Cyr et al. (2022) reported 28% of participants as from ethnic minorities.

Table 2*:*

Study characteristics, outcomes, and effects

Author, Location, Design	Participants N, Age	Intervention	Attrition	F/U	Control	Aims/Hypothesis	Outcome in relation to child welfare decision	Impact of IMH intervention on IMH measures
1. Stacks et al., 2020 USA Uncontrolled trial	Infants and toddlers N=25 Age M=17.48 months	Infant Mental Health – Home Visiting (IMH-HV) in context of Baby Court	N=7 (28%)	Approx.. 9 months	n/a	1. Describe rates of permanency after Baby Court participation 2. Assess changes in development pre to post-test 3. Assess changes in infants positive and negative behaviour	Court decisions on permanency: 69.9% (n=16) infants reunified; average 18.7 months in out of home care	Bayley III measured developmental delay: significant improvement in expressive language scale t(13) = -3.39, *p* <.01; *d*=.83 Crowell measured infant behaviour: significant increase in positive affect t(14) = -2.28, *p* <.05; *d*=.80 Significant increase in enthusiasm t(14) = -2.49, *p*<.05; *d*=.91
2. Chinitz et al., 2017 USA Uncontrolled trial	Parent-infant dyads N=142 *69% (35) of sample under 1 year old	Child Parent Psychotherapy (CPP) with feedback, training and recommendations to Baby Court	N=82 (58%)	n/r	n/a	1. Improved parent interactions 2. Improved safety, permanency and wellbeing outcomes for infants 3. Impact on child welfare practices and	86% (n=35) of children who completed intervention were reunified with birth parents Impact on child welfare practice: authors report training 150 interagency staff during one year of the 6-year project	KIPS measured parent-child interactions: Authors report significant (*p*=.05) change in promoting learning; *d*=.59 Authors report significant improvements (*p*=.05) in 5 subdomains: promoting learning, language experiences, reasonable expectations, adapts strategies and encouragement

							policy related to infants		APPI-2: Authors report significant increase in empathy for children needs and decrease in parents in 'high risk' category from 46% of sample to 29% Safety: 3.5% (n=5) maltreatment recurrence
3. van der Asdonk et al., 2020 Netherlands RCT	Parent-infant dyads subject to parenting capacity assessment in the CWS N=56 Age M= 3.48 years	Evaluation of parent's engagement with VIPP-Sensitive Discipline (SD) on court recommendations	N=7 (13%)	10 months post-test	Regular Assessment Procedure aimed at improving family dynamics	1. 2. 3. 4.	Recommendations for OOH placement would be modified more often for VIPP-SD group Therapist would feel more confident in their recommendations based on VIPP-SD VIPP-SD children would show fewer emotional and behavioural issues Fewer recurrences of maltreatment	No significant change or difference in placement decision recommendation No significant difference in confidence in recommendation	No significant reduction or difference in emotional or behavioural problems No significant difference in maltreatment recurrence

							for VIPP-SD group		
4.	Van der Asdonk et al., 2019. Netherlands Between groups - Cross-sectional	Participants (social workers, judges and masters level students in these subject areas) N=144 N=34 social workers N=85 students N=25 children's court judges	Vignette including description of parents' response to an attachment-based video feedback intervention, like VIPP for maltreated infants (aged 1-6)	n/a	n/a	Vignettes with case descriptions normally used for decision making	There would be higher decision-agreement on vignettes that included description of an attachment-based intervention	OOH placement advised more often for control condition: t(143)-2.05, *p*=.04; *d*=.24 Professionals paid significantly more attention to parental response to intervention than students did: t(142) = -2.03, *p*=.045. *d*=.37 Participants paid more attention to positive parental changes: t(83) = 5.94, *p*=.001; *d*=0.85 In ambiguous vignettes significantly higher decision-making agreement when intervention information included: mean difference = 0.29, *p* =0.26; *d*=.41	Outcome not reported on
5.	Casanueva et al., 2019 USA Observational	Infants and toddlers N=251 Age: 0-36 months	Safe Babies Court Team (SBCT) with CPP the main evidence-based intervention offered	n/r	n/r	n/a	1. To what extent is there evidence of better in practice at sites implementing SBCT? 2. What outcomes occur for infants served by SBCT?	Permanency = 78% (n=137), of these 48.9% were reunified with birth parents 94.2% children in care for less than 12 months and placed in less than 3 placements	Maltreatment recurrence for 1.2% 93.9% of infants received CPP

6. Casanueva et al., 2013 USA Uncontrolled pre and post/Observation	Parent-child dyads N=33 Age: younger than 3 years	CPP in the context of the Child-Wellbeing Court Model (CWBC)	n/r	After average of 25 CPP sessions	n/a	Report preliminary findings on safety, wellbeing and permanency for children who completed CPP intervention	Permanency achieved for 90.4% (n=31); 58.1% of this group reunified with parents	No reports of maltreatment recurrence up to 6 months post-intervention (n=33) ASQ: authors report developmental risk significantly decreased in problem solving scores (n=29) increased from a mean difference of 5.1 (12.99) to 10.6 (10.30), $p < .05$; **d*=-0.4 Socioemotional scores (n=26) improved from mean difference 19.2 (34.25) to 31.9 (26.23), *p*<.001; **d*=-0.4 Crowell pre and post intervention: authors report significant increases in scores on parenting scale (n=13) for behavioural responsiveness (mean changed from 3.15 (0.89) to 4.15 (0.89), *p*=.002); **d*=1.1 emotional responsiveness (mean changed from 3.76 (1.09) to 4.23 (1.01), *p*=.02); **d*= 0.4; significantly decreased use of physical aggression (mean changed from 2.23 (1.53) to 3.07 (1.60), *p*=.009); **d*=0.5; children showed significant increase in means for enthusiasm with task (3.79 (1.01) to 4.30 (0.75), *p*=.002; **d*=0.7

7.	Hazen et al., 2021 USA Observational	Juvenile court involved parents N=448 Age of oldest child M=4.99 (SD=4.77)	Court ordered CPP	n/a	n/a	n/a	Assess impact of court ordered CPP on: 1. Physical reunification 2. Successful case closure 3. Time to case closure If CPP effects on these outcomes varies by case severity controlling for other variables known to influence these variables (e.g. number of children in the family)	Parents not ordered to participate in CPP are more likely to be reunified with than those ordered to participate (B = 1.48 (0.57), t(445) = 2.60, $p < .05$); *d=0.8 Parents who attend CPP consistently are more likely to be reunified (B = 1.43 (0.30), t(455) = 4.77, $p < .001$); *d=0.78 Greater CPP participation associated with successful case closure(B=2.17 (0.67), t(445) = 3.2, p<.01); *d=1.19 CPP ordered participation did not predict successful case closure CPP ordered increased time to case closure (B=78.17 (39.08), t(445) = 2, p<0.05)	Outcome not reported on.
8.	Cyr et al. 2022 Canada RCT	Maltreated infants N=69 Age= 0.26months to 69.54 months	Parenting capacity assessment-Attachment video-feedback intervention (PCA-AVI)	N=21	12 months post-test	Parenting capacity assessment with psycho-educational intervention	To test if the AVI leads to better parenting and child benefits. Hypothesised PCA-AVI group to show: 1. Higher quality parent-child interactions 2. More court decisions in	Regardless of PCA group parents evaluated as more capable were significantly more likely to have children placed at home at post-test (PCA-AVI: $\chi^2(1, N = 42) = 4.49$, p = .02, d = 0.69, CI [0.05, 1.33]; PCA-PI: $\chi^2(1, N = 27) = 6.22$, p = .01, d = 1.09, CI [0.23, 1.95]) and 1 year after PCA-AVI ($\chi^2(1, N = 42) = 7.33$, p = .006, d = 0.92, CI [0.25,	PCA-AVI group evaluations of capacity to care significant predictor of re-reports of maltreatment at 1 year post intervention ($\chi^2(1, N = 42) = 7.25$, p = .01, d = 0.91, CI [0.25, 1.58]) Increase in parent-child interaction at post-test (F(1, 68) = 5.13, d = 0.62, CI [0.11, 1.12]).

							favour of parent 3. Fewer placements 1 year post intervention 4. Fewer re-reports of maltreatment 1 year post intervention Examine case orientated benefits through CPS evaluators conclusions of parents' capacity to care	1.59]) and PCA-PI (χ^2(1, N = 27) = 5.74, *p* = .02, *d* = 1.04, CI [0.19, 1.89])	
9.	Twomey et al., USA uncontrolled trial	Perinatal substance users N= 195 mothers, 203 infants Age: neonates	Vulnerable Infants Program of Rhode Island N= 79 of this group also enrolled in the Rhode Island Family Drug Court (RI-FDCT)	n/r	12 months	n/a	1. Decrease length of hospital stay 2. Identify permanent placements to policy timelines 3. Optimise opportunities for parental reunification	24% more infants placed with biological parents post intervention X^2=25.01, *p*<.001; **d*=0.7 Mother who participated in family drug court and intervention significantly more likely to be reunited compared to infants of mothers attending standard court (34% more; Fisher's exact test; p<.001)	AAPI-2 Parenting measures: Authors reported statistically improvement on domains discipline (*p*<0.05) and parent-child role responsibilities (*p*<0.001)

								4. Compare intervention families seen in FDCT with standard court			

Abbreviations: n/r = not reported; n/a = not applicable; F/U= follow up; N = sample size; M = mean age; *effect size/mean age not reported, calculated by researcher. Assessment Tools: Adolescent and Adult Parenting Inventory (APPI-2); Keys to Interactive Parenting (KIPS); Ages and Stages Questionnaire (ASQ)

3.3 High quality studies

3.3.1 Intervention components and method of interaction with decision-making:

Of the three studies rated as high quality, two studies used video-feedback interventions; one (van der Asdonk et al., 2020) 'based' on VIPP and the other on Attachment Video-feedback (Cyr et al., 2022). Van der Asdonk et al. (2020) provided the VIPP-SD intervention across four family residential clinics wherein parenting capacity assessments (PCA) usually take place. Families received an average of 4.36 sessions of a VIPP-SD-based PCA protocol. The PCA assessors then evaluated families exposed to the intervention using a VIPP-SD PCA and provided a recommendation to the children's court judge or family guardian. PCA evaluators in Cyr et al. (2022) conducted the Attachment Video-feedback intervention at clinics mandated to provide specialised PCA for difficult to assess cases. An average of 8.33 sessions were completed per family. Evaluators were hired by child welfare to conduct PCAs and provided qualitative reports on parents' capacity to social work and the courts.

The remaining study had Infant Mental Health-Home Visiting as an intervention (with Infant-Parent Psychotherapy the main approach therein) (Stack et al., 2020). This intervention was delivered in the context of an IMH-informed Baby Court, where "science informed" jurists strived to create a non-adversarial setting and referred to the IMH intervention. Parents were also provided with additional support to access community resources. Information on the number of sessions was not provided. The method of influencing court decision making was through IMH clinicians providing testimony.

3.3.2 Outcomes measured and effects:

Among the three high quality studies, two measured permanency or reunification outcomes (Cyr et al., 2022; Stacks et al., 2020) by reviewing child welfare system files for placement decision outcomes. Cyr et al. (2022) found a large effect size for evaluations of parental capacity to care in intervention group and placement at home one year post test. Stacks et al.'s (2020) uncontrolled trial reported that 69.9% of infants were reunified with parents. Van der Asdonk and colleagues (2020) found no significant between group difference for changes in, or confidence in, decisions made by CWS professionals in their recommendations to courts.

On infant mental health related outcomes, for developmental delay, Stacks et al. (2020) had a follow up of approximately nine months and found large effect sizes for expressive language improvement on the Bayley III and found medium increases in infant behaviour, as measured by outcomes on the Crowell. Increases in parent-child interactions were assessed using an observation and rating of interactions by Cyr et al. (2022), (rating system from Moss et al., 2011) with increases in interactions reported in the medium effect range. Van der Asdonk (2020) found parents received less intensive support at follow-up, but this was not statistically significant.

Both RCTs (Cyr 2022 and van der Asdonk 2020) had very small sample sizes so imbalances across the groups could have introduced bias.

3.4 Medium quality studies

3.4.1 Intervention components and influence or interaction on decision-making:

Three studies of medium quality explored the influence of IMH interventions delivered in the context of infant or family drug courts. CPP was used in two studies: Casanueva et al's. (2013) observational study reports on the Child Wellbeing Court Model where parent-child dyads received an average 25 sessions of manualised CPP. The intervention interacted with decision-making as IMH clinicians were supported by judges to provide feedback to inform court proceedings. Hazen et al. (2021) reviewed dependency court case files where parents had participated in CPP. Twomey et al. (2010) reported on a hospital-based care co-ordination programme for mothers of substance exposed neonates. The intervention aimed to facilitate and expedite referral to support services for parents (e.g. food bank, medical, financial). Participants were offered the opportunity to engage with the family treatment drug court (FTDC) during the intervention. The intervention remained involved until permanent placement had been identified for infants. IMH clinicians had contact with the FTDC through accompanying parents as supports, providing updates on progress and recommendations for outcomes. Van der Asdonk et al. (2019) assessed influence through decisions made by professionals involved in child welfare decisions for an attachment video-feedback intervention and control-case report vignettes.

