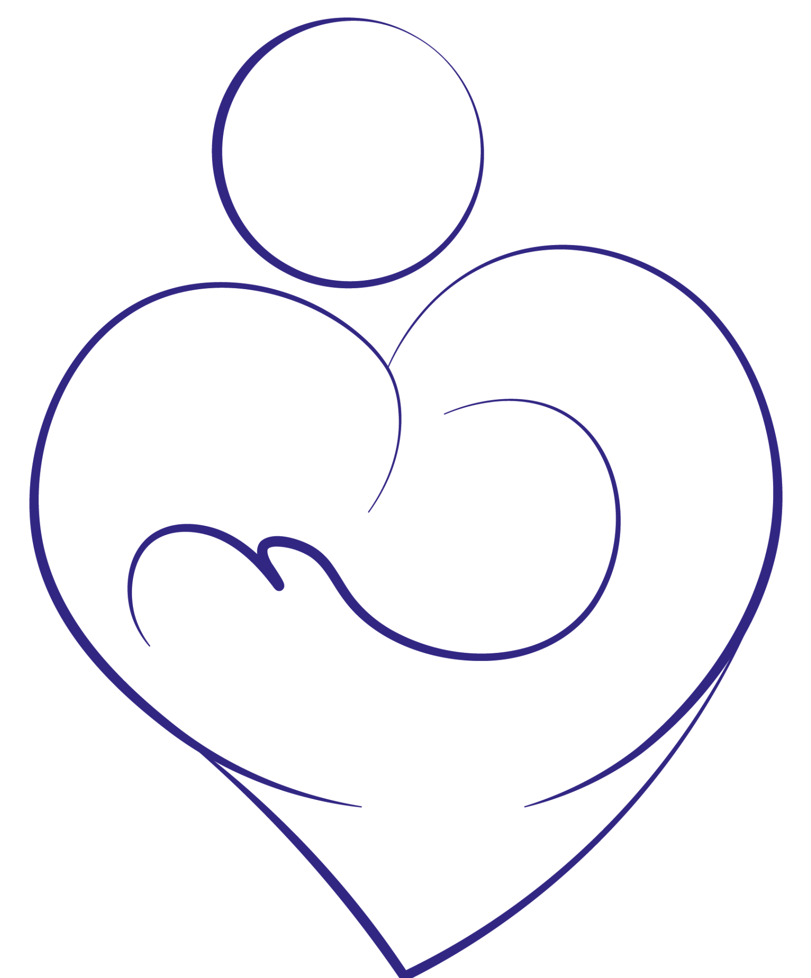
Shared Health Foundation.
Reducing the Impact of Poverty on Health.

THE TOGETHER SERVICE

Babies, Families and Mental Health

A Five-Year Review



THE TOGETHER SERVICE

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About the Service

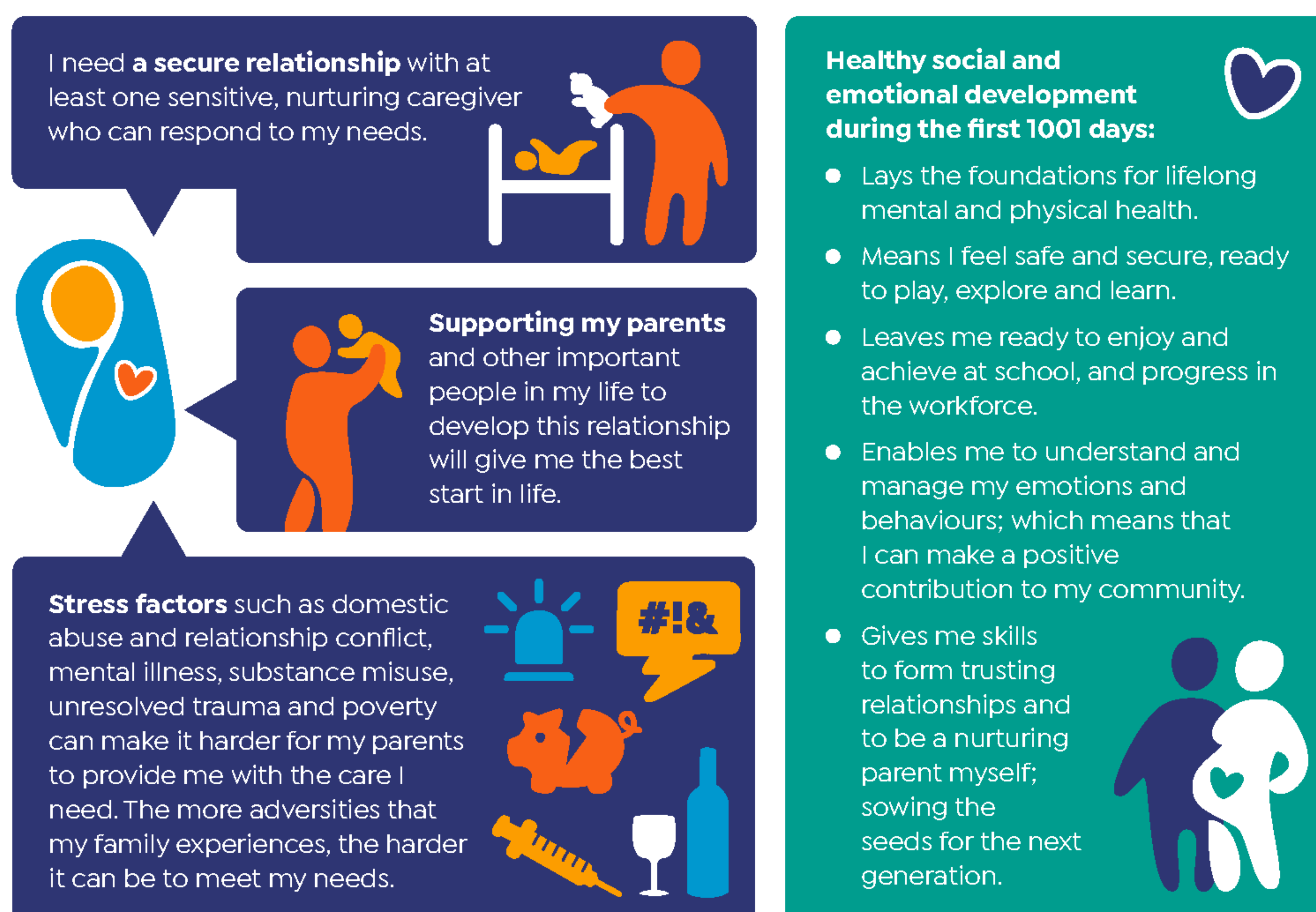
The Together Service is an Infant-Parent Service which provides a universal offer to all families registered at a GP practice. A Clinical Psychologist provides support from planning a pregnancy through a child's first year of life. The input is tailored to suit the family's needs. It draws on various psychological models including attachment theory, infant-parent psychotherapy, compassion-focussed therapy and narrative approaches. The service was piloted in Manchester from January 2020-2021. This report updates on the five years since then, including the outreach work with homeless families that developed from the pilot.

The Rationale

There is a growing body of research around the importance of the first 1,001 days for babies (pregnancy to age two), the crucial role the parent-infant relationship plays and the impact that inequality has on this period of life and beyond[1].

Investing in the emotional wellbeing of our babies is a wonderful way to invest in the future.

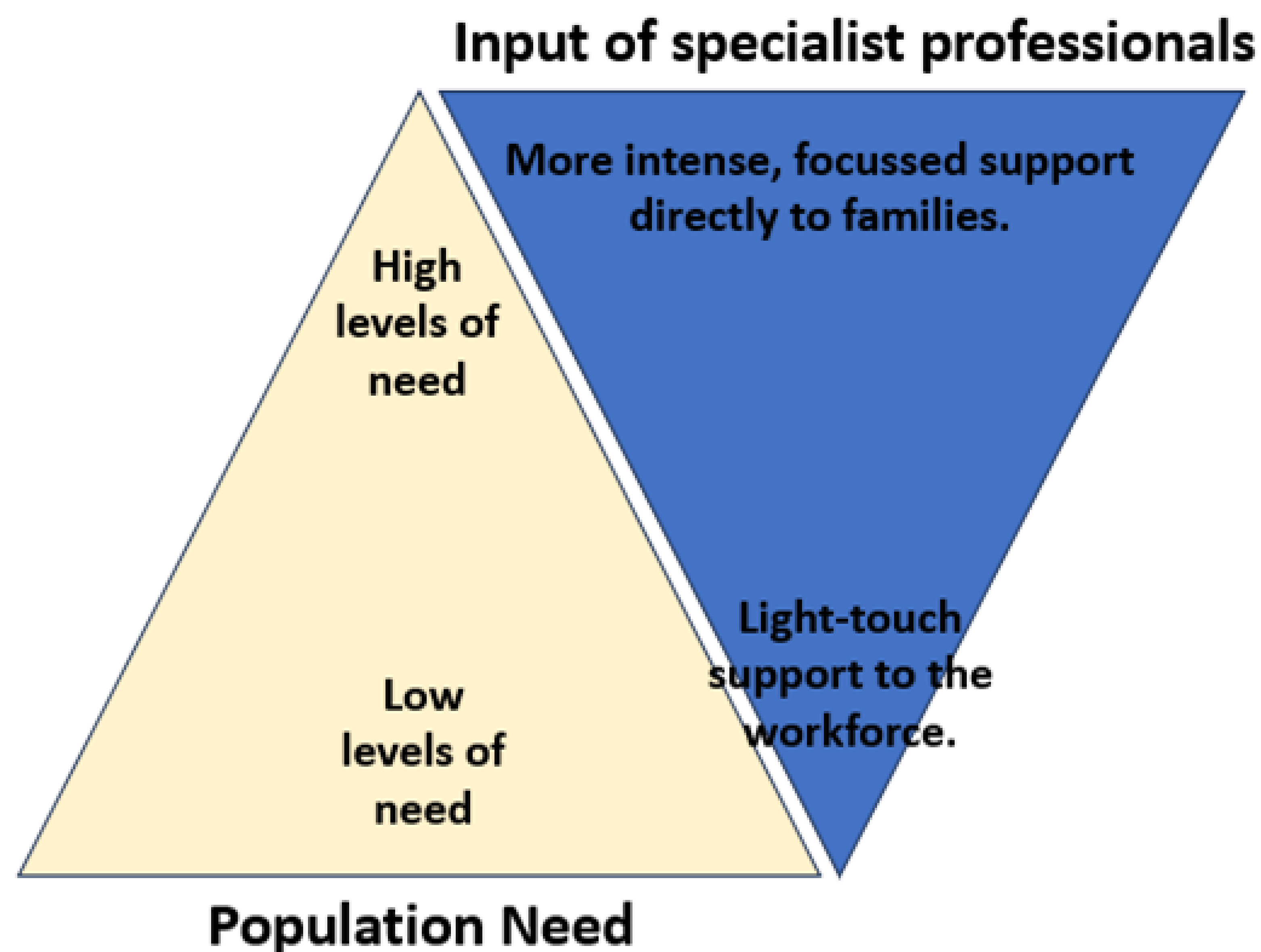
Early relationships between babies and their parents are incredibly important for building healthy brains.



Tackling adversity + supporting early relationships
healthier brains + better futures

References and further information can be found on **https:/1001days.org.uk/resources**

The Together Service aims to provide support for families facing inequalities. The rationale is that placing this universal support in primary care reduces stigma, increases accessibility and reaches the underserved populations with the greatest need. This is in line with the NHS 10-year plan; moving from 'hospital to community', 'sickness to prevention' (NHS, 2019) and the 'two triangle' model (Hogg, 2024)[2].



The service ethos is to offer families what they need, when they need it, supporting both parents and babies at this crucial time. Up to 1 in 4 women and birthing people are estimated to experience mental health problems during the perinatal period[3] with suicide being one of the leading causes of maternal death in the year after birth (MBRRACE-UK 2025)[4]. The risk of maternal death is particularly high for those families experiencing the most inequality[5]. Our aim is to engage these families, building trusting relationships that facilitate access to our own and other services.