3.4.2 Outcomes measured and effects:

Three studies measured permanency or reunification outcomes through court (Casanueva et al., 2013; Hazen et al, 2021) and hospital records (Twomey et al., 2010). Authors dichotomised outcomes for coding purposes. Twomey et al. (2010) reported a medium-sized intervention effect on placement with biological parents. Hazen et al. (2021) reported a large effect for ordered CPP participation associated with lower likelihood of reunification. However, when controlling for whether the parent was ordered to participate, those who participated more consistently were more likely to be reunified (large effect size). They also found significant influence of CPP increasing time to case closure. However, the explanatory power of the model used was limited, and the correlational nature of the study challenges inferences; unobserved variables are likely to have confounded findings.

For infant mental health related outcomes, Casanueva et al. (2013) reported some significant findings for outcomes in relation to developmental and behavioural factors. The Crowell and ASQ had medium-large effect sizes (calculated for the purpose of this review). No reports of maltreatment recurrence were noted by authors.

While the study by van Der Asdonk et al. (2019) was deemed to be of medium quality, the results were well rated. They reported a large effect size for professionals paying more attention to positive parental changes due to an IMH intervention.

3.5 Low quality studies

3.5.1 Intervention components and influence or interaction on decision-making:

Both studies were focused upon CPP delivered within the context of infant court teams. As with the ethos of the court team in Stacks et al. (2020), the settings were described as developmentally informed and non-adversarial. Chinitz et al. (2017) reported on parent-infant dyads who completed 26 sessions of CPP. The intervention interacted with the courts system as referrals to CPP were received from those involved in legal proceedings (e.g., judges, attorneys, child welfare professionals). The intervention aimed to influence decision making as CPP clinicians provided training to improve IMH informed practice in the legal system, and also provided written feedback to court-based teams to be used to inform decisions on contact type and frequency, and relationally informed decision on permanency. Casanueva et al.'s

(2019) CPP intervention was delivered in the context of the Safe Babies Court team, a structure for collaboration and information sharing regarding infants' developmental needs and placement decisions. The mechanism by which CPP clinicians specifically shared information with court teams was unclear. Follow-up times for both studies were unclear.

3.5.2 Outcomes measured and effects:

Due to the low-quality appraisal of these studies, outcomes and effects will be reported summarily, with further detail available in Table 2. Chinitz et al. (2017) and Casanueva et al. (2019) reported on placement and reunification. For IMH outcomes, both authors also reported low rates of maltreatment recurrence. Additionally, Chinitz et al. (2017) reported significant improvements on parent-child interaction domains.

4. Discussion

This review sets out to answer the question of which infant mental health interventions are being used within the child welfare decision-making system (with children aged 0-5) and what are the outcomes for decisions in relation to placement types, parenting capacity assessments, and professionals appraisals of their decisions. Secondarily, when available, IMH outcomes were also explored.

A narrative synthesis and quality appraisal were used to investigate the state of the literature and answer the questions posed. Overall, the literature indicated that a range of IMH interventions are being used within decision-making settings of the CWS. CPP and home-visiting in the context of therapeutic Baby Courts, video-feedback and social support interventions were found to be used. However, the quality of the literature was mixed, impacting significantly on the robustness of the evidence-base in this setting.

Outcomes related to court decision-making were reported using measures of permanency, placement decisions, reunification with birth parents, and professional's confidence in court recommendations. The mixed quality of these studies makes it difficult to draw firm conclusions; the usefulness of embedding IMH interventions within the decision-making process of the CWS remains equivocal. The promising results regarding reunification with birth parents from two of the three high quality studies indicate that this is an area which warrants further investigation. However, differing results of the two high quality RCTs provide inconclusive evidence on IMH interventions.

For permanency outcomes to have real world utility, evidence-based permanency planning must consider risk of maltreatment recurrence, previously found to occur at high rates in maltreated children (Minnis et al., 2010). Four studies reported on both permanency outcomes and maltreatment recurrence, with two studies of high quality based on an IMH informed PCA. These found mixed results – significantly more likely to be at home and not have maltreatment recurrence (Cyr et al., 2022), versus no significant difference from control group in placement recommendations and maltreatment recurrence (van der Asdonk et al., 2020). Furthermore, the variation in

studies reporting on length of time to follow up limits clarity regarding the longer-term outcomes for children's cases, the average follow-up time of four studies in this review was 10.75 months. The shorter follow up duration has been noted as limitation of the literature in meta-analysis on parenting-interventions and maltreatment recurrence (Vlahovicova et al., 2017), and while risk of re-reports of maltreatment is suggested to reduce over time (Kim et al., 2020) the mean time to reports of maltreatment for infants has been reported to be 18 months (Palusci, 2011), highlighting the limitations of shorter study durations in this review in capturing a true picture of placement stability and recurrence outcomes.

Greater clarity is needed on how professionals are using the information from IMH interventions to inform decisions. A vignette study included within the current review provided insight into how professionals approached decision making, and found professionals advised OOH care for the control condition more often than IMH condition, and greater agreement for ambiguous cases when exposure to an IMH intervention was described (van der Asdonk et al., 2019). While this study was of medium quality, it indicates innovative ways of exploring the use of IMH interventions in decision- making. Overall, the use of court records to measure permanency and maltreatment (six of seven studies that included these outcomes used CWS data – van der Asdonk et al., 2020 used parent interview) represents a strength in the evidence base. Measuring maltreatment recurrence and placement outcomes through 'soft outcomes' based on psychometrics has previously been criticised for robustness (Whitcombe-Dobbs & Tarren-Sweeney, 2019).

There was inconsistency in how IMH was measured across included studies. High quality studies demonstrated improvements on some aspects of development, increased positive emotions (Stacks et al., 2020) and parent-child interactions (Cyr et al., 2022), however, findings must be balanced against the lack of significant findings by van der Asdonk and colleagues (2020). The variability in measures used, high rates of attrition in studies and variability on how assessments were complete are limitations of the literature, and challenge the utility of the evidence-base for complex decision-making on maltreatment in the CWS (Forslund et al., 2021).

For both decision-making outcomes, and the secondary question on IMH outcomes, the suitability of the methodologies employed by the evidence-base warrant consideration. The two RCTs described control groups treatments that were not dissimilar to the component parts of IMH interventions (e.g., relationships, specialist mental health work) and this might have reduced the difference between the groups. The small sample size might also have reduced the likelihood of detecting differences between the groups (Nayak, 2010).

Interventions were found to fall into three different categories: 1) CPP or home-visiting interventions offered in the context of baby or drug dependency courts aiming to promote IMH informed decision-making in the judiciary; 2) Interventions using video-feedback embedded within parenting capacity assessments with the aim of orientating court decision-making; 3) IMH social support interventions. For interventions in the context of Baby Courts, referrals to IMH interventions were court mandated, and IMH clinicians were supported to provide testimony on parents' engagement. Studies on parenting capacity assessment interacted with court decisions through capacity evaluators, including their evaluation of parents who had been exposed to the intervention in their court recommendation. The variety in approaches to embedding IMH within decision-making demonstrates the ways in which infants voices (often overlooked) can be represented within the court and decision-making setting (Miron et al., 2013). The review also highlighted the potential roles for various professionals in contributing to decision making in this context, for example, IMH intervention therapists (e.g. clinical psychologists) having opportunities to feedback to court systems regarding the outcomes of interventions, which would reflect the multi-disciplinary ethos of the IMH field. Having a variety of professionals involved from both health, social care and criminal justice fields may help support scrutiny of evidence and reflections on the evidence base, as professionals have been found to be influenced by their professional lens when interpreting IMH information (Gregory-Wilson et al., 2022). It might be that training with the judiciary offered by the court-based programmes in this review support sufficient developmental knowledge on infants. However, the quantitative results reported by authors in this review do not

provide sufficient insight for conclusions to be drawn. It is likely qualitative research would be warranted for richer understanding of the process.

Contrasting the interventions found in this review with the wider literature on maltreatment should be considered. Two studies (van der Asdonk et al., 2020 & van der Asdonk et al., 2019) reported on interventions based on VIPP, previously studied within maltreated children with good effect (O'Farrelly et al., 2021; Pereira et al., 2014). Attachment Video Feedback-intervention (AVI) provided by Cyr and colleagues (2022) is based upon an intervention with limited research and validation (Moss et al., 2011), however, the intervention has been developed specifically for maltreated children and their parents. CPP has been found to be effective over time in sustaining positive attachments between mothers and maltreated infants, and was developed for to reestablish relationships for children who had experienced trauma (Lieberman, 2004; Stronach et al., 2013).While the IMH-HV intervention used included CPP as a central modality. Theoretically, VIPP, AVI and IMH-HV interventions are explicitly based upon principles of attachment and have been developed or researched within maltreated children, and are positioned as theoretically and practically appropriate for this population (Lederman et al.,2007). However, unclear or lacking descriptions of interventions within included studies was found to limit understanding of how they were used and likely would impact on replicability. Furthermore, evidence for the use of such interventions specifically with infants in maltreated children has been highlighted as a limitation of the literature (Hare et al., 2023). It is interesting that specific interventions developed for use with maltreated children in the CWS such as ABC (Grube & Liming, 2018) were absent from this review. It is also of note that the review included a social support intervention, which included a mental health component but was not theoretically attachment focused. The focus was on increasing access to service and social support to reduce vulnerability of parents to maltreatment, in line with social stress theory (Mossakowski, 2014). The differences in theoretical focus are of interest, while attachment interventions aim to increase sensitivity within relationships, social support aims to reduce stressors faced by families, and research has suggested that stress can cause deterioration in family relationships (Theule et al., 2012). Research exploring which combination of

theoretical modalities best serves maltreated infants is warranted to explore at what points in families' trajectories different types of interventions are useful, if at all (Minnis & Forde, 2023).

The review uniquely aimed to capture interaction with decision making, and the outcomes selected to do this may not have matched with the outcomes reported in other studies within the CWS. The role of funding in delineating outcomes measured by researchers must be considered here; while IMH is purported to represent an interdisciplinary field IMH, the small number of studies in this review may suggest that IMH research remains focused on health and mental health outcomes. Indeed, governmental funding supporting health systems would support this suggestion (Scottish Government, 2023).

The findings of this review should be interpreted in the context of its limitations. While the review aimed to focus on infants, some studies included children outside this age range. These were included due to the low number of papers published on this topic. Social support interventions were found in the review, although they were not explicitly searched for. The nature of the systematic review necessarily limited the focus on papers that examined decision-making and applied an IMH lens, therefore papers discussing social support interventions in the legal CWS setting, but without an IMH lens, would not have been included. It would be useful for future research to expand and include such papers, exploring if outcomes of IMH interventions and social support interventions are related. Given the inter-disciplinary nature of the IMH field the ASSIA database was used within the current research to return social science orientated papers, however, further searching of social sciences databases which include grey literature (e.g. Social Services Abstracts or Social Care Online) may have been useful in returning a wider breath of papers based within social sciences perspectives. Publication bias may have been a limitation of returned articles as papers outlining real-world practice in this interdisciplinary area may be published outwith peer-reviewed journals, including grey literature would be an important consideration for future research.

4.1 Conclusions

The findings of this review suggest that a variety of IMH interventions are being used within the context of decision-making in the child welfare system. Child welfare decision-making related outcomes of permanency, reunification and confidence in decision-making were reported on, as well as IMH outcomes relating to child-parent interactions and infant development. The literature base on this topic remains mixed in quality and may occlude conclusions being made regarding the fit between interventions and decision-making settings.

4.2 Implications for practice and further research

A strength of this review is the indication of the status of literature within this under-researched area, which provides a firm rationale for utilising qualitative methodology to gain insight into the process of *how* professionals are using information on IMH interventions, a current area of paucity (Gregory-Wilson et al., 2022). As regards practice and policy, further RCT and supporting qualitative research may support the implementation of evidence-informed policies within this complex setting.

Therapeutic jurisprudence underlines the rationale for the court-based intervention studies within this review, and tools for measurement have been developed (Kawalek, 2020). Further research on this concept in relation to IMH may provide insight into how courts are currently performing, alongside studies on IMH related outcomes.