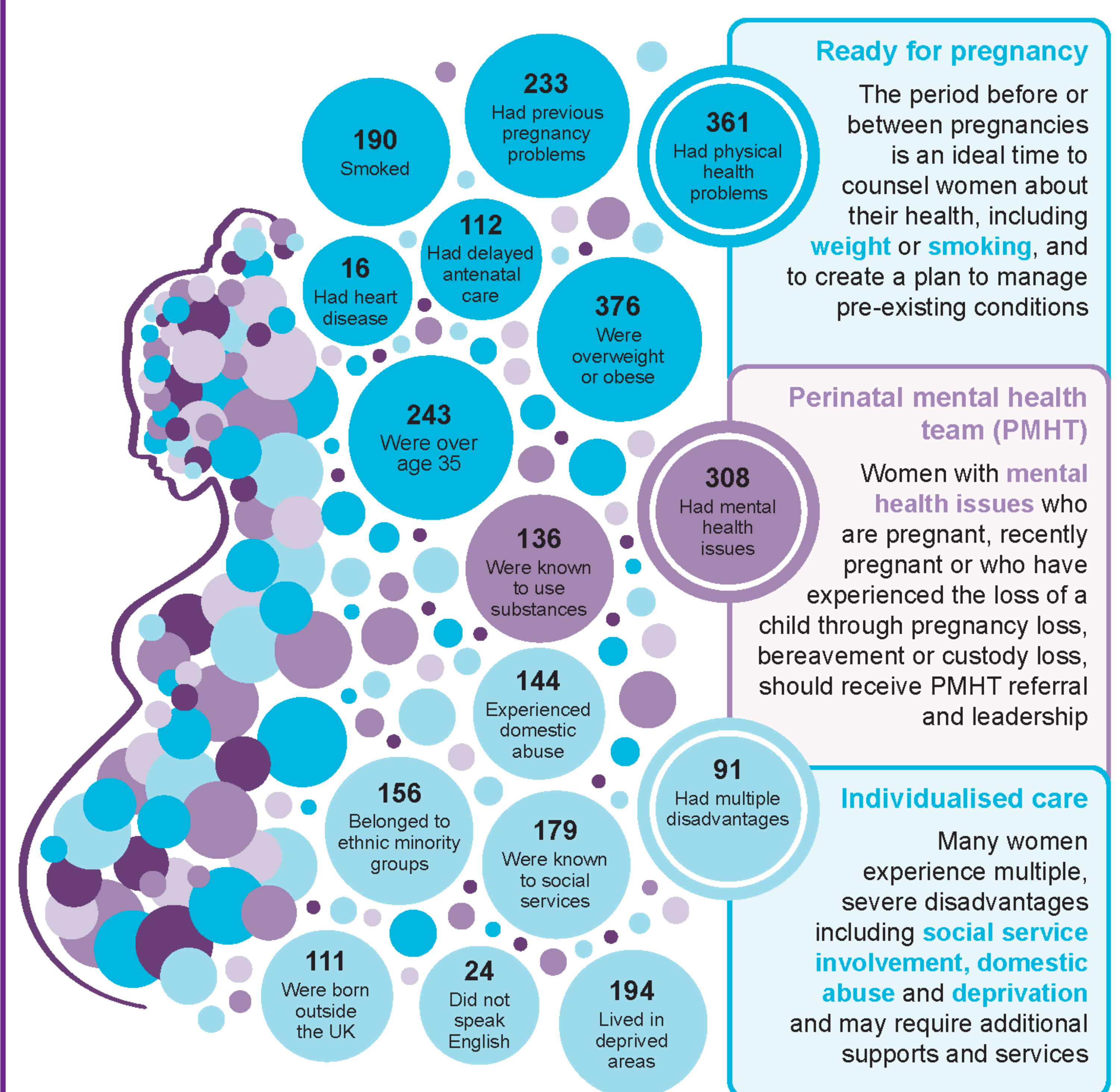
Key messages

from the confidential enquiries 2025

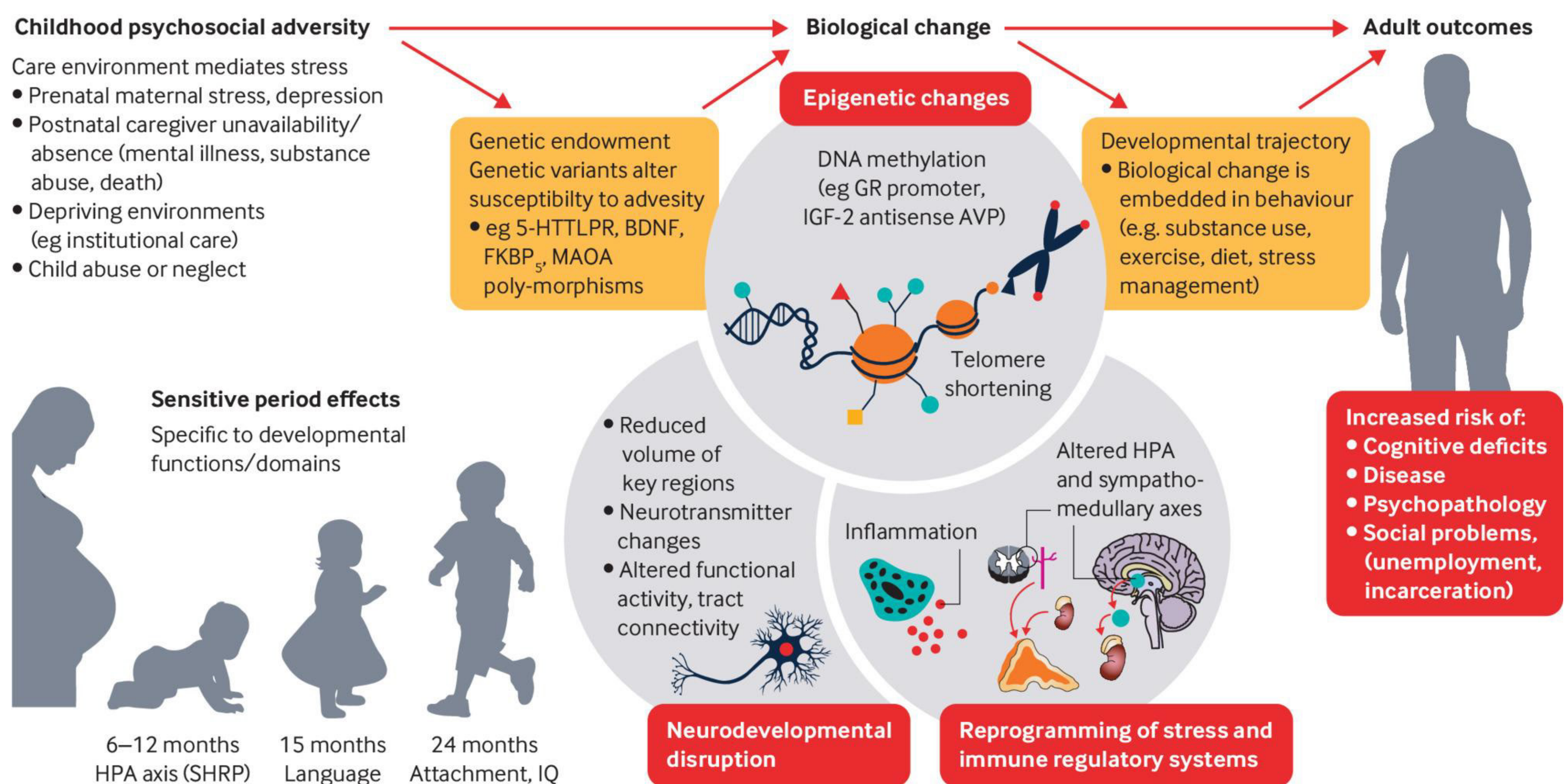
A constellation of biases

The 2025 MBRRACE-UK report looks at the care of **643 women** who died during or up to one year after pregnancy in the UK and Ireland

Of these women, **583 (91%)** faced multiple interrelated challenges



In addition to this being of benefit to families, the service helps GPs to address the fact that 40% of consultations involve a mental health component with significant numbers of people having their referrals to specialist mental health services rejected (Naylor et al, 2020)[6]. In addition to mental health being of particular concern for parents and babies during the perinatal period, there is increasing evidence around the long-term impact of Adverse Childhood Experiences on physical health (including respiratory and cardiovascular disease, obesity, arthritis and diabetes)[7] and the crucial role of positive attachment relationships in alleviating toxic stress[8].



The Together Service Aims

- to support families throughout the perinatal period – from planning a baby, to adjusting to pregnancy and parenthood, to coping with loss;
- to increase awareness of the developmental stages of infants and how families can support healthy development;
- for parents to reflect on, and develop, a healthy and helpful relationship with their baby;
- to help parents understand their own mental health and wellbeing and what improves it;
- to build family, community and peer support.

The Service Offer

- Antenatal group sessions;
- Postnatal 'stay and play' group sessions;
- Personalised therapy sessions throughout this period (infant-parent, parental mental health, couples/family therapy);
- Training and consultation for staff working in the GP surgery and the temporary accommodation settings;
- Partnering with community organisations to better support families.

How the Service is Advertised/Promoted

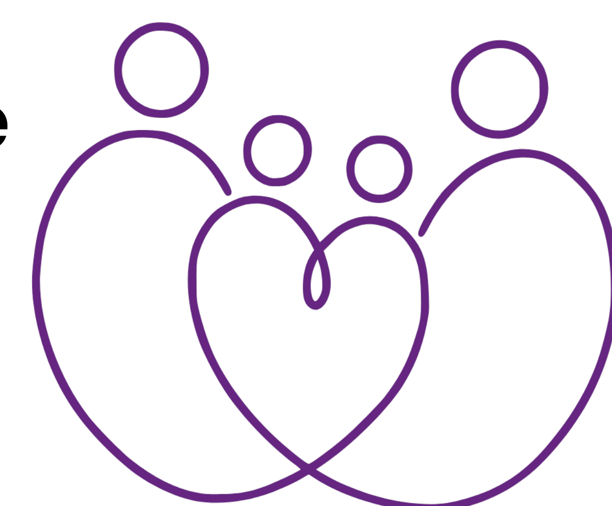
A notice board in the waiting area of the GP setting displays details of the service. Additionally, flyers are given to pregnant people attending the midwife clinic in the GP surgery and to families bringing their babies for immunisations. Text messages are also sent to all pregnant people and people once they have had a baby alerting them to the service. There are also outreach events such as activities during Infant Mental Health Awareness week; families registered at the practice are invited.

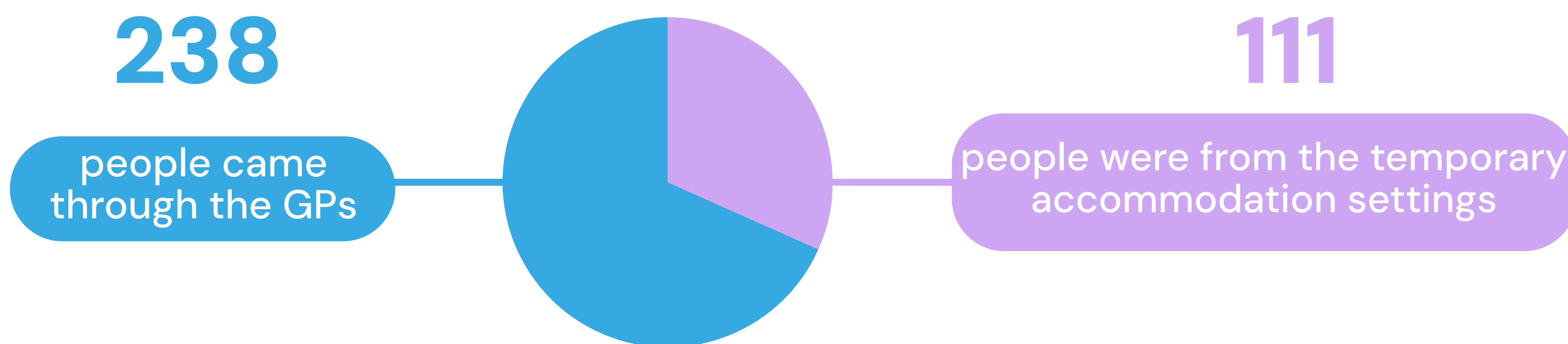
In addition to this universal approach, which promotes self-referral, all staff within the GP setting are encouraged to refer families where they feel support may be beneficial. There is also outreach to two temporary accommodation settings for homeless families where the service is offered to all residents.

The Families

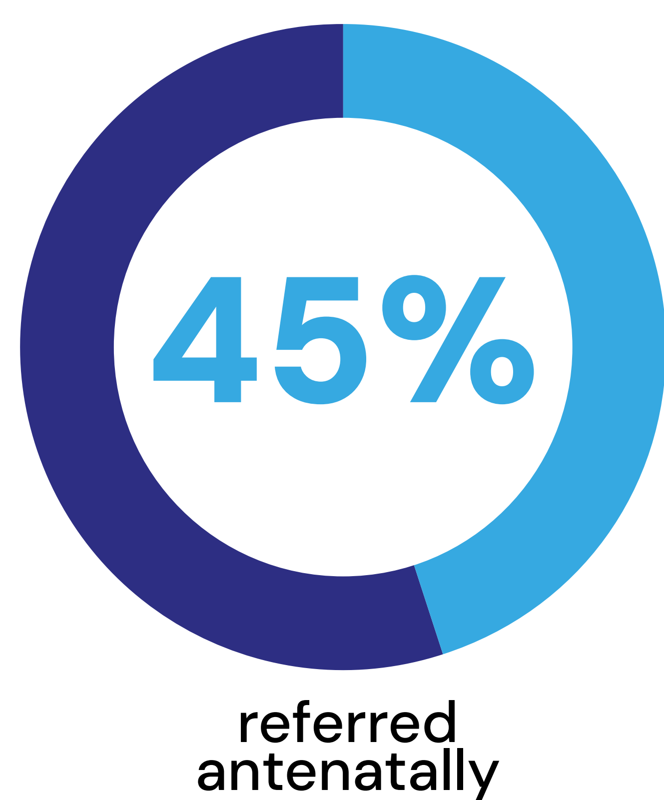
WHO WAS REFERRED TO THE SERVICE?

349 people from **282 families** were referred to the service between 2021 and 2025.

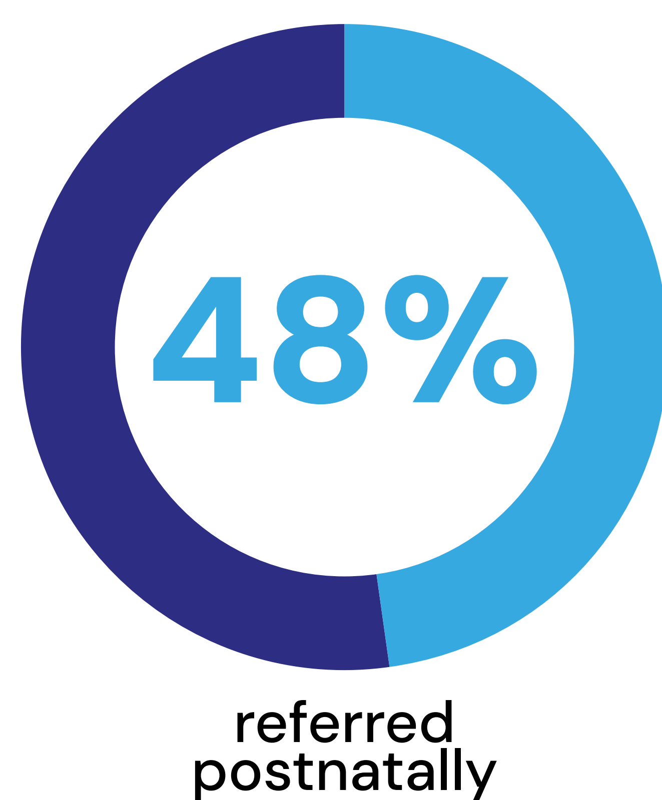




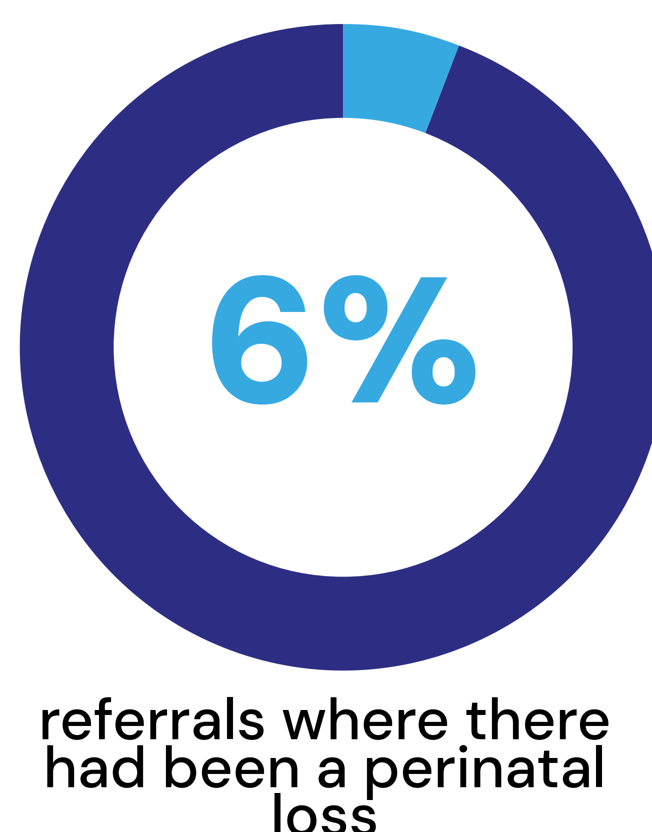
OVERALL VIEW OF REFERRALS



referred antenatally



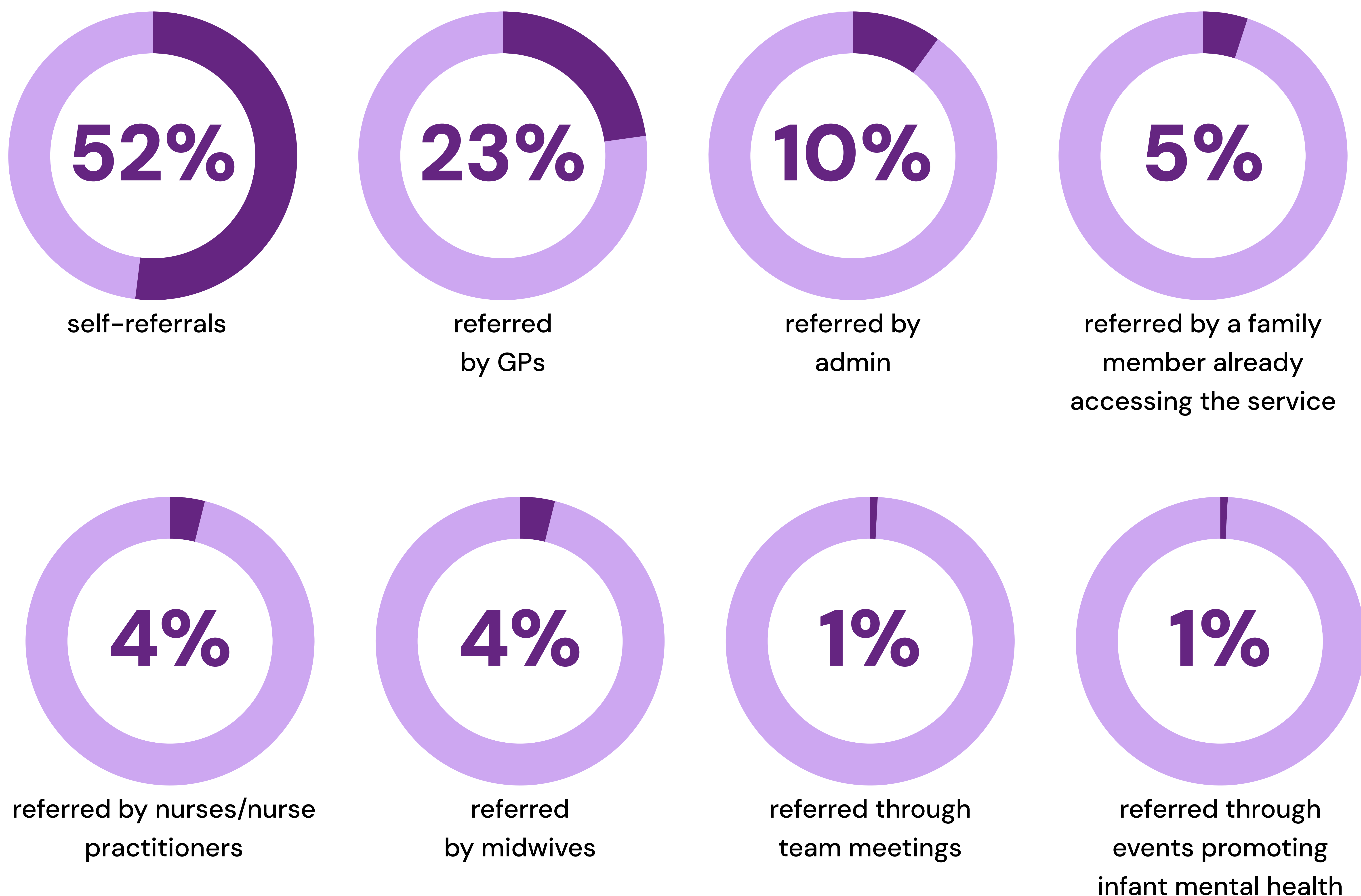
referred postnatally



referrals where there had been a perinatal loss

referrals where there were concerns pre-conception

IN THE GP SETTING



All of the homeless families were engaged through outreach work by visiting the temporary accommodation settings on a weekly basis.