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Chapter 2: Major Research Project

A new infant mental health approach to assessing and treating cases of maltreatment: how does it impact perceptions of social workers in the child welfare system? A qualitative exploration

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Plain Language Summary

Title: A qualitative analysis exploring how social workers perceive a new infant mental health approach to assessing and treating cases of maltreatment.

Background: Infant mental health (IMH) is an infant's ability to develop socially, emotionally, physically and psychologically. It is supported through warm and close relationships with their primary caregivers. Maltreatment can disrupt infant mental health. This study is situated within the BeST? Services Trial, a Randomised Controlled Trial (RCT) studying outcomes for maltreated infants entering care who are exposed to an infant mental health approach. The RCT is happening in the Glasgow child welfare system. Social workers have been exposed to the infant mental health approach over the course of it being introduced to the Glasgow child welfare system. It is not yet known how social workers perceived the infant mental health approach over the course of the trial.

Aims and questions: 1) How do social workers perceive the introduction of an IMH approach to assessing and treating cases of maltreatment; 2) how have social work practices and perceptions in relation to an IMH approach changed over time.

Methods: This study analysed data from twenty-five social workers that was gathered through semi-structured focus groups, interviews and case studies. The data came from three time points: 2013, 2019 and 2023. Data gathered in 2023 was done after preliminary analysis of the existing data to inform what areas needed further information gathered. All participants had cases being assessed and treated by the IMH approach. The transcribed data was analysed using reflexive thematic analysis to generate themes to answer the research questions.

Main findings: Three main themes were generated. Perceptions of uncertainty and concern about the IMH approach were evident from data during the early stages of the IMH approach being implemented. Social workers perceptions showed greater acceptance and inclusion towards the IMH approach in the data from later timepoints. They also included the IMH approach in their practice more. A theme on the reasons these changes happened was developed, and highlighted the increased awareness of

IMH in society, the resource limitations faced by social worked, and that the legal system is adversarial.

Conclusions: The study found that social workers were more aligned in their work with the IMH approach over time. The research highlighted that the reasons for changes in perceptions were linked to exposure to the IMH approach and due to factors happening in the local context that did not link with the IMH approach.

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Minnis, H. (2016). The Best Services Trial (BeST$^{?}$): Effectiveness and cost-effectiveness of the New Orleans intervention model for infant mental health. Lancet Protocol. D-15-06090R1, ClinicalTrials.gov Identifier: NCT02653716. 24

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Abstract

Background: The BeST? Services Trial represents the first time that an infant mental health (IMH) intervention has been implemented and tested in the UK child welfare system for cases of infant maltreatment. How social workers respond to, and understand this approach is vital to examine given that the IMH model has been introduced into a traditionally social work-based system. Their perceptions are posited to provide integral context for understanding how an IMH approach embeds.

Objective: To explore how social workers perceive the introduction of an IMH approach to assessing and treating cases of maltreatment; and to investigate how social workers perceptions and practices in relation to an IMH approach may have changed over time.

Participants and Setting: Participants comprised of twenty-five area team local authority social workers working in the Glasgow child welfare system.

Methods: Reflective Thematic Analysis (RTA) was conducted with data collected through interviews and focus groups.

Results: Three overarching themes relating to perceptions of the IMH approach were identified: Social workers initially expressed uncertainty towards the approach (theme 1). Drivers of change behind why these perception and practice changes occurred were generated (theme 2). Greater acceptance and inclusion (theme 3) of the IMH approach was evident in perceptions as time passed.

Conclusions: Perception of an IMH approach changed significantly over time and drivers for change were identified. The study found increased IMH consciousness and collaborative work between the IMH approach and social work, that occurred in the context of an adversarial and resource limited system.

Keywords: Maltreatment, social work, infant mental health, implementation, qualitative

Introduction

The revolving nature of children's movement through the care system has been highlighted in the Scottish context, where two thirds of children in Glasgow who returned home after an episode of maltreatment returned to care at a later point (Minnis et al., 2010). A focus on infant mental health (IMH), as a multidisciplinary field of research, policy and practice has developed alongside such findings and is orientated towards preventative relational and strengths-based interventions for infants and their families to "alleviate suffering and enhancing the social and emotional competence of young children" (Zeanah et al., p 6, 2019). However, implementing IMH at a systems level so that those in need can have timely access to intervention remains a challenge. A qualitative study on practitioners' views of developing IMH services in Scotland found that while there was optimism and enthusiasm around implementation, there were also barriers, such as lack of collaboration between disciplines, lack of understanding and stigma (Weaver et al., 2022). Barriers have also been found in relation to implementing IMH approaches in the context of the child welfare system, despite the mental health of maltreated infants being of key concern (Whitcombe-Dobbs & Tarren-Sweeney, 2019). Social workers have reported disagreement on what constitutes IMH, a lack of clarity regarding their roles in interventions and a need for access to IMH providers in the community (Hoffman et al., 2016). In alignment, Walsh and colleagues (2021) suggest that social workers require a more robust delineation of roles regarding IMH and understanding of it as a construct.

It is critical to consider how IMH approaches are being utilised by social workers within the child welfare system, a group integral to both decisions and care for maltreated infants. Findings from the preceding systematic review (see chapter 1) suggest that the role of IMH interventions within decision-making in the child welfare system remains limited and poorly developed. Social workers have a clear role in mediating the implementation of IMH interventions, impacting upon the outcomes for maltreated children in the child welfare system; e.g., in making recommendations on parenting capacity to courts, based on IMH intervention (Cyr et al., 2022). However, a

paucity of knowledge persists regarding how social workers perceive IMH as a concept and how they relate in their practice to IMH approaches.

BeST? Trial

The BeST? Services Trial represents a novel examination of the ability of an IMH approach to enhance outcomes for children in a social work focused system. It is an ongoing randomised control trial (RCT) investigating the outcomes for infants and their placement decisions following exposure to an attachment based IMH intervention versus social work service as usual (Crawford et al., 2022).

The IMH approach used in this trial was developed in New Orleans (The New Orleans Intervention Model: NIM) (see Zeanah et al., 2001) and has been adapted for the Scottish context in Glasgow. The IMH approach is delivered by the Glasgow Infant and Family Team (GIFT) who carry out 3 months of assessment and 6-9 months of tailored treatment for birth parents with the aim of improving family functioning, enhancing IMH and maximising the chances of infants being returned to their families should this be in the best interests of the child (Turner-Halliday et al., 2017). The GIFT team is multidisciplinary and comprises of staff from psychiatry, psychology, social work, and psychotherapy (Crawford et al., 2022).

The GIFT approach provides an IMH approach to assessment and intervention, tasks previously completed by social workers. GIFT are employed to do a piece of work that constitutes a parenting capacity assessment, that is used to inform decision making. Its use is entirely advisory, and the social work area team (in the local authority) maintain responsibility for case holding, care planning, and to pursue recommendations in the legal system about whether the child should go home or not.

At the end of their approach, GIFT make a recommendation on whether the child should be reunified with their birth parent/s or not. This may, or may not, align with the opinion of the case-holding local authority (area team) social worker. Without doubt, GIFT is being implemented within a complex system with multiple stakeholders. Alongside the RCT, a qualitative process evaluation aiming to understand “what works, for whom and in what context?” has been embedded in the research strategy (Kainth et al., 2022). Investigating these questions across a range of

settings and stakeholders bring robust qualitative and contextual understanding to quantitative findings, so that the later quantitative outcomes of the study may be explained in relation to the contextual factors that have affected the embedding of the model into the child welfare system.

The perceptions of social workers towards the GIFT approach were gathered early in the process evaluation (Turner-Halliday et al., 2017). These findings interestingly showed that social workers were focused on hypothesising how GIFT recommendation reports would be received in legal system; referred to as evidence of a "legal consciousness" around the introduction of the IMH approach (p. 193). Social workers conjectured that the in-depth nature of GIFT reports, perceived objectivity, multi-disciplinary focus and provision of family treatment would enhance GIFT's "clout" in relation to being 'heard' in the legal setting. Conversely, social workers perceived these "clout" factors to potentially provide more opportunity for legal contest of recommendations in the legal system (coined as "doubt"). Social workers perceived the social work approach as being more robust within the legal context, but conversely as having less clout.

Taking a broader scope and understanding what an IMH approach means to social workers in terms of their cases (both the process of working with the approach and how they perceive outcomes for their cases) represents an important next step to furnishing a broader understanding of how an IMH approach embeds within a system that is traditionally led by social work. Whether, for example, social workers see an IMH approach as aligned with their practice, may inform attempts to increase social workers' understandings of their roles in relation to IMH (as advocated by Walsh et al, 2021). In addition, understanding area team social work perceptions about the implementation of an IMH approach may affect whether or not the approach is successful in various ways, such as its ability to embed into the system, to be delivered in the way that was intended and, essentially, to improve IMH outcomes. Previous research suggests that social workers interpretation of policies and programmes is central to how they are implemented (Gopalan et al., 2019).

The aim of this study is to understand how the embedding of this IMH approach within the child welfare system in Glasgow, Scotland, has been perceived over time by local authority (area team) social workers, a group key to early intervention for maltreatment and facilitating access to appropriate treatments and interventions.

Aims

This study aims to:

1. Explore how social workers perceive the introduction of a new IMH approach to assessing and treating cases of maltreatment.
2. Investigate how social workers' perceptions and practices in relation to an IMH approach may have changed over time as the IMH team has embedded.

Research Questions

In relation to the aims of this study, the following research questions will be answered:

1. How do social work area teams in Glasgow perceive the GIFT approach to assessing and treating their cases of maltreatment?

2. In what ways, if any, have perceptions and practices of area team social workers in relation to GIFT changed over time?

Methods

Design

This study utilised a qualitative research design to examine social work perceptions of a new IMH service via semi-structured interviews and focus groups. The data was collected as part of the BeST? trial's process evaluation (as described by Kainth et al, 2022). An iterative approach to data collection was adopted (Braun & Clarke, 2019) and data were collected over three timepoints between 2013 and 2023 in order to examine any changes in perception over time (as per Research Question 2). As the focus of this research was perceptions of social workers within area teams at three discrete time-points, rather than a focus on specific individual social workers across time, data were collected from a range of social workers from area teams across three time points to capture perceptions within teams more generally. Data were analysed using Reflexive Thematic Analysis (RTA) (Braun & Clarke, 2021, 2022).

Theoretical Framework

A theoretical and epistemological stance of contextualism was assumed in this research. This stance posits that there is no "one reality" and instead that knowledge is "local, provisional and situation dependent"; so that results will vary according to context and cultural meanings (Madill et al., 2000, p.9). Taking this stance in the current study means a broader social context was assumed and related to how participants made meaning of an IMH approach. RTA is a theoretically flexible approach, noted to fit with experimental orientations (Braun & Clarke, 2021). It was thus deemed suitable for the contextual stance of the current project (Braun & Clarke, 2013).

Participants

Participants were area team social workers working in child protection and recruited as part of their involvement in the BeST? Trial. Social workers were an identified stakeholder group who were invited to participate in focus groups and interviews based on working in area teams with exposure to the models examined by the BeST? Trial (GIFT or social work services as usual). Data came from focus groups and case studies completed between 2013 and 2019 which were gathered by different researchers in the BeST? Trial team as part of the BeST? Trial's process evaluation (see Table 1). Participants were made aware that researchers were not part of the GIFT

team, and that a range of views were welcomed, to help promote participants comfort to share their views. This data was reviewed and used to drive purposive recruitment of five additional participants for interviews and focus groups in 2023, reflecting the iterative approach of this research. A total sample of 25 participants across the timepoints were included, further details on sample and data collection modalities are detailed in Table 1. All social workers were recruited via their consent to take part in the BeST? Trial process evaluation.

Table 1

Information on format of data collection across timepoints

2013	**2019**	**2023**
Three area team focus groups (n=10)	One focus group with social workers from various teams (n=6)	Three interviews with social workers
Case study data time 1: Two interviews collected as part of two different case studies on children going through GIFT (n=2)	Case study data time 2: Two interviews collected as part of two different case studies on children going through GIFT (n=2)	One focus group (n=2)
2013 participants: n=12	2019 participants: n=8	2023 participants: n=5

Procedure

Ethical approval was granted for the BeST? Services Trial from the West of Scotland Research Ethics Committee (Appendix 4). The current research fell within the approval for the process evaluation project. The researcher was added to the study team as part of an amendment to ethics (Appendix 5). All data pertaining to the project was stored on a secure server in accordance with the data protection policies of the BeST? Services Trial and transcripts were anonymised.

The research followed an iterative 2 stage approach: 1) secondary analysis of existing data from the BeST? process evaluation was completed; 2) additional interviews and a

focus group with social workers were conducted based on development of the research aims, and areas for further exploration identified from stage 1 (Lyons, 2016).

All data were collected through semi-structured topic guides that were developed iteratively over time. Topic guides aimed to support data collection for tracking changes and developments over the course of GIFT's introduction to the Glasgow child welfare system (Turner-Halliday et al., 2018). The first stage of analysis for the current project informed development of the topic guide for data gathered at the 2023 time point to include specific exploration of social workers views on IMH and the GIFT approach, a focus in line with the research aims, while still providing space for inductive discussions (Appendix 8). The data gathered in 2023 was done so by a researcher from the BeST? Trial team, and the researcher from this project joined for one interview. The current researcher also had access to audio-recordings of all previous interviews included in this research to help support familiarity with the data. All interviews and focus groups lasted between 60 and 90 minutes and were conducted in-person or online, depending on participant preference. All data were audio-recorded with consent and transcribed verbatim. The active nature of this process resulted in changes made to the project aims from the original research proposal (Appendix 9).

Data analysis

The RTA method requires moving recursively through the six stages of familiarisation; coding; generating initial themes; reviewing and developing themes; refining, defining and naming themes; writing up findings (Braun & Clarke, 2021).

The first stage of analysis was secondary analysis of existing data. Existing data were collected for purposes that are superfluous to the aims of this study and so the researcher used a process of familiarisation to review transcripts and filter data relevant to the aims of the research. This process was inclusive, keeping any data relevant, in its broadest sense, that related to IMH.

Following immersion of the researcher in existing transcripts, the second stage of data collection was completed based upon researcher identified areas for further exploration and development. As outlined above, this stage of data collection took a

specific focus upon the research aims and questions that were refined through iterative team discussion and reflection following stage one of analysis (Braun & Clarke, 2023).

Data from both stages were compiled for analysis using the RTA method. Familiarisation was performed with the entire dataset. Two rounds of coding were completed, the first to capture codes in a fine-grained way, with a second round of coding completed to capture the researchers "analytical take" (Braun & Clarke, 2022; p35), which informed the generation of initial themes. The researcher moved recursively between coding and searching for initial themes, before developing and naming final themes. At this stage the researcher discussed and reflected on themes in supervision, this supported development of rich themes. The robustness of themes was also reflected on through discussions, with a focus on enrichment of the researchers interpretation, that has been highlighted as a way to support the analytical process, but does not represent an attempt to achieve consensus – which would lie contrary to the RTA method (Byrne, 2022).

Reflexivity

Experience framing interpretations of data is expected in RTA (Braun & Clarke, 2021) and researchers 'owning' their perspective is considered best-practice in this method (Braun & Clarke, 2023). In line with RTA, the researcher acknowledged and examined their subjectivity during the process of the analysis through reflexive journaling and discussions on research perspectives during supervision meetings (Braun & Clarke, 2013). This provided the researcher opportunity to acknowledge assumptions, motivations, and their personal approach to the research (Appendix 10).

Results

Three overarching themes were developed in relation to the research questions posed. The flow and structure of these themes are outlined in Figure 1.

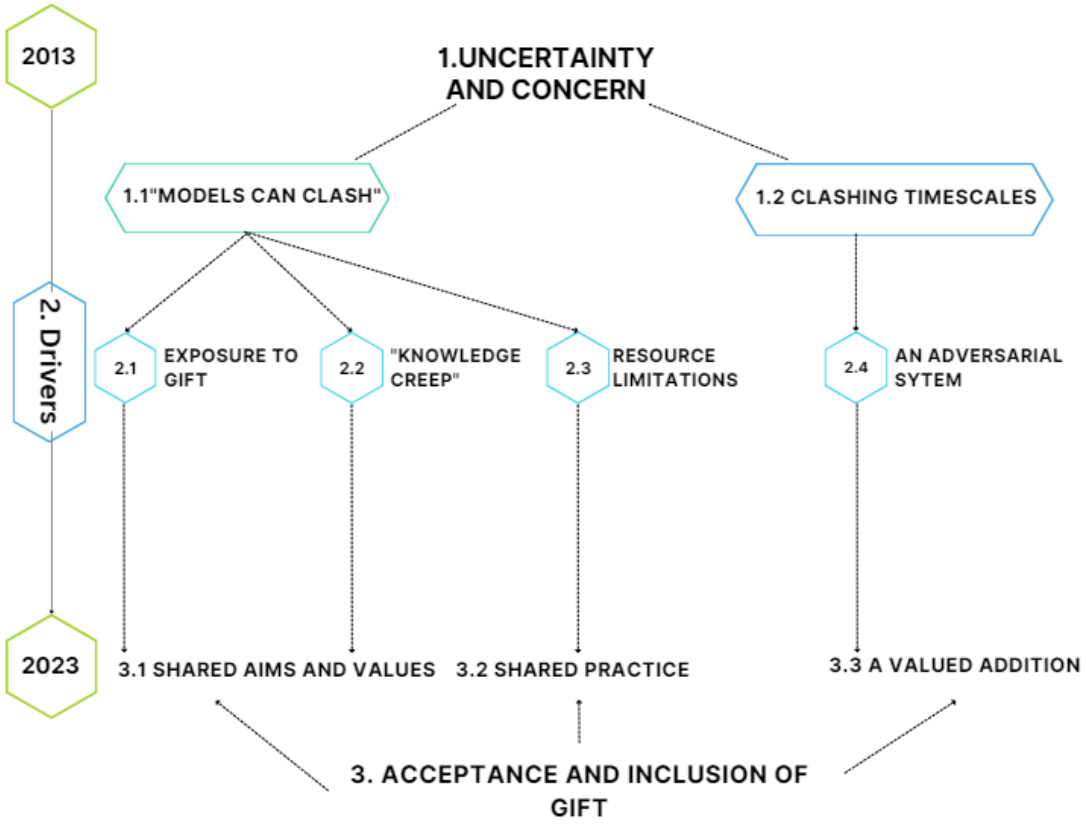
Two overarching themes, housing sub-themes that represent the different dimensions of each theme, were interpreted from the data in response to the first research question *"how do social workers perceive the GIFT teams' approach to assessing and treating their cases of abuse and neglect in families with young children?"*:

1. Uncertainty and concern: "This is a different place"
3. Acceptance and inclusion of the GIFT approach: "I've only seen benefits from GIFT"

These themes represent a change in social workers attitudes towards GIFT as the model embedded into the system, from uncertainty and concern (theme 1) to acceptance and inclusion of the GIFT approach (theme 3). Whereas theme 1 was identified in data following the introduction of GIFT into the child welfare system, theme 3 was interpreted from the later data 6 years thereafter. To explain the changes, drivers of change were sought in relation to the second research question - *"in what ways, if any, have perceptions and practice of SW changed over time in relation to a new IMH approach to maltreatment?"* These drivers are outlined in theme 2, and the results are structured to provide a chronological representation of change over time, i.e. from initial perceptions of GIFT (theme 1) to aspects that were interpreted to drive changes (theme 2) through to later perceptions of GIFT (theme 3).

Figure 1:

Themes on perceptions towards GIFT at introduction, drivers for change in perceptions, and changes in perception



1. From 2013 - Uncertainty and concern: "This is a different place" (see Figure 1)
This theme is both prevalent and strongly expressed in the 2013 data, during the early implementation period of GIFT. Uncertainty and concerns were constructed around social workers perceptions of the GIFT approach as a new way of working within the Glasgow child welfare landscape. Social workers viewed the GIFT approach as a different model to that used by social work and were concerned about its potential to miss out on important information usually gathered by the social work model (subtheme 1.1.) and the negative influence of GIFT upon children's timelines (subtheme 1.2.)

1.1 "Models can clash": a social work model vs the GIFT approach

This research interpreted the social work approach as embedded within the local context through its ownership of assessment in cases of maltreatment and its longevity in the system. Uncertainty about the fit and adequacy of the GIFT approach to the local system as well as around how to conceptualise it was evident. Social workers conceptualised the GIFT approach as a "medical model," despite it being a multidisciplinary approach including social workers, and it was not perceived as necessarily adding value compared with the "social model":

> *"but if you ask any social worker what they think about a medical model coming up against a social model of intervention, I guess they would probably say 'leave us alone, our social model of assessing....we've got lots, and lots of experience, built up lots and lots of effective interventions' [….] Now on the other side of that, you know of course the medical model whereas you have got psychiatrists and psychologists involved in that, much as we welcome that, a social worker 'dyed in the wool' will initially baulk maybe at that idea of pathologising problems"* – SW 2013

As GIFT were perceived to have been developed outwith the local context, its suitability was questioned, and social workers highlighted that the recommendations of the GIFT approach may not fit with resource availability:

> *"[GIFT] might be able to say well a child could go home if this was in place, that was in place....and the area team might be saying 'but we can't facilitate that' or you know that kind of thing, and we would then say that the risk would remain".* – SW, 2019

Social workers discussed the GIFT approach in relation to their own practice norms, how GIFT used assessment and intervention focused on clinic-based interactions between parents and children, and were perceived to overlook historically and

contextually grounded information (e.g. past contacts with social work and families home environment). Such information was positioned as the basis of social work assessments. The GIFT approach to assessment and intervention was therefore situated as a fundamentally different lens to social work, and their clinic-based approach was perceived not to meet the required rigour of assessment and intervention to meet child safety needs. Social workers were concerned that the balance of the rehabilitation approach taken by GIFT was tipping towards GIFT providing parent-centered, rather than child-centered intervention and recommendations following an assessment phase that was not always seen to generate a picture that was reflective of reality:

> *"parents are coming up and they are putting on a show, so to speak, [….] although they [GIFT] are videoing it and they are trying to unpick it, the parents are still going to be putting on the best show that they can and it is artificial and it is quite clinical […] my anxiety is that once the assessment phase is over and if that child is returned home that things would revert back to the previous behaviours"* – SW, 2013

Social workers spoke of the value inherent in GIFT offering in-house treatment for families, whereas social work are required to refer out, e.g., addition services. However, they also discussed their fears and reticence that the rehabilitative focus on parents provided by GIFT would lead to recommendations for children to be reunified with parents in cases where the social worker felt that the child should not return home. At this early stage of GIFT's introduction, a sense of fear around disagreeing with GIFT existed across social workers, despite not having experienced such disagreement occurring about outcome recommendations:

> *"The two cases that I've got with GIFT, we've not seen it right through to the very end, so I don't know exactly what their outcome or recommendation would be. So there could be a part where there could be conflict. I think if you had a case where, you know the [social work] area team are very much of the view that the risks are far too high for a rehabilitation and they [GIFT] are working towards a*

rehabilitation and saying 'no this should be what we would recommend to support the family' I think there could be a lot of conflict when maybe the area team would be saying, 'but we can't manage that risk', even with [GIFT intervention] it is too high." – SW 2013

1.2 Clashing timescales

Throughout the data, social workers spoke about children's timescales (working to children's developmental timelines) and drift (children waiting longer than necessary within care system for decisions); as best practice social work concepts relating to timely decision making. Social workers perceived GIFT to jeopardise the process of working to children's timescales, and therefore potentially impacting negatively upon children's outcomes and contributing to drift. For some social workers this was caused by the length of the GIFT intervention delaying the time taken to make a recommendation:

> *"And truthfully I am thinking is this just delaying getting the actual piece of work done that we want done, and whilst I am not underestimating that [the GIFT intervention] is worthwhile ultimately what we want for our families is to get these assessments done so we can make quick decisions about children's futures and not have children in care longer than necessary"* – SW, 2013

For other social workers, the same anxiety about taking too long to make a recommendation was positioned within a broader concern, that GIFT may be giving parents too long a timescale in which to enact change in parenting capacity:

> *"We give people too long to try and fix things, you know because it is amazing how quick a year goes like that (clinging her fingers) in this job, two years does, so if a child comes into care at 10 months, if the process drags out and drags out and drags out we know there is less chance of going adopted after the age of 5. So you know I think we should tighten up on how many chances the*

parents get to recover […] think we could do that quicker as a whole process" – SW, 2019

2. Between 2013 and 2023 - Drivers for change (see Figure 1)

As outlined later in theme 3, there were identifiable changes over time in social work attitudes towards GIFT. Firstly, however, the drivers for these changes in perceptions and practice are presented here (within subthemes 2.1-2.4) to reflect the chronological order of change. The way in which specific drivers related to specific changes is contained within Figure 1.

Looking first at drivers behind the shift towards recognising the shared aims and values (subsequently presented in subtheme 3.1): the influence of exposure to GIFT (2.1) and social workers recognition of changes in their awareness and understanding of IMH – termed "knowledge creep" (2.2) were interpreted from the data. Further subthemes were constructed, named resource limitations (2.3); identified as the driver behind shared practice (3.2), and an adversarial system (2.4); identified as the driver behind a valued addition (3.3).