HERITAGE AND ETHNICITY

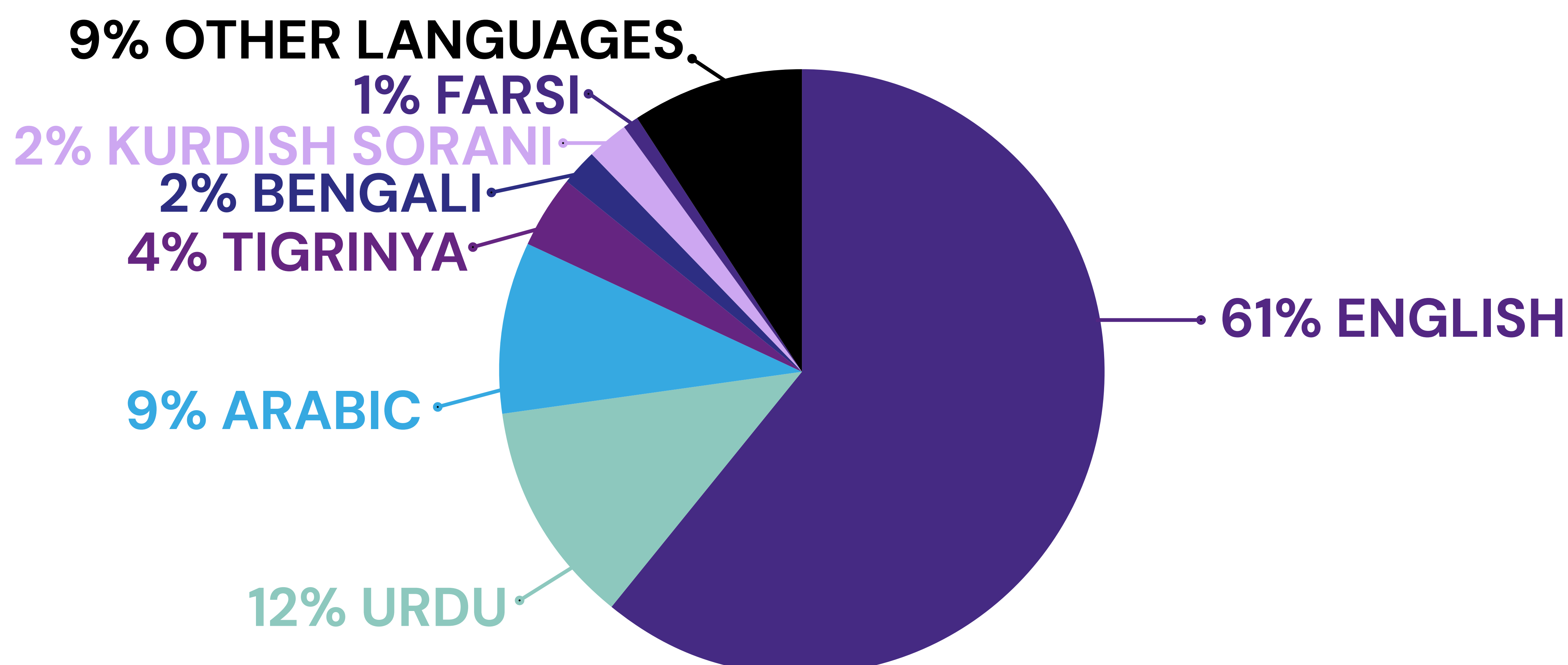
People with a broad range of backgrounds were referred to the service as detailed in Table 1. 54% of the adults referred to the service identified as British. This included 25% 'White British' and 29% from ethnically minoritised backgrounds with the highest proportion identifying as British Pakistani (10%). 46% of the adults were born in a country other than Britain with the highest percentages identifying as Asian Pakistani or Black African.

Heritage and Ethnicity[10]		Percentage of Referrals %
Asian	British Pakistani	10%
	British Bangladeshi	2%
	British Indian	2%
	British Asian Other	2%
	Pakistani	14%
	Bangladeshi	3%
	Indian	1%
	Other	1%
Black	British Caribbean	3%
	British African	1%
	African	12%
Multiple Ethnic Groups	British Asian and White	3%
	British Black and White	6%
	Other Black and White	1%
White	British English	23%
	British Scottish	1%
	British Welsh	<1%
	Irish	2%
	Gypsy/Irish Traveller	<1%
	Roma	1%
	Other	4%
Other	Arab	4%
	British Arab	<1%
	Other	3%

Table 1: Percentage of Referrals by heritage/ethnicity

LANGUAGE

The families referred spoke 26 different languages as their first language*. The most common was English (61%) followed by Urdu (12%), Arabic (9%), Tigrinya (4%), Bengali (2%), Kurdish Sorani (2%) and Farsi (1%).



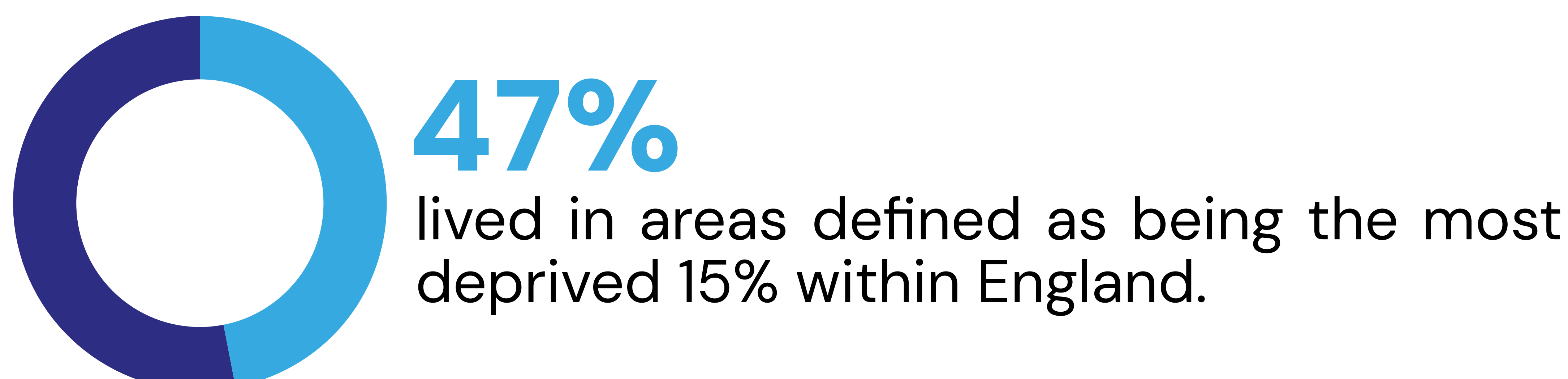
GENDER AND SEXUALITY

The vast majority of people identified as being cis-gender and heterosexual although our families include those in same-sex relationships and transgender parents.

68 MALE
281 FEMALE

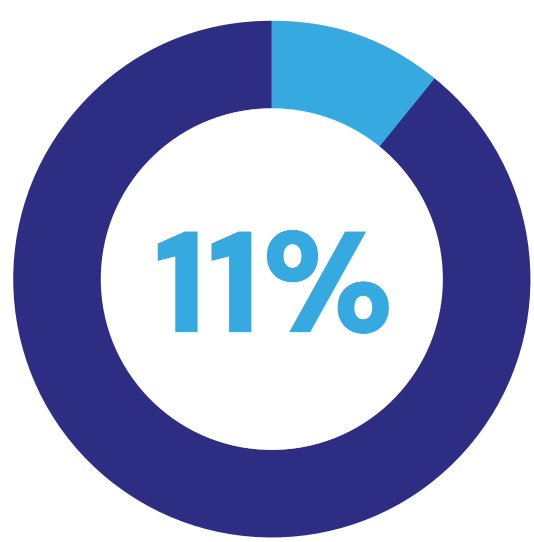
DEPRIVATION[11]

The Together Service is based in an area with a higher rate of income deprivation affecting children than most neighbourhoods in England. The families the service worked with were some of the most disadvantaged.
All 193 families who were not homeless and living in temporary accommodation were classified as living in areas defined as being more deprived than the average general population.

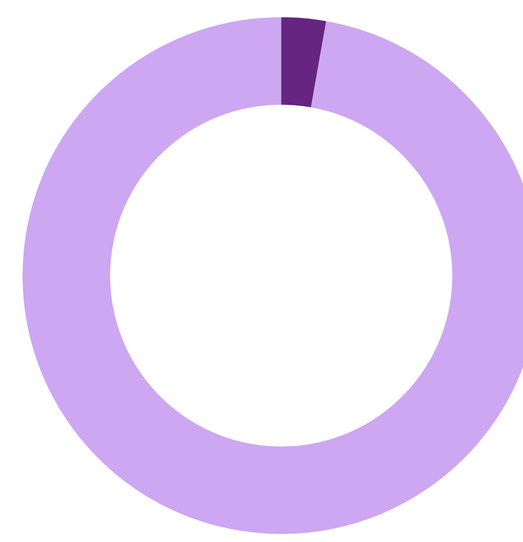


* Amharic, Arabic, Bengali, Bulgarian, Czech, English, Farsi, French, Gujarati, Hindi, Hungarian, Italian, Kikongo, Kurdish Sorani, Lingala, Oromo, Polish, Portuguese, Punjabi, Romanian, Somali, Spanish, Tigrinya, Urdu, Vietnamese

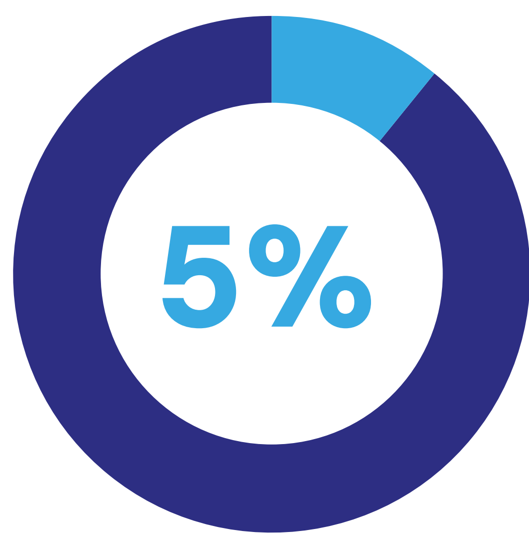
SAFEGUARDING AND DOMESTIC ABUSE



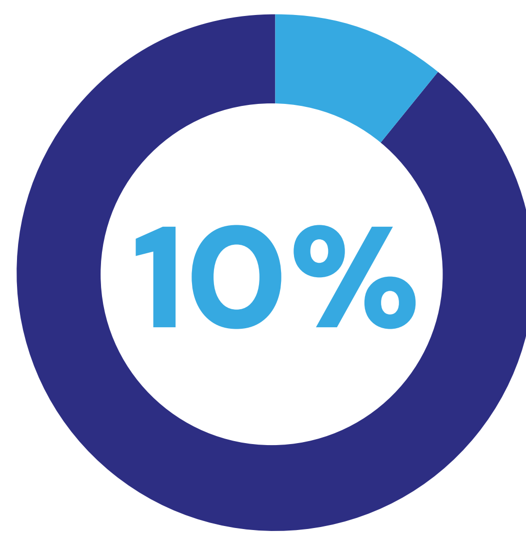
30 FAMILIES
referred to the service had social services involvement