2.1 The influence of exposure to GIFT on acceptance

Positive experiences of working with GIFT, and exposure to how GIFT worked, appeared as a driver for social workers recognition of the shared aims and values between the services (later outlined in 3.1). Through exposure to the GIFT process, social workers were able to see the robustness of GIFT's assessment (previously viewed as artificial) and understand how GIFT developed their perspective on IMH. This social worker acknowledged how GIFT provided a framework of understanding for cases they worked with, e.g. how exposure to the use of video feedback interventions had increased understanding of relationship patterns:

"When [GIFT] showed us some of the video footage back it wasn't just interactions between [infant] and her parents, but they showed some of the interviews that they did with the parents in the sessions and that was quite

interesting because, certainly as the team leader, you tend not see those kind of thing. If you are the social worker involved then you are there, but you tend not to see those things and there was stark stuff that got highlighted" – SW, 2019

GIFT provided psychoeducation through exposure to their approach for social workers with cases in GIFT. In the following extract this social worker reflected on using new mental health terminology, as she learned and applied the concept of re-traumatisation following a shared case with GIFT:

"*Interviewer: you used the word 're-traumatisation' - is that a word that you have used in the absence of GIFT?*
SW: They initially used it, but I would agree that was an appropriate word […] I don't really know if I would have necessarily come up with the word previously or would have necessarily come up with that *word, but I do think it's an appropriate word for what we seen […] I suppose, I would have been saying that the children are displaying anxiety and negative impact from the contact*" – SW, 2023

2.2 "Knowledge creep"

An internally driven change in the social work system's awareness and practice also appeared to drive the recognition of shared aims and values between social work and GIFT that is described later in 3.1. Social workers discussed how IMH had become incorporated into the social work system through top-down processes (e.g. development of a social work led IMH initiative) and through social workers challenging unhelpful narratives in their teams about the need for IMH. The availability of training suggested how IMH was being prioritised within the social work system:

"People have been on training, there's been lots of training about it and training events everywhere about children's mental health, and infant mental health, and what that looks like. […] there is a recognition within, I guess, social

work services that this is something that we're learning more about. There's an evidence base for it, you know, and that people need to know" – SW, 2023

"Knowledge creep" of mental health and IMH concepts into social work practice were also positioned as being influenced by the societal changes over the course time. The contextual nature of knowledge was reflected as social workers discussed societal awareness driving social workers awareness of concepts:

"Its knowledge creep, if that's an expression [..] so, probably people who work in our sector are becoming much more aware, but then society more generally is much more interested and aware about mental health generally…… and the mental health needs of young people generally, whether it's actually got down in the mental health needs of infants in terms of the wider societal understanding, I don't know that, but I think there is kind of definite knowledge creep that people are becoming much more aware of and it's okay to talk about it… which hasn't always been the case" – SW, 2023

2.3 Resource limitations

Another main expression of the drivers behind GIFT being perceived more helpfully by social workers, described in subtheme 3.2, was captured by discussions on the reality and impact of working within a resource stretched system and profession:

"Well I've been a social worker for a long time, permanence is not something we're good at, and again it's time constraints, being over-worked, it's not individual workers" – SW, 2023

Social workers acknowledged how social work practice and child-centered values often did not line up, and they reflected they would like to be practicing in a more child-centered way (e.g. supervising contacts). Social workers expressed frustration at how resource limitations created a social work system that was not as child-centered as it could be:

> *"I think [social work systems] pay lip-service to [being child-centered]. I mean, I was speaking to a colleague the other day, who was being asked to go and speak to two grandparents and ask them to take children into their kinship care, children that they had not been allowed to see for the past few years, because they were deemed a risk, so there's your answer to that question. And it's not the first time I've heard it in social work."* – SW, 2023

2.4 Driver: An adversarial system

One of the main ways it was noticeable that GIFT was being accepted and included as a support for social work was in how social workers perceived the system they worked in to be adversarial:

> *"I know from meetings and chatting to my colleagues the overall feeling is that actually they kind of rule social work out or just disagree, I think, children's hearings are very much led by the solicitor for the parent, and the parent, and about the parent's needs"* – SW, 2023

Throughout transcripts, the challenge of facing the legal system and getting the best outcomes for infants and IMH loomed large. Early transcripts perceived GIFT reports as adding clout to social workers recommendations in court in the context of the adversarial legal system and resource limitations faced:

> *"It isn't just you going in alone to a hearing or you know for permanence decisions yourself, it is your own assessment, you know you've got more stuff behind you, which is good and the assessments [GIFT] do are much more in-depth than the assessments we do, we just don't have the time to do those kind of assessments. So it is positive in that sense, and I am hoping that it will mean that decisions can be made quicker, you know for children so that things don't drift."* -SW, 2013

3. 2019-2023: Acceptance and inclusion of the GIFT approach "I've only seen benefits from GIFT" (see Figure 1)

Balanced with the uncertainty and concern in social workers perceptions of GIFT from the early, GIFT as a positive addition is increasingly solidified over the course of the data, driven by the drivers outlined above in 2.1-2.4 and depicted in Figure 1. How GIFT comes to be accepted and included is constructed in two main ways: 1) via perceptions of sharing of aims and values (3.1) with GIFT and via social workers descriptions of new shared practice (3.2); 2), via GIFT being incorporated within the social work system as a valued addition (3.3), which relates to the already outlined driver an adversarial system (2.4).

3.1 Shared aims and values

While the early data suggests that social workers are aware that the GIFT approach and social work approach share similar ethos of rehabilitation; this did not translate into a perception of shared aims when working on cases. Through drivers of exposure to GIFT over time and knowledge creep in terms of an increased understanding and awareness of IMH, there was a perception of greater cohesion in orientation and service aims as child centeredness appeared to be realised as a shared value between the services. Social workers' concerns that GIFT would lead to rehabilitation recommendations that were contrary to their own concerns about child safety did not transpire:

> *"I can't even think of an area of controversy [in GIFT recommendations], to be honest, I think, [GIFT] is received well. I'm not conscious of any real differences of opinion. The way that they write up their work, I find this is well received It's clearly detailed about why they've came to that conclusion [...]I think people welcome that type of clarity."* – SW, 2023

The shared aims of child centeredness were evident in working relationships between the services. As an example of this, the following social worker discussed making changes to contact arrangements to support the GIFT intervention to achieve better

therapeutic outcomes for children:

> *"The contact was obviously impacting on the work [GIFT] were doing with [child] because [child] were doing work with [GIFT]. [Child] was going to the contact and then he were just basically regressing, we actually got contact stopped completely because he was just so struggling with the contact […]. So, it's almost a year now since he's had any contact and he's really progressed really well without that contact."* - SW, 2023

3.2 Shared practice

Shared practice is also a subtheme of acceptance and inclusions of the GIFT approach (theme 3), and resource limitations (2.3) were interpreted to drive this change. Shared practice is constructed on the collaborative relationship that developed between social work and GIFT. With roots in the early data, there is a notable shift across time from social work perceptions of GIFT as an approach that potentially disrupts social work practice, to an approach that aligns with social work, and may enhance practice. GIFT offered social workers access to in depth intervention and assessment that was outwith their capacity due to their time and resource pressured roles, and supported them to work in line with their ethos of being child-centered, thus moving past rhetoric to action:

> *"I think the GIFT assessment that I got for that family I am talking about, I found it very useful because they had the staff, the expertise, so they were able to analyse the children and do really in-depth assessments and I found it, you know, very useful, and I found that it highlighted weaknesses in the foster-carers as well, because obviously they were part of that process. So that identified maybe further training as well that I maybe wouldn't have picked up on"* – SW, 2019

This social worker reflects on resource limitations impacting their ability to supervise contact, highlighting how working with GIFT overcame this limitation:

> *"Although there is contact all the time we don't always cover the contact or if I am covering the contact with mum and four children I miss things, whereas GIFT were in a much better position to zoom in on their relationships and they had individual contact and all that, so it was very valuable*" – SW, 2019

There was concordance in the working practices between social work and GIFT, that positioned GIFT and social work as two teams working towards shared outcomes (e.g. GIFT taking on intervention and assessment, social workers taking this forward to court):

> *"We've got the adoption panel for that wee one on [date] and obviously the fact that we've been able to evidence, not only how much we tried to support her, but also all the lengths that GIFT went to, to try and support her in terms of the work they were going to do, I think, that's been really helpful for hearings [legal forum in Scotland] to see. When we go to court, for the court to see just how much extra support was offered by all of these services to try and help her"*- SW, 2023

3.3 Valued addition:

In the context of the adversarial system (2.4), social workers discussed how GIFT's addition was advantageous to supporting their work in the legal system. These discussions were interpreted to signal a change in perception to regarding GIFT as a valued addition to the aims of the social work system:

> *"I think that has been very much an advantage for us to get a better assessment, that's what it is about, it is not about you know who's right, who's wrong, it is about what's right for [infant]"* – SW, 2013

Perceptions that GIFT had more clout in the legal system than social workers continued. The utility of GIFT's clout for social workers achieving their desired outcomes in court was valued and utilised:

> *"Um, so that's been really positive and again without GIFT, we would have never got that, because he had 3 times a week contact and we got that stopped from 3 times a week to absolutely nothing, and that was with the support of GIFT, we would have never got that without GIFT."* – SW, 2023

Social workers acknowledged that their views were often overlooked within the legal system and that a double standard existed. By referencing GIFT reports, highlighting the additional assessment and intervention work completed by GIFT, and having GIFT workers provide evidence, social workers were able to use GIFT's clout in their practice to try and achieve an outcome they perceived as best for children:

> *"that was a very, very difficult hearing, and having [GIFT staff] there as a psychologist… I think really helped. I think, as well that the fact that the report is coming from a psychological perspective and you've got psychologist involved in doing the assessment, it's like that hierarchy of professionals, isn't it, and people's perceptions…… and, you know, obviously solicitors come in on these panels and they argue right, left and centre, but if you have got someone that's seen as a medical professional sitting there talking about stuff, even though it's the same stuff, maybe you would say… I think the panel perceive it very differently."* – SW, 2023

Finally, perceived clashes in the timescale of the GIFT assessment and intervention process vs social works timelines, previously perceived to disrupt children's timelines, had a notable shift. This was interpreted as underlined by social workers seeing greater value in and understanding of the GIFT perspective, and thus tolerating the time it took for their assessment and intervention:

> *"I mean that's okay, you need to get these decisions right, you are talking about a child being adopted, so if there is scope for them to be returned to their parents' care that's what we would want to do. So I have absolutely no objection if this takes a bit longer, but we get the decision right, that's fine".* – SW, 2019

Discussion

This research set out to examine how local authority area team social workers, (who have case holding and care planning responsibility for cases assigned to GIFT) perceive the introduction of an IMH approach to assessing and treating cases of child maltreatment in young children in the context of child protection in Glasgow. By conducting interviews and focus groups at three time points (2013, 2019, 2023), it also aimed to investigate how social workers' perceptions and practices in relation to an IMH approach to maltreatment may have changed over time as it embedded into Glasgow's child welfare system. Three overarching themes were interpreted from the data and suggest two key messages from the findings of this study:

1) Social workers' perceptions about GIFT have changed over time, from a position of uncertainty and concern (theme 1), to expressions of acceptance and inclusion of the IMH approach (theme 3).

2) Drivers of perception changes can be identified (theme 2), which provides an explanation of how and why the process of change has occurred.

These key messages, and related themes, are now discussed in turn:

How do social workers perceive an IMH approach?: From uncertainty and concern to acceptance & inclusion

In the early data, theme 1 was interpreted from perceptions of uncertainty and concern based upon two key areas of trepidation about GIFT: Firstly, social workers conveyed concern that GIFT would clash with the existing social work model. This theme housed perceptions around GIFT as a "medical model", social workers struggled to reconcile GIFT's ability to assess the complexity of cases in the way the locally embedded social work model could. Hesitancy towards what they termed as the "rehabilitative" approach taken by the IMH team was also evident, and was seen as having the potential for GIFT to tip towards a parent-centered rather than a child-centered focus in their cases. Striking a balance between infant's rights and their parents within this setting is already known to be contentious. Infants are often deemed as voiceless and with needs that can be overshadowed by the focus on others (e.g. legal system priorities or parents' rights) (Miron et al., 2013). In Turner-Halliday's (2017) aforementioned 'clout versus doubt' study, social workers'

perceptions of GIFT as a "medical model" were related to an identified "legal consciousness" by social workers about how GIFT evidence would be viewed in legal fora. In comparison, the findings of the current study extend the focus to allow us to consider the implications for IMH; e.g., regarding where IMH 'sits' in relation to social work. The IMH team being perceived as utilising a "medical model", when it is a multi-disciplinary approach that includes social workers, may suggest that ownership of IMH is perceived to be located in the domain of health rather than social care. This could be partly explained by a lack of training on IMH in social work courses, as highlighted by Walsh and colleagues (2021). Governmental funding around IMH remains focused within multi-disciplinary health professionals, which may reinforce the notion that IMH comes from a medical model (The Scottish Government, 2023).