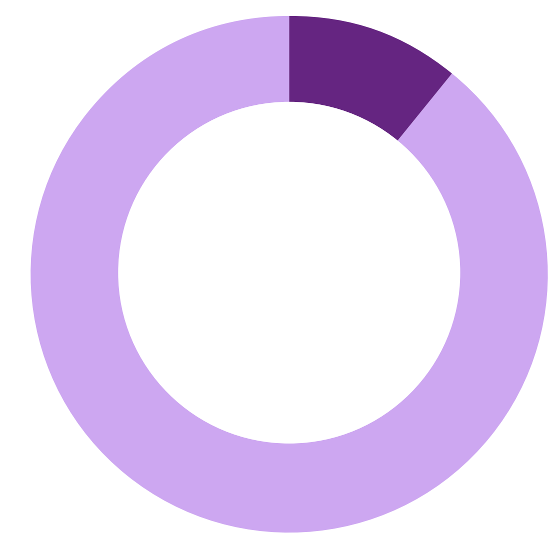
3%
national rate for children with social services involvement[12]



14 FAMILIES
reported domestic abuse as an active concern

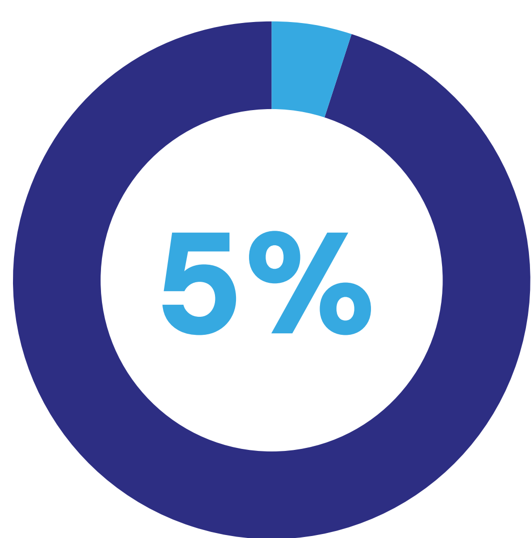


29 FAMILIES
experienced domestic abuse at some point



7.8%
national rate for people experiencing domestic abuse[13]

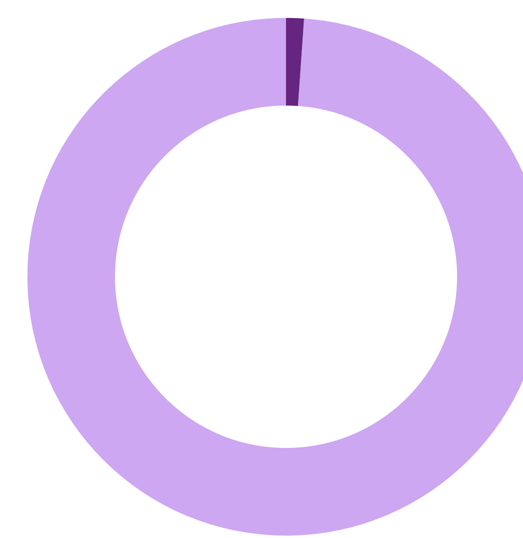
MENTAL HEALTH



19 PEOPLE
referred to the service had serious mental health difficulties, including

8 people with a diagnosis of psychosis and

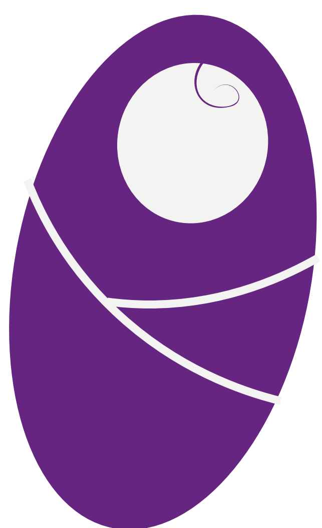
9 people who were actively suicidal.



1.2%
national rate for the prevalence of severe mental illness[14]

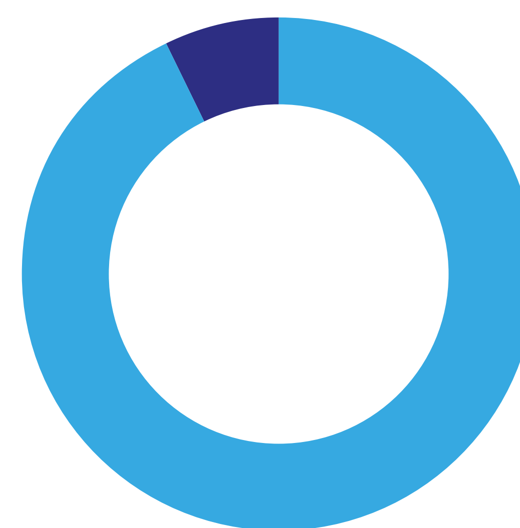
In summary, the population referred faced multiple disadvantages as outlined in The Core Story by the Parent-Infant Foundation[15] and the key messages of MBRRACE-UK 2025[16].

Did the Families Engage?



219 babies

accessed the service between 2021 and 2025.



93%

of the 89 homeless families engaged with the service.

The service was offered through outreach work to the temporary accommodation settings. Only two families declined the service stating that they did not require the support, three families were moved out of the accommodation prior to engagement, and one had not been approached at the time of data collection.

Although most of the families in the GP setting also took up the service offer, 23% did not engage. Of those families that did not engage, five had self-referred; enquiring about the antenatal sessions but then not attending them. The majority (90%) of the families who did not engage were referred by professionals. Closer examination indicated that this was mostly due to admin referrals as Table 2 indicates. Admin staff typically made referrals as a result of reviewing clinical notes e.g. miscarriage recorded, concerns around mental health or safeguarding noted at discharge from maternity. This varied from the other types of referrals which usually involved a conversation about the Together Service as part of a clinical appointment.

Referrer	Percentage Engagement
Midwife	92%
Self	90%
Nursing Team	82%
GP	70%
Admin	33%

Table 2: Rate of Engagement by Referrer

All the men who were referred to the service engaged. It is noteworthy that only five of the referrals that came from professionals were for men. Most men accessed the service by first coming with their partner to an antenatal session (42%), their partner recommending the service (14%) or through outreach to the temporary accommodation settings (35%).

Women who were referred antenatally and postnatally had engagement rates of 85% and 82% respectively. There was lower engagement from those who had experienced baby loss (75%) or were referred pre-conception (50%).

In terms of deprivation as measured by postcode, there did not appear to be any significant difference between families that did and did not engage with the service. Considering heritage and ethnicity, there were similar rates of engagement from British people and people born in other countries (86% and 84% respectively) and people identifying as white and people from ethnically minoritised groups in the UK (84% and 86% respectively). There was a slightly lower rate of engaging with the service if your first language was English (83%) than if it was another language (89%).

80% of people where there were active concerns around safeguarding engaged with the service and in all instances, including where there was no direct engagement from the family, indirect work was provided to the systems around them. 93% of the families where domestic abuse had been reported engaged with the service and again consultation and indirect work were provided to the systems around these families.

100% of families where there was a diagnosis of severe mental illness engaged with the Together Service at some point within their perinatal journey and the Together Service worked with the Perinatal Mental Health Team and other CMHTs to ensure ongoing care and infant-parent work.

The Interventions: What did families want help with?*

Group Sessions

- *Antenatal Group Sessions:* 25% of the people who accessed the Together Service attended our group antenatal session, Bloom. This session focuses on baby development and communication, and the social, emotional and relational aspects of becoming a parent. The majority self-referred through the GP setting but 16% were from the homeless families population. For 7% of our families this was enough input but most of the families who accessed Bloom also attended 'individual' sessions.

- *Postnatal Group Sessions for Homeless Families:* Through collaboration and consultation with parents, stay and play groups were established for families living in temporary accommodation. They explored concepts such as baby communication and baby development (using the ASQ-SE activities[17]), attachment (using the circle of security[18]) and 'soothing through senses' for both parents and babies. They included sharing games, stories and songs with babies in the session. There was also the opportunity to borrow toy/book bags** with information about how to use them to support baby development. The group sessions also served a peer support function as families were not allowed visitors in the temporary accommodation (TA). One group was run in the community room at the GPs on a monthly basis and was attended by 26% of the parents from the nearby TA setting. The other TA setting had a family room on site and weekly group sessions were held there with 58% attending. Only two dads attended the stay and play groups.

* Percentages are calculated as a proportion of the parents who engaged with the service

** An initiative initially established with a local community organisation

Individual/Family Sessions

- *Understanding Baby Development and Communication Sessions:* 46% of the parents we worked with accessed individual post-natal sessions that focussed on understanding babies' development and communication. This involved using tools such as the Newborn Behavioural Observation[19], the ASQ-SE activities and, for the homeless families, the toy/book bags which were used to support conversations around baby development and infant-parent communication.

- *Postnatal Infant-Parent Relationship Sessions:* 52% engaged with more in-depth infant-parent work using play sessions and tools such as the circle of security, video feedback and therapeutic work focussed on inter-generational patterns.

- *Antenatal Infant-Parent Relationship Sessions:* 5% engaged in antenatal sessions focussed on bonding with bump in the context of trauma and relational or situational challenges.

- *Sessions around Loss/Pre-conception:* 6% accessed sessions supporting them with baby loss, either through death or babies being placed into care, and/or pre-conception work where people were planning to have a baby in the context of trauma and/or challenging circumstances.

- *Parental Mental Health:* 41% of the people that engaged with the Together Service asked for some support around their own mental health. At times this meant linking them in with other support services such as the Perinatal Mental Health Team, Talking Therapies or other specialised mental health services e.g. Eating Disorders Service. However, a large number of them were unable to access timely support that was tailored to their needs. Interventions such as compassion-focussed therapy and the Tree of Life narrative approach were offered to these families.

- *Couples Sessions:* 13% of the parents found they were struggling in their relationship with their partner. 'Couples' sessions were provided, informed by ideas around adjustment to being a parent and non-violent communication approaches. 4% of the couples had a history of domestic abuse and, in this case, there was close liaison with other agencies.

- *Family Sessions:* 38% of people accessing the service had at least some sessions where other family members attended as appropriate. This included partners (where there was no specific relationship struggle), baby's grandparents and baby's siblings.

Link with other Services

- 30% of families required some work linking with other agencies including social care, health visiting, physical health, mental health, child and family services, housing, police and benefits. This work involved helping families to negotiate complex systems, ensuring the experience and 'voice of the baby' was heard. Systems work was of particular relevance when families were referred due to concerns around safeguarding and they were not engaging. This applied to five of our families over the five years reviewed.

What Did the Staff/Wider Community Want Help With?

GP and TA staff asked for training to support them with their work. This included training sessions around compassionate care including care for self, communication skills, perinatal mental health, infant-parent relationships and team building sessions.

Consultation sessions were also offered on a needs-led basis for staff in both GP and TA settings and a weekly reflective practice/well-being group was offered in the TA setting for staff.

The Together Service delivered teaching to various training programmes including a clinical psychology training programme, a GP training scheme and CPD sessions for qualified GPs. Clinical training placements were offered to ten GP trainees and five Trainee Clinical Psychologists over the five years. An additional group of six trainees completed a community capacity building project with the Together Service developing guidance about setting up peer support groups for homeless families[20]. Over the five years, trainees have helped to grow and develop the service, and they have been a much-valued resource.

Wider community development work included running an event each year during Infant Mental Health Awareness week which local organisations attended building links with families. In turn the Together Service was asked to attend various community events focussed on inclusivity to talk about our work. Various joint initiatives were undertaken with different community organisations including the development of the toy/book bag scheme mentioned earlier and work around supporting families where there is a disability.

Number of sessions and the resource needed

The number of sessions that families attended over this 5-year period varied greatly from 1 to 124. This range included families who had experienced more than one pregnancy/birth and some where there were multiple losses. The primary care service model offered families access to support throughout the perinatal period (from planning a baby to having a baby that is 1 year old).

There was no waiting list in operation throughout this period, and the Clinical Psychologist was able to serve the practice population of approximately 6,500 patients working 15 hours a week (January 2021- August 2023 inclusive). This was increased to 22.5 hours a week from September 2023 to include outreach work to two temporary accommodation settings (housing 38 families at any one time).

How did we measure our impact?

Outcomes

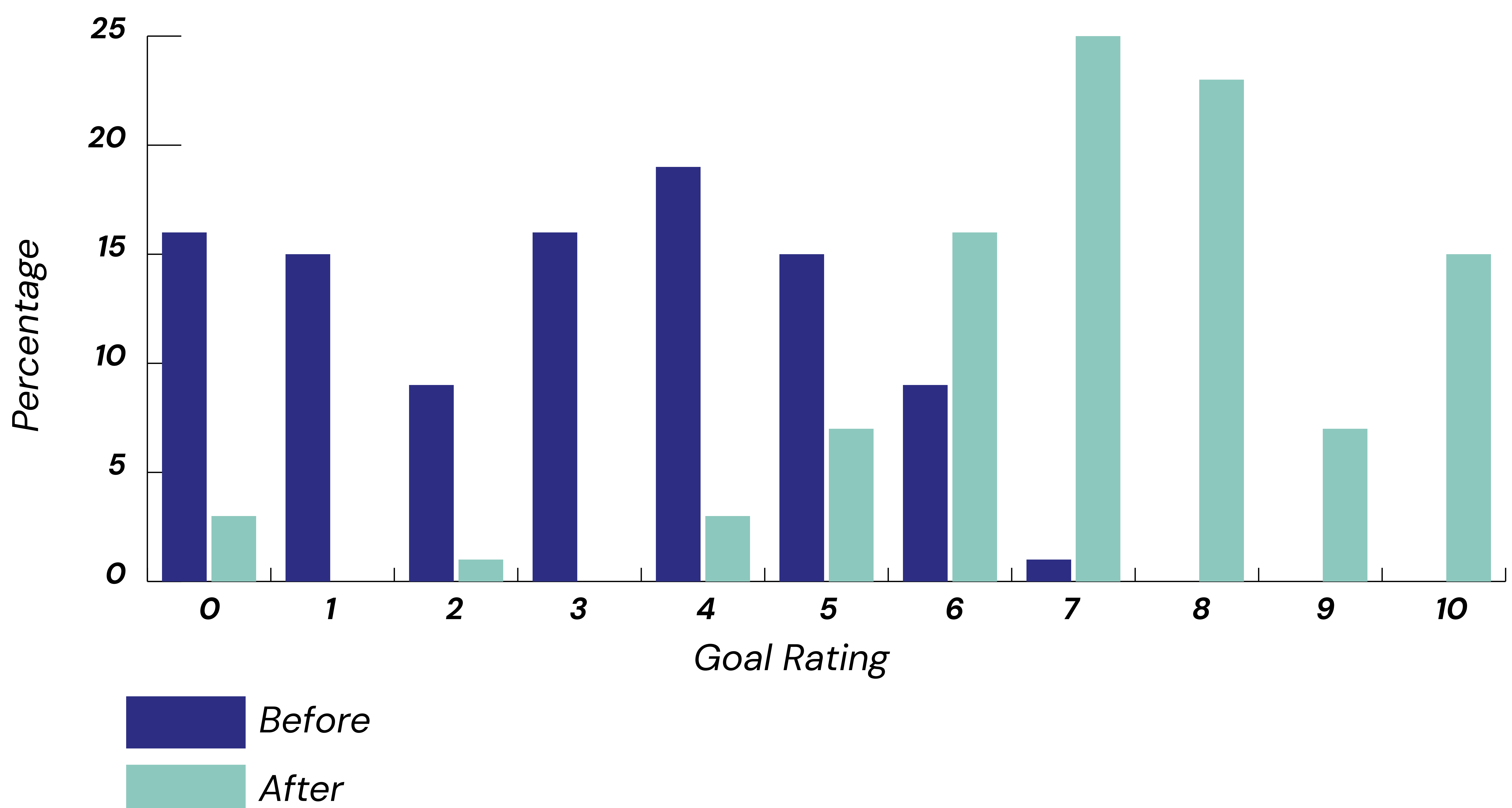
Various outcome measures were used; Goal-Based Outcomes[21] set and scaled by the family, the CORE-10[22] assessing low mood and anxiety and the MORS My Baby measure[23] assessing the warmth and sense of invasion in the parent infant relationship.

Goals

Families set their own goals for the work. Examples of these include 'to manage my anxiety more', 'to understand my baby better', 'to become the parent I want to be'. They then scaled them from 0 to 10 with a higher rating indicating a more positive outcome.