Secondly, clashing timelines were interpreted in relation to social workers' uncertainty and concerns about GIFT; that intervention work would contribute to disruptions to children's decision timelines and resulting potential for drift. Whereas it is proposed by GIFT that a treatment phase may improve accuracy of decision-making (Turner-Halliday et al, 2017), area team social workers often saw the GIFT process as unnecessarily long when it comes to the best interests of the child.

Contrasting with perceptions earlier in the implementation of GIFT, the findings indicated significant changes in perceptions towards acceptance and inclusion (theme 3), that were conveyed more strongly by social workers over time. This theme was interpreted around perceptions of greater awareness and recognition of shared aims, values and practice between social workers and the GIFT approach, focused on a perceived shared ethos of child-centeredness. Fears regarding disagreements with GIFT did not come to fruition, and therefore the "clout" that GIFT evidence was projected to have in the legal system relative to social work (Turner-Halliday et al, 2017) was not seen as having the potential to de-stabilise social work recommendations regarding children. Instead, the inclusion of GIFT evidence in the assessment of their cases was often see as strengthening the position social work put forward. In this sense, there is still a legal consciousness apparent amongst social workers at later stages of data collection, however they are not positioned in the context of fear. Indeed, "doubt" perceptions, i.e., fears that GIFT evidence could be

easier to contest in a legal forum, were not evident in the perceptions of social workers.

Why and how changes in perception and practice occurred: identified drivers for change

In examining what mechanisms may be behind the shift in perceptions and practice to a more positive outlook on GIFT, drivers of change were identified. Firstly, increased consciousness in relation to IMH was evident. This represents a change from earlier findings, which reported legal consciousness, but not the presence of IMH consciousness (Turner-Halliday et al., 2017). It is interpreted that this change was driven through both exposure to GIFT and via internally driven training and societal "knowledge creep" of mental health concepts into social work. Exploring this process through the lens of Normalisation Process Theory (NPT) (May et al., 2016) a framework for implementation in complex systems; it may be that knowledge creep 'normed' IMH within the social work system and supported the 'mobilisation of resources' i.e. social structure norms and cognitive resources such as commitment, that facilitated social workers ability to engage with the GIFT approach.

Social workers faced systemic barriers in the resource limitations of the system as they strived to work to child-centered values. The capacity of GIFT to offer in-depth work outwith the resources of social work may be contextualised as meeting a need within the social work system. Qualitative research from an IMH implementation site in London found social workers perceiving GIFT as a means of reducing waitlists (Baginsky et al., 2017). It might also work the other way around; that the IMH team have adapted their way of working to increase their utility and usability to social work, and have become 'normalised' within the system (May et al., 2016). Updated research regarding the interventions interaction with the system may provide insight on this, once the trial is complete (Kainth et al., 2022).

Stretched, resource limited social work(ers) faced with the ever-looming adversarial legal system, possibly created an environment ripe to necessitate the addition of GIFT and the support it provided. The adversarial nature of the court setting in this context has been previously documented (Turner-Halliday et al., 2017). Our findings that the threat presented by the adversarial system drove perceptions of GIFT as a valued

addition to social work may be explained through social identity theory (Tajfel et al., 1979). Inter-group conflict - found to be a primary determinant of social identity – explains how people mobilise and cooperate around a perceived threat to their in-group (Weisel & Zultan, 2016) , in this case, there is an identified process of social workers and GIFT pulling together because of the perceived threat of an adversarial legal system.

Strengths & Limitations:

It should be considered that while drivers are mapped onto individual change themes, it is likely that there are multiple ways in which drivers interplay with the changes in perception and practice. It may be that greater trust developed regarding the alignment of the IMH social work ethos, this would echo findings on the key role of trust for negotiating successful collaborative relationships in this space (D'Amour et al., 2008).

As the data was collected by different researchers and with different participants across time-points it is likely that the dynamics within each interview or focus group may have differed, and influenced on how discussions occurred. While researchers convening the interviews and focus groups were not members of the GIFT team, some of them came from professional backgrounds perceived to be "medical" (e.g. psychologists) and may have introduced power dynamics to the data collection process and influenced what and how participants shared their views. Likewise, participants may have perceived the researchers to be aligned with the GIFT team, as both the BeST$^{?}$ research team and the GIFT team were introduced as new teams in an existing system around the same time. Due to data not being collected at more frequent intervals, definite conclusions about length of time and stages of GIFT's acceptance cannot be drawn. The research was limited in its ability to explore perceptions of GIFT across a spread of social work teams due to a smaller dataset for the 2023 timepoint, however, it was felt that data gathered from this time point was rich in contextual and conceptual meaning.

Despite these limitations, the research was able to provide in-depth insights into social work perceptions that aligned with the research questions of this study, particularly

the richness of the data allowing an ability to detect *why* changes occurred and not just the change itself. As far as the researcher is aware, this is the first study to examine changes in social workers perceptions towards an IMH approach for maltreatment within a complex system, and related changes in practice over time.

Implications and conclusions:

Capturing how social workers react and adapt to an IMH approach provides insight into social workers increasingly perceiving IMH to be aligned with their practice, moving beyond a firm focus on legal consciousness (Turner-Halliday, 2017) to include IMH consciousness. Our findings suggest the importance of alignment between services in supporting shared working and how shared working can enhance capacity for child-centered work. However, the findings also suggest the need for additional funding for social work, who emerged as unable to provide their desired standard of care due to resource limitations. The findings on the pervasive nature of the stretched social work system, though not surprising, are striking in light of the number of infants in care and decreasing number of social workers in Scotland (Sottish Government, 2022).

This research tracked social workers changes in perceptions and practices during the implementation of an IMH approach over ten years. The significant changes in perceptions over time and their influence on interactions with the model, suggests the vital importance of understanding the perspectives of key stakeholders to explore why and how models are implementing (or not) within established systems. The drivers for change identified, suggests the importance of contextual information in informing *why* such changes occur. Findings that factors outwith the GIFT intervention: conceptual understanding of IMH, resource limitations, and an adversarial setting; alongside exposure to GIFT, drives acceptance, provides novel insight into how social work and IMH models coalesce within the child welfare system. This is vitally important for furthering understanding of how social workers react to and work with IMH interventions within real-world settings. Is the acceptance of the IMH approach within the current findings due to the challenges of the wider context? Further research around barriers to acceptance would be interesting. By capturing how the IMH/social work relationship evolved over time towards increased IMH consciousness and

collaborative work driven by contextual factors, this study provides explanatory power on the significance of alignment between services in the child welfare system for working towards an ethos of child-centered care.

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Appendix 1: Systematic review search strategy

PSYCHINFO:	**Concept 1**	**Concept 2**
Key concepts	**Maltreated Infants in CWS**	**IMH intervention**
Free text terms / natural language terms	1. ((Parent* or famil*) adj2 (capacity or assess* or contact*)).ti,ab. 2. (((child* or infant* or toddler* or preschool*) adj3 (social work* or social service*)) or child welfare or child protection or child protective).ti,ab. 3. ((child* or infant* or toddler* or preschool*) adj3 (legal or placement* or court* or justice or judicial or decision*)).ti,ab.	1. (video-feedback intervention parenting program* or video feedback intervention parent* program* or VIPP).ti,ab. 2. ((attachment and biobehavioural catchup) or (attachment and biobehaviour catch-up) or (attachment and biobehavioural catch up) or ABC).ti,ab. 3. ((child or infant adj1 parent psychotherap*) or CPP).ti,ab. 4. (circle of securit* or COS).ti,ab. 5. (family nurse partnerships or infant mental health home visiting or infancy home visiting or prenatal nurse visitation or IMH-HV or home-visitation or home visitation).ti,ab. 6. ((parent* or mother* or caregiver* or father* or infant* or attach*) adj1 (program* or train* or interven* or trial* or project*)).ti,ab.

Controlled vocabulary terms / Subject terms	Concept 1: 7. child welfare/ or family preservation/ or permanency/ or protective services/ 8. social services/ or family reunification/ 9. social casework/	Concept 2: 10. attachment behavior/ or emotional development/ 11. parent child relations/ father child relations/ or mother child relations/ 12. 10 or 11 13. parent training/ 14. early intervention/ 15. family intervention/ 16. intervention/ 17. OR 13-16 18. 12 and 17

MEDLINE:	**Concept 1**	**Concept 2**
Key concepts	**Maltreated Infants in CWS**	**IMH intervention**
Free text terms	1. ((Parent* or famil*) adj2 (capacity or assess* or contact*)).ti,ab. 2. (((child* or infant* or toddler* or preschool*) adj3 (social work* or social service*)) or child welfare or child protection or child protective).ti,ab. 3. ((child* or infant* or toddler* or preschool*) adj3 (legal or placement* or court* or justice or judicial or decision*)).ti,ab.	1. (video-feedback intervention parenting program* or video feedback intervention parent* program* or VIPP).ti,ab. 2. ((attachment and biobehavioural catchup) or (attachment and biobehaviour catch-up) or (attachment and biobehavioural catch up) or ABC).ti,ab. 3. ((child or infant adj1 parent psychotherap*) or CPP).ti,ab. 4. (circle of securit* or COS).ti,ab. 5. (family nurse partnerships or infant mental health home visiting or infancy home visiting or prenatal nurse visitation or IMH-HV or

		home-visitation or home visitation).ti,ab. 6. ((parent* or mother* or caregiver* or father* or infant* or attach*) adj1 (program* or train* or interven* or trial* or project*)).ti,ab.
Controlled vocabulary terms / Subject terms	Concept 1: 15. Social Work/ 16. child protective services/ 17. family separation/ 18. child welfare/ or child custody/	Concept 2: 1. Psychosocial Intervention/ 2. parent-child relations/ or father-child relations/ or mother-child relations/ or paternal behavior/ 3. Infant Behavior/ 4. 1 AND 2

ASSIA	**Concept 1**	**Concept 2**
Key concepts	**Maltreated Infants in CWS**	**IMH intervention**
Free text terms / natural language terms	1. ((abstract((Parent* OR famil*) NEAR/1 (capacity OR assess* OR contact*)) OR title((Parent* OR famil*) NEAR/1 (capacity OR assess* OR contact*))) 2. (abstract((child* OR infant* OR toddler* OR preschool* NEAR/2 social work* OR social service*) OR child welfare OR child protection OR child protective) OR title((child* OR infant* OR toddler* OR preschool* NEAR/2 social work* OR social service*) OR child welfare OR child	1. (abstract(((parent* OR mother* OR caregiver* OR father* OR infant* OR attach*) NEAR/1 (program* OR train* OR interven* OR trial* OR project*))) OR title(((parent* OR mother* OR caregiver* OR father* OR infant* OR attach*) NEAR/1 (program* OR train* OR interven* OR trial* OR project*)))) 2. (abstract((family nurse partnerships OR infant mental health home visiting OR infancy home visiting OR prenatal nurse visitation OR IMH-HV OR

	protection OR child protective)) 3. abstract((child* OR infant* OR toddler* OR preschool*) NEAR/2 (legal OR placement* OR court* OR justice OR judicial OR decision*)) OR title((child* OR infant* OR toddler* OR preschool*) NEAR/2 (legal OR placement* OR court* OR justice OR judicial OR decision*))))	home-visitation OR home visitation)) OR title((family nurse partnerships OR infant mental health home visiting OR infancy home visiting OR prenatal nurse visitation OR IMH-HV OR home-visitation OR home visitation))) 3. (abstract((circle of securit* OR COS)) OR title((circle of securit* OR COS))) 4. (abstract((((child OR infant) AND parent psychotherap*) OR CPP)) OR title((((child OR infant) AND parent psychotherap*) OR CPP))) 5. (abstract((("attachment AND biobehavioural catchup") OR ("attachment AND biobehaviour catch-up") OR ("attachment AND biobehavioural catch up") OR ABC)) OR title(((attachment AND biobehavioural catchup) OR (attachment AND biobehaviour catch-up) OR (attachment AND biobehavioural catch up) OR ABC))) 6. (abstract(("video-feedback intervention parenting program*" OR "video feedback intervention parent* program*" OR VIPP)) OR title((video-feedback intervention parenting program* OR video feedback intervention parent* program* OR VIPP))))

Web of Science Core Collection	**Concept 1**	**Concept 2**

Key concepts	Maltreated Infants in CWS	IMH intervention
Free text terms / natural language terms **( )**	(TI=((((child* OR infant* OR toddler* OR preschool*) NEAR/2 (legal OR placement* OR court* OR justice OR judicial OR decision*))) OR ((((child* OR infant* OR toddler* OR preschool*) NEAR/2 ("social work*" OR "social service*")) OR "child welfare" OR "child protection" OR "child protective")) OR(((Parent* OR famil*) NEAR/1 (capacity OR assess* OR contact*))))) OR AB=((((child* OR infant* OR toddler* OR preschool*) NEAR/2 (legal OR placement* OR court* OR justice OR judicial OR decision*))) OR ((((child* OR infant* OR toddler* OR preschool*) NEAR/2 ("social work*" OR "social service*")) OR "child welfare" OR "child protection" OR "child protective")) OR(((Parent* OR famil*) NEAR/1 (capacity OR assess* OR contact*)))) and Preprint Citation Index (Exclude – Database)	((TS=(((((("attachment AND biobehavioural catchup") OR ("attachment AND biobehaviour catch-up") OR ("attachment AND biobehavioural catch up") OR ABC))))) OR AB=(((((("attachment AND biobehavioural catchup") OR ("attachment AND biobehaviour catch-up") OR ("attachment AND biobehavioural catch up") OR ABC))))) OR TI=((((parent* OR mother* OR caregiver* OR father* OR infant* OR attach*) NEAR/1 (program* OR train* OR interven* OR trial* OR project*))))) OR AB=((((parent* OR mother* OR caregiver* OR father* OR infant* OR attach*) NEAR/1 (program* OR train* OR interven* OR trial* OR project*)))) and Preprint Citation Index (Exclude – Database) or (TI=((("family nurse partnerships" OR "infant mental health home visiting" OR "infancy home visiting" OR "prenatal nurse visitation" OR "IMH-HV" OR "home-visitation" OR "home visitation")))) OR AB=((("family nurse partnerships" OR "infant mental health home visiting" OR "infancy home visiting" OR "prenatal nurse visitation" OR "IMH-HV" OR "home-visitation" OR "home visitation"))) and Preprint Citation Index (Exclude – Database) or TI=(((((child OR infant) AND ("parent psychotherap*")) OR CPP)) OR (("circle of securit*" OR COS)) OR ((("video-feedback intervention parenting program*" OR "video feedback intervention parent* program*" OR VIPP))))) OR AB=((((((child OR infant) AND ("parent psychotherap*")) OR CPP)) OR (("circle of securit*" OR COS)) OR ((("video-feedback intervention parenting program*" OR "video feedback intervention parent* program*" OR VIPP))))) and Preprint Citation Index (Exclude – Database)

Appendix 2: Data extraction and synthesis table

Title, authors, location	Sample size, age, target population
Intervention, setting, characteristics	TAU, setting, characteristics
Attrition	Time to follow up
If and how information was shared with court/decision makers	Measurement tools used
Findings on child welfare decisions	Findings on impact on IMH (child or parent)

Appendix 3 Prisma check list

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	10
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	11
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	12
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	14
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	16-17
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	17
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	17,89
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	16,19
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	17
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	16-18
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	16-18
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	18
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	18
Synthesis	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention	17-18

Section and Topic	Item #	Checklist item	Location where item is reported
methods		characteristics and comparing against the planned groups for each synthesis (item #5)).	
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	17-18
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	17, 93
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	17-18
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	17-18
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	18
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	18
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	18
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	20
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	19-34
Study characteristics	17	Cite each included study and present its characteristics.	22
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	23-29
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	19-34
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	24-30
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	19-34
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	23-29

Section and Topic	Item #	Checklist item	Location where item is reported
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	24-30
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	24-34
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	22
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	35
	23b	Discuss any limitations of the evidence included in the review.	35-39
	23c	Discuss any limitations of the review processes used.	38
	23d	Discuss implications of the results for practice, policy, and future research.	38
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	16
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	16
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	16
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	n/a
Competing interests	26	Declare any competing interests of review authors.	n/a
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	16-30

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71

For more information, visit: http://www.prisma-statement.org/

Appendix 4: NHS GGC Ethical Approval for BeST? Services Trial

WoSRES
West of Scotland Research Ethics Service

NHS
Greater Glasgow and Clyde

West of Scotland REC 3
West of Scotland Research Ethics Service
West Glasgow Ambulatory Care Hospital
(former Royal Hospital for Sick Children Yorkhill)
Dalnair Street
Glasgow G3 8SW
www.nhsggc.org.uk

Professor Helen Minnis
Professor of Child and Adolescent Psychiatry
University of Glasgow
Department of Mental Health and Wellbeing
University of Glasgow, Caledonia House,
Yorkhill Hospital, Dalnair Street
Glasgow
G3 8SJ

Date 23rd December 2015
Your Ref
Our Ref
Direct line 0141 232 1805
E-mail WOSREC3@ggc.scot.nhs.uk

Dear Professor Minnis

Study title:	**The Best Services Trial (BeST?): Effectiveness and cost-effectiveness of the New Orleans Intervention Model for Infant Mental Health**
REC reference:	**15/WS/0280**
IRAS project ID:	**178440**

Thank you for responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered in correspondence by a Sub-Committee of the REC. A list of the Sub-Committee members is attached.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact the REC Manager, Mrs Liz Jamieson, wosrec3@ggc.scot.nhs.uk.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised,subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for NHS permission for research is available in the Integrated Research Application System, www.hra.nhs.uk or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

The Committee has not yet completed any site-specific assessment (SSA) for the non-NHS research site(s) taking part in this study. The favourable opinion does not therefore apply to any non-NHS site at present. We will write to you again as soon as an SSA application(s) has been reviewed. In the meantime no study procedures should be initiated at non-NHS sites.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Covering letter on headed paper [Cover letter]		
GP/consultant information sheets or letters [GP Information Sheet]	1.0	11 November 2015
Interview schedules or topic guides for participants [Disturbances of Attachment Interview]		
Interview schedules or topic guides for participants [This is My Baby]		
IRAS Checklist XML [Checklist_11112015]		11 November 2015
Letters of invitation to participant [New Parent Letter of Invitation]	1.0	11 November 2015
Letters of invitation to participant [Kinship Carer Letter of Invitation]	1.0	11 November 2015
Non-validated questionnaire [Additional Service User Questionnaire - 1 year follow up]		
Other [Potential Child Development Concern Letter]	1.0	11 November 2015

Other [Potential Child Protection Concern Letter]	1.0	11 November 2015
Other [Missed contact letter]	1.0	11 November 2015
Other [Baseline Research Assessment Letter]	1.0	11 November 2015
Other [Letter confirming research assessment visit]	1.0	11 November 2015
Other [Child's guidance for study visit]	1.0	11 November 2015
Other [Birth Parent/Kinship Carer Research Assessment Letter]	1.0	11 November 2015
Other [Missed appointment/questionnaire letter]	1.0	11 November 2015
Other [Questionnaire letter after telephone call]	1.0	11 November 2015
Other [Example of translated information leaflet]	1.0	11 November 2015
Other [Measures Table]		20 October 2015
Other [Email from CI re Measures etc]		13 November 2015
Other [consent for routine data]	1	21 December 2015
Other [recruitment guidance for professionals]	1	07 December 2015
Other [ethics response cover letter]		
Participant consent form	2.0	21 December 2015
Participant consent form [consent tracked]	2.0	21 December 2015
Participant information sheet (PIS) [Professional Information Leaflet]	2.0	21 December 2015
Participant information sheet (PIS) [PIS tracked]	2.0	21 December 2015
REC Application Form [REC_Form_11112015]		11 November 2015
Research protocol or project proposal [BeST Protocol]	1.0	11 November 2015
Summary CV for Chief Investigator (CI) [Prof H. Minnis CV]		
Validated questionnaire [Strengths and Difficulties]		
Validated questionnaire [PIR-GAS]		
Validated questionnaire [Rough Descriptions for Emotional Signalling Scale Modified]		
Validated questionnaire [ITSEA]		
Validated questionnaire [WPPSI-III Record Form]		
Validated questionnaire [PedsQL]		
Validated questionnaire [RPQ]		
Validated questionnaire [Observational Schedule for Reactive Attachment Disorder]		

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports

- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

15/WS/0280	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely

Liz Jamieson
REC Manager
On behalf of Eoin MacGillivray, Vice Chair

Enclosures: *List of names and professions of members who were present at the meeting*

"After ethical review – guidance for researchers"

Copy to: *Mrs Lynn McMahon, Senior Trials Manager*
Mr Paul Dearie, NHS Greater Glasgow and Clyde

Appendix 5: Researcher Added to Delegation log

Dear Helen and Karen,

R&I Ref: GN14CO183P **Ethics Ref:** 15/WS/0280
Investigator and site(s): Prof Helen Minnis (CI/PI)
Project Title: The Best Services Trial (BeST?): Effectiveness and cost-effectiveness of the New Orleans Intervention Model for Infant Mental Health.
Protocol Number: V8 (14.12.2021)
Amendment: Substantial Amendment 12 – 20.12.2021 (Cat B)
Sponsor: NHS GGC

I am pleased to inform you that R&I have reviewed the above study's Amendment 12 (20.12.2021 - Cat B) and can confirm that Management Approval is still valid for this study.

Document	*Version*	*Date*
[redacted]		
Summary CV for student [Niamh Bergin CV]	1.0	20 December 2021
[redacted]		

I wish you every success with this research project.

Kind regards,

[redacted]

Appendix 6: Proceed to Ethics Letter

University of Glasgow

Institute of Health & Wellbeing

[redacted]

Dear Niamh,

Major Research Project Proposal

A new infant mental health approach to assessing and treating cases of maltreatment: does it change perceptions in the child welfare system?

The above project has been reviewed by your University Research Supervisor and by a member of staff not involved in your project, and has now been deemed fit to proceed to ethics.

Congratulations and good luck with the study.

Yours sincerely

[redacted]

Institute of Health and Wellbeing

[redacted]

The University of Glasgow, charity number SC004401

The Queen's Anniversary Prizes For Higher and Further Education 2013

Appendix 7: Participant Information Sheets

Case study participant information sheets:

An Invitation

We would like to invite you to give us your views on the services that you have experienced as part of the ***Best Services Trial (BEST?)*** As a parent or foster carer, you are already taking part in the trial and we are very interested in your views about the services (GIFT or FACS) that you have received. If you are a social worker, health professional or children's hearing member, we are very interested in your views about the services in terms of the work you are doing with children and families. Before deciding, it is important that you understand what is being done and why. Please take the time to read the following information. Please phone us (contact number below) if you have any questions.

What is the trial?

In Glasgow, health and social work services are working together to try to improve services for children who come into foster care, and their families. The ***Best Services Trial (BEST?)*** aims to find out which of two new services that have recently been introduced works best for children's development. One of the new services has already been used successfully in New Orleans, USA, and when it was used there, children's development improved whether they went back to their birth families or remained in foster care. But the USA is very different to Scotland: there is much less of a welfare state and families with difficulties usually don't have access to free healthcare. We think it is very important to find out whether the new service, developed in New Orleans, is any better than our own services when those services work the way they are supposed to. We want to compare the New Orleans service with a streamlined version of the service provided in Glasgow where we employ staff to ensure that families get the services they are entitled to.

Why is the trial important? We want to make sure that the new services in Glasgow are the very best for children and their families.

What is this part of the trial about?

If you are a parent or carer, you have already given consent to take part in the trial. As you will be aware, all families with a child aged 6 months to 5 years who have been referred to Glasgow child care services for foster care are being invited to take part in an assessment of their child's development as the child comes into foster care and also 1 year later. Each family who takes part will be offered either the new version of the service in Glasgow or the New Orleans model. Because we don't know which will be best, and to be as fair as possible, families will be allocated at random to one of the two new services. This is a bit like tossing a coin.

At this stage of the research, we are also conducting case studies, where we will gather the views of parents, foster carers, health professionals, social workers and representatives from the children's hearing system about a small group of children involved in the trial. The purpose of this will be to compare the experiences of the two different services, to track the journey of children and families through the services and to find out what it is like to be part of either service if you are a parent or foster carer. It is really to gather your views about the services and how they affect you or the work that you are doing.

What would be your involvement?

If you are a parent or foster carer, we are hoping that you would be able to tell us what you think about the service that you are part of, and what it is like from your experience so far. If you are a health professional, social worker or children's hearing representative, we would be looking for your opinions about how the new services are working out and what impact you think they are having on your practice, decision-making and on the children and families you work with. This would involve taking part in a one-to-one interview with the researcher on this study, or taking part in a focus group where this might be more suitable. Because we want to study your views in a lot of detail, so as to inform the development of the new services, we would like to audio-record the discussion that takes place in each group. These audio-recordings would then be transcribed verbatim, but all identifying information (such as names and work-places) will be removed so that you cannot be identified.

How much of your time will this take?

An interview or focus group will take around an hour of your time. Refreshments will be provided and we hope the experience will be rewarding for all involved. We would arrange to meet you at a time and place that is convenient to you.

Confidentiality

All information will be stored according to the Data Protection Act and kept in strict confidence within the research and clinical team, except in the unlikely event of concerns about safety of the child or of others in which case NHS Greater Glasgow & Clyde child protection procedures would be followed.

Do I have to take part?

You do not have to take part in the study and your decision to participate or not participate will not be communicated to anyone outwith the research team. In addition, you are free to withdraw from the research at any time without giving a reason.

Feedback

At the end of the study, we will provide you with a summary of the findings of the study and, if you want more detailed feedback, we will also send you copies of any published papers.

Any Questions? Please contact our research team on 0141 201 9239 and ask to speak to Helen Minnis.

Consent

►Make sure you understand and are happy with everything about the project before you sign the consent form. If you have any questions, please contact ***Dr. Helen Minnis*** on:

[redacted]

Please initial box

►I have read and understood the information sheet and have had the chance to ask questions.

►I understand that I do not have to take part, that I am free to withdraw at any time without giving any reason.

►I agree to an audio-recording being made of an interview or focus group

►I am happy to take part in an interview or focus group for the ***BEST?*** Study.

►I would be happy to be contacted for future research studies.

Name of participant	date	signature
Name of researcher	date	signature

General GIFT participant information sheet :

New Services for Children in Foster Care

An Invitation

We would like to invite you to take part in a research study. Before deciding, it is important that you understand what is being done and why. Please take the time to read the following information. Please phone us (contact number below) if you have any questions.

What is the study?

In Glasgow, health and social work services are working together to try to improve services for children who come into foster care, and their families. The ***Best Services Study (BEST?)*** aims to find out which new service works best for childrens' development. One of the new services we are introducing has already been used successfully in New Orleans, USA, and when it was used there, children's development improved whether they went back to their birth families or remained in foster care. But the USA is very different to Scotland: there is much less of a welfare state and families with difficulties usually don't have access to free healthcare. We think it is very important to find out whether the new service, developed in New Orleans, is any better than our own services when we make sure those services work the way they are supposed to. We want to compare the New Orleans service with a streamlined version of our Scottish services where we employ staff to ensure that families get the services they are entitled to.

Why is the study important?

We want to make sure that the new services we introduce in Glasgow are the very best for Scottish children.

How will we do the study?

We are inviting all Glasgow families where a child aged 0-5 years has been placed in foster care to take part in an assessment of their child's development as the child comes into foster care and also 1 year later. Each family who takes part will be offered either the new version of our Scottish services or the New Orleans model. Because we don't know which will be best and to be as fair as possible, families will be allocated at random to one of the two new services. This is a bit like tossing a coin.

We are also asking a selected group of stakeholders (including social workers, foster carers and children's panel members) for their views on our progress as we go along.

What would your involvement consist of?

We are hoping that you will become a member of one of our Process Advisory Groups. These groups will meet 3 times during the BEST? Study and would consist of approximately 6 people (the same people would be asked to meet each time). We would be looking for your opinions about how the new services are working out and what impact you think they are having on your practice and on the children and families you work with. Because we want to study your views in a lot of detail, so as to inform the development of the new services, we would like to audio-record the discussion that takes place in each group. These audio-tapes would then be transcribed

verbatim, but all identifying information (such as names and work-places) removed so that you cannot be identified.

How much of your time will this take?

Each group should take up to two hours of your time. Refreshments will be provided and we hope the experience will be rewarding for all involved.

Confidentiality

All information will be stored according to the Data Protection Act and kept in strict confidence within the research and clinical team, except in the unlikely event of concerns about safety of the child or of others in which case NHSGCC child protection procedures would be followed.

Do I have to take part?

You do not have to take part in the study and your decision to participate or not participate will not be communicated to anyone out-with the research team. In addition, you are free to withdraw from the research at any time without giving a reason.

Feedback

At the end of the study, we will provide you with a summary of the findings of the study and, if you want more detailed feedback, we will also send you copies of any published papers.

Any Questions?

Please contact our research team on 0141 201 9239 and ask to speak to Helen Minnis or Fiona Turner

Appendix 8: Topic Guides

Social work focus groups 2013

- What does the group know about the BeST Services trial? (to open up discussion and probe understanding/awareness)

- What do you think of the BeST services trial? (to open up discussion) (probe – what is the aim of the trial do you think? E.g. to get assessments and recommendations right? To rehabilitate more families? To help improve infant mental health? - i.e. how do area teams see it?

- Gain an idea about number & frequency of dealings with FACS and GIFT from individuals in the group (examples of cases)

- Those with experience of working with FACS on cases – what has the overall experience been like? (probes – joined up working? In agreement with recommendations? Is FACS necessary? Effect on workload (i.e. reports from FACS & GIFT so far that it reduces SW workload but need to explore this with area teams themselves)

- Those with experience of working with GIFT on cases – what has the overall experience been like? (probes – joined up working? In agreement with recommendations? Is FACS necessary? Effect on workload (i.e. reports from FACS & GIFT so far that it reduces SW workload but need to explore this with area teams themselves)

- Hearing system and courts – differences in views of reports from area teams Vs FACS & GIFT? (probe – which reporting has most 'clout'? Do area teams see GIFT and FACS reports as adding positively to the gathering of evidence or duplication of their work?)

- Joint working – inviting FACS & GIFT to hearings etc – does this happen and is it necessary/useful/positive/negative?

- Delays & timescales in the system – are area team recommendations & reviews and FACS/GIFT recommendations lining up in terms of timing? (waiting on FACS/GIFT seen as delay? Pressure from FACS/GIFT to come to recommendation if they have?)

- Experiences of feeling that a child should/should not be part of the trial – communicating it to others?

-

Social work case study interview topic guides 2013-2019:

GIFT/FACS/Area teams

- General overview of the assessment stage
- This specific case (specific issues highlighted in assessment)
- Expectations v what's happened
- Challenges
- Positive
- Like/unlike other cases?
- Engagement of parents/carers
- Working with another team, i.e. for area teams what has it been like working with FACS/GIFT on case? For FACS/GIFT, what has it been like working with the area team?)
- Recommendation (what do you expect to happen?)
- Relations and interactions with other systems e.g. court, hearings etc…
- Being part of the BeST trial – experiences & effects
- How do we keep a tab on what happens during these cases – hearings/meetings/reviews?

2023 social worker interviews and focus groups topic guide:

- Have you been involved with BeST? *[MAKE SURE THEY KNOW DIFFERENMCE BETWEEN GIFT/BEST]*
    - What has that been? *[i.e. GIFT or FACS]*
    - When was that?
    - What was the nature of the carer *[FOSTER V KINSHIP]*

- [*If GIFT]* What do you understand GIFT to be, and to do, as a service?
    - *[CAN WE PROBE FURTHER TO BE SPECIFIC ABOUT THE GIFT APPROACH]*
    - *[DOES IMH COME UP?]*
    - *[GET THEM TO EXPLAIN WHAT THEY MEAN BY IMH]*

- Have you had any experience of under 5s in care?
    - what did you do?
    - *[ASSESSMENT]*
    - *[INTERVENTION]*
    - *[TIMESCALES]*
    - *[REPORTS]*
    - *[DECISION MAKING]*
    - *[YOUR INVOLVEMENT?]*

- How did the process fit with the wider system?
    - Social work systems
        - Reviews etc
        - contact
    - Legal system

- What were the positives?
- What were the challenges?

- Did you learn anything?

- Have there been implications for your practice?
- If they were involved in GIFT have they adopted any IMH related practices/thinking?

- Have things changed in the way that we approach laac cases for under 5s in the last 12 years?

- *[IF THEY DiDNT GO TO GIFT OR TALK ABOUT IMH ASK:]*
- Are you aware of GIFTs approach (if not talk about IMH)
- How does it compare to the approaches we've talked about (i.e. sw /facs approaches)
- Look for specific differences or similarities
- Have the social workers adopted this into their practice?
- If so when did that happen?
- Was that as a result of GIFT/BeST?

Appendix 9: Final approved MRP proposal (online)

https://osf.io/jbdkz/

Appendix 10: Reflexive Journalling

Reflecting on the project following RTA completion:

As a researcher completing Clinical Psychology Doctorate, I have thus had to reflect on how I brought a psychological lens to data analysis, such as understandings of what constitutes infant mental health. I was new to the BeST? Trial which presented some benefits (openness regarding outcomes), but also challenges (lack of knowledge of local context and experiences of trial). I tried to hold an awareness of this and supervision was provided by a supervisor with experience of the BeST? Trial over time and who is an experienced qualitative researcher. My supervisor helped me understand the BeST? trial and remain focused in my analysis on the research questions at hand.

Reflective journaling extract during the familiarisation phase of analysis:

I am feeling the anger and frustration from the social workers that GIFT are swooping in and offering something new in the system, which social workers perceive themselves to already be offering. For me, this is saying that GIFT is not a valued addition. I notice that I am feeling that GIFT do do something different than social workers. Social workers speak about parents 'hoodwinking GIFT', I notice how I am feeling a professional allyship with GIFT (whose team includes psychologists), and based of my knowledge of psychological formulation I think that it is unlikely the GIFT team will be tricked by parents. It is really useful to note this down, as I am noticing my feelings of othering the SW and siding with GIFT. When I reflect on how I would feel in their situation I am sure I would feel the same, frustrated that someone is coming in adding expertise that I feel I am providing, taking over my territory and doing work that I think will ultimately not have a positive impact for children.

Appendix 11 Standards for Reporting Qualitative Research (SRQR)

Title and abstract

Title - Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended	51
Abstract - Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions	52

Introduction

Problem formulation - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement	53
Purpose or research question - Purpose of the study and specific objectives or questions	56

Methods

Qualitative approach and research paradigm - Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale**	57
Researcher characteristics and reflexivity - Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability	60

Context - Setting/site and salient contextual factors; rationale**	57-60
Sampling strategy - How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale**	57
Ethical issues pertaining to human subjects - Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues	58
Data collection methods - Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale**	57-60

Data collection instruments and technologies - Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study	58,
Units of study - Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	58
Data processing - Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/de-identification of excerpts	58
Data analysis - Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale**	57-60
Techniques to enhance trustworthiness - Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale**	60

Results/findings

Synthesis and interpretation - Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	61-74
Links to empirical data - Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings	61-74

Discussion

Integration with prior work, implications, transferability, and contribution(s) to the field - Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field	75-79
Limitations - Trustworthiness and limitations of findings	78

Other

Conflicts of interest - Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed	n/a
Funding - Sources of funding and other support; role of funders in data collection, interpretation, and reporting	n/a

*The authors created the SRQR by searching the literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.

**The rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and

transferability. As appropriate, the rationale for several items might be discussed together.

Reference:

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. **Standards for reporting qualitative**

research: a synthesis of recommendations. *Academic Medicine*, Vol. 89, No. 9 / Sept 2014 DOI: 10.1097/ACM.0000000000000388

Appendix 12: Description of infant mental health interventions

Infant Mental Health Intervention	Description
Child-Parent Psychotherapy	High intensity (50+ weekly sessions) family psychotherapy modality based upon attachment, trauma and psychodynamic theories; with a focus on re-establishing the relationships between a young child (who has experienced at least one traumatic event) and their primary caregiver. Intervention is dyadic, focused on the child and caregiver together (Lieberman, 2004).
Infant Mental Health – Home Visiting (IMH-HV)	Relationship based, home visiting intervention, aim is to increase parental reflective functioning through enhancing parents capacity to provide sensitive, responsive care that supports child development. Infant- parent psychotherapy is a central component of the intervention, alongside increasing knowledge on development, assessment and screening, emotional support for parents and supporting families to meet material needs and develop social support networks and coping skills (Stacks et al., 2019)
Video-feedback intervention to promote positive parenting and sensitive discipline (VIPP-SD)	Based on attachment and social learning theory, the focus is on improving parenting sensitivity and limit setting through video feedback, and reducing behaviour problems in children. Parent-child dyads are videotaped during daily interactions such as playing or eating (van der Asdonk et al., 2020)
Attachment Video-feedback Intervention (AVI)	Short term (8 week) strengths based home visiting program, focused on enhancing parental sensitivity and child attachment with parents reported for child abuse or neglect. Achieves change through reinforcing parent's positive behaviour throughout the session and during feedback on a brief videotaped interactive session of play between parent and child (Moss et al., 2011).
Social support intervention – Vulnerable Infants Program of Rhode Island	This is a care co-ordination program, with mothers enrolled during hospitalisation with new-borns who are open to child welfare. Following assessment it focuses on

	facilitating and expediting referrals to services, ensure parents are given consistent messages from involved services, and refers to the Family Treatment Drug Court which takes an interactive and therapeutic approach with close monitoring of cases and referrals to health services (Twomey et al., 2010).