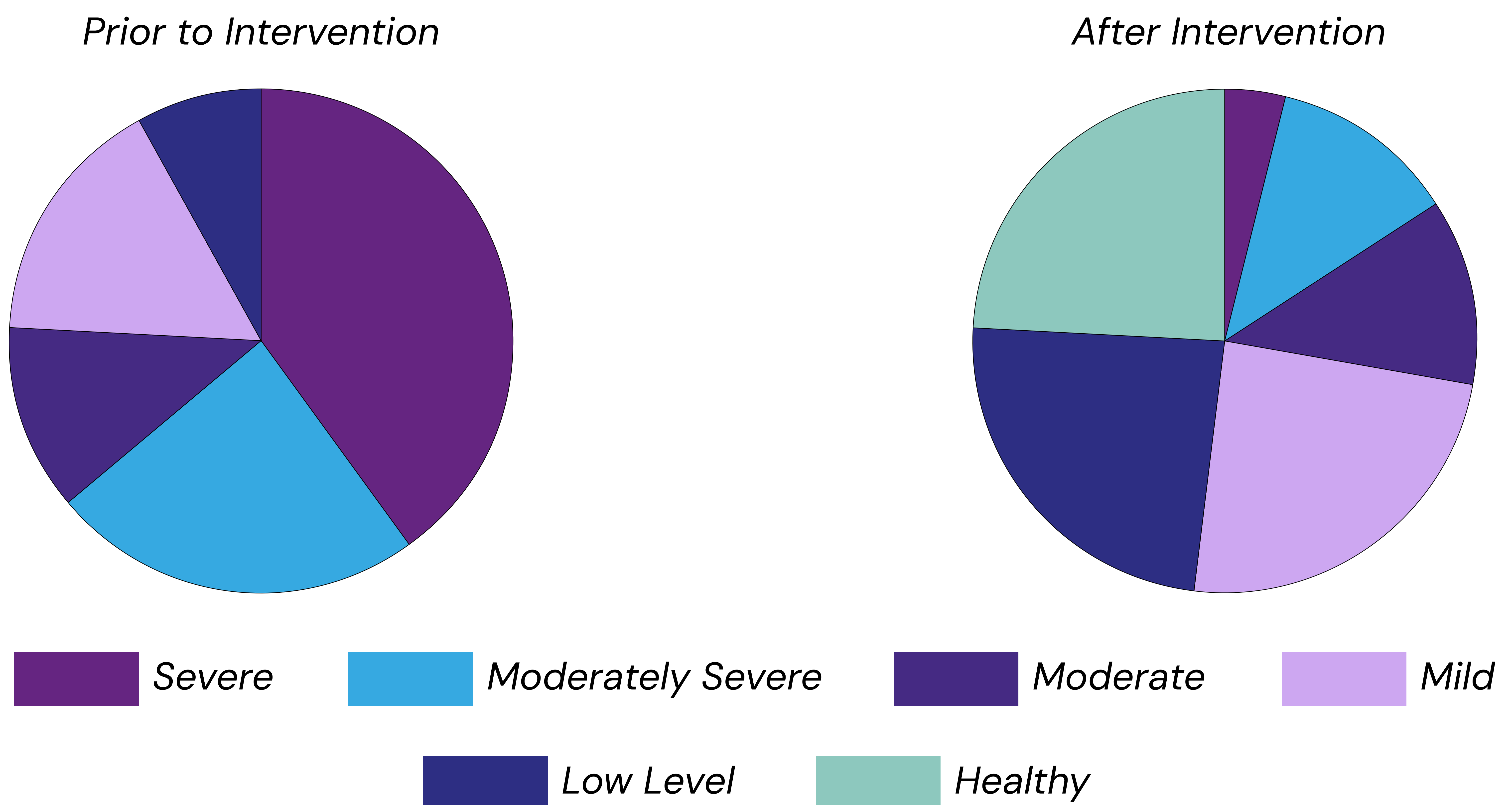
'Before' and 'after' intervention ratings covered the full range from 0 to 10. 97% of parents scored themselves as moving in a positive direction towards their goals. The average rating increased from a 3 to 7.

Goal-Based Outcome Scores Before/After Intervention



Mental Health Outcomes

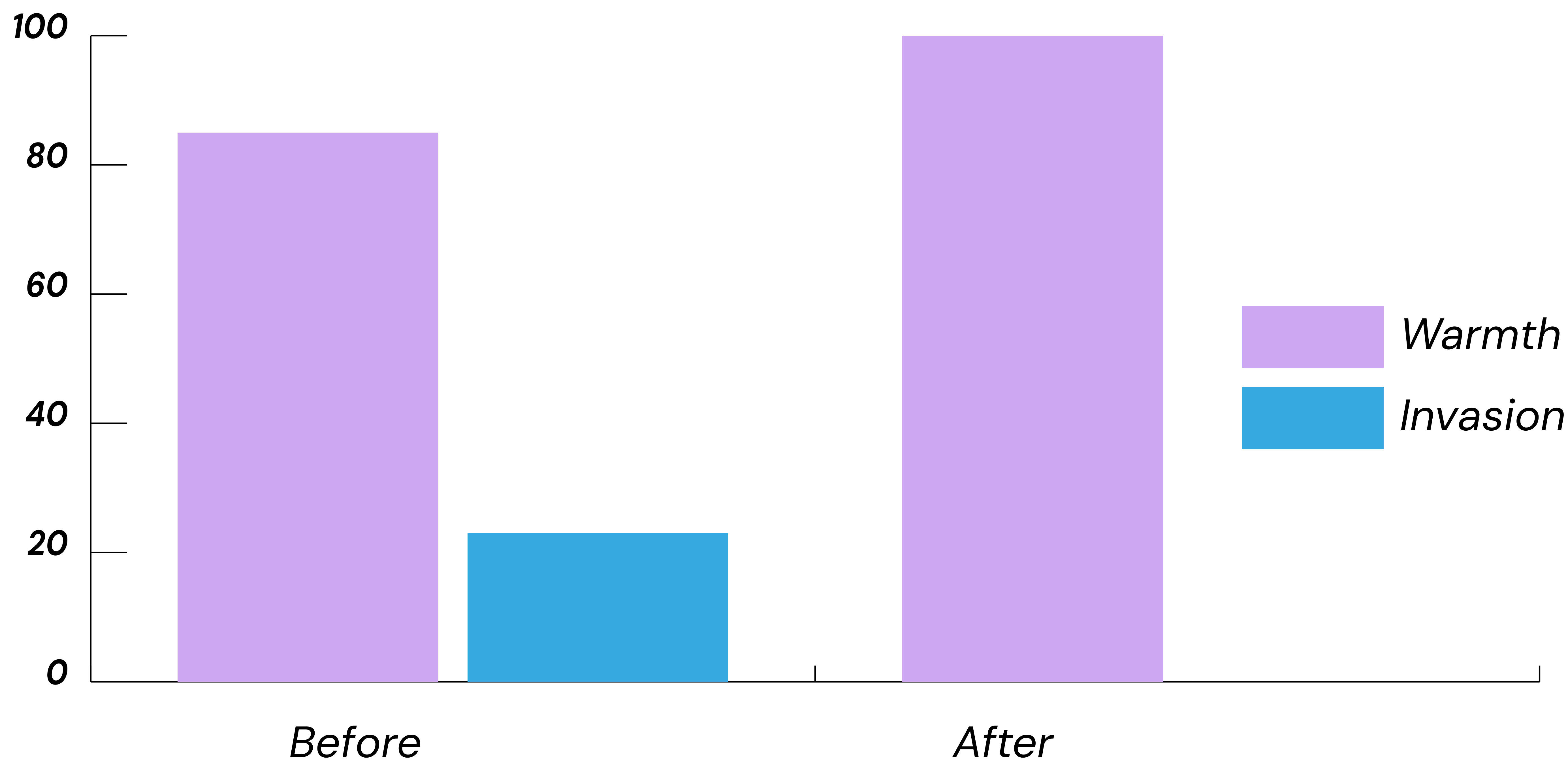
There was a range of scores out of 40 prior to intervention on the Core-10 (8-32) with an average score of 22 which indicates moderately severe psychological distress. This decreased by 10 points over the course of the intervention to an average of 12 out of 40 (in a range of 2-29) which falls in the range of mild psychological distress. The charts below illustrate the change in terms of level of distress as assessed by this measure. Prior to intervention 76% of families were scoring in the most distressed categories (severe, moderately severe and moderate distress) and after intervention 72% were scoring in the least distressed categories (healthy, low level and mild). This still left 28% of people experiencing moderate to severe levels of distress when they left our service e.g. due to geographical relocation. The service offered transition sessions to assist families to engage with alternative support.



The Parent Infant Relationship

The My Baby measure indicated that 85% of parents scored their relationship in the 'warm' range both before and after intervention with the remaining 15% moving from a score indicating concern to a warm score by the end of intervention. Overall, parents' scores increased by an average of 6 points on the warmth scale.

Parents' ratings of how invasive they found the relationship decreased over the course of the intervention by an average of 3 points. All 23% initially scoring within the range for concern around invasiveness, moved out of this range by the end of the intervention.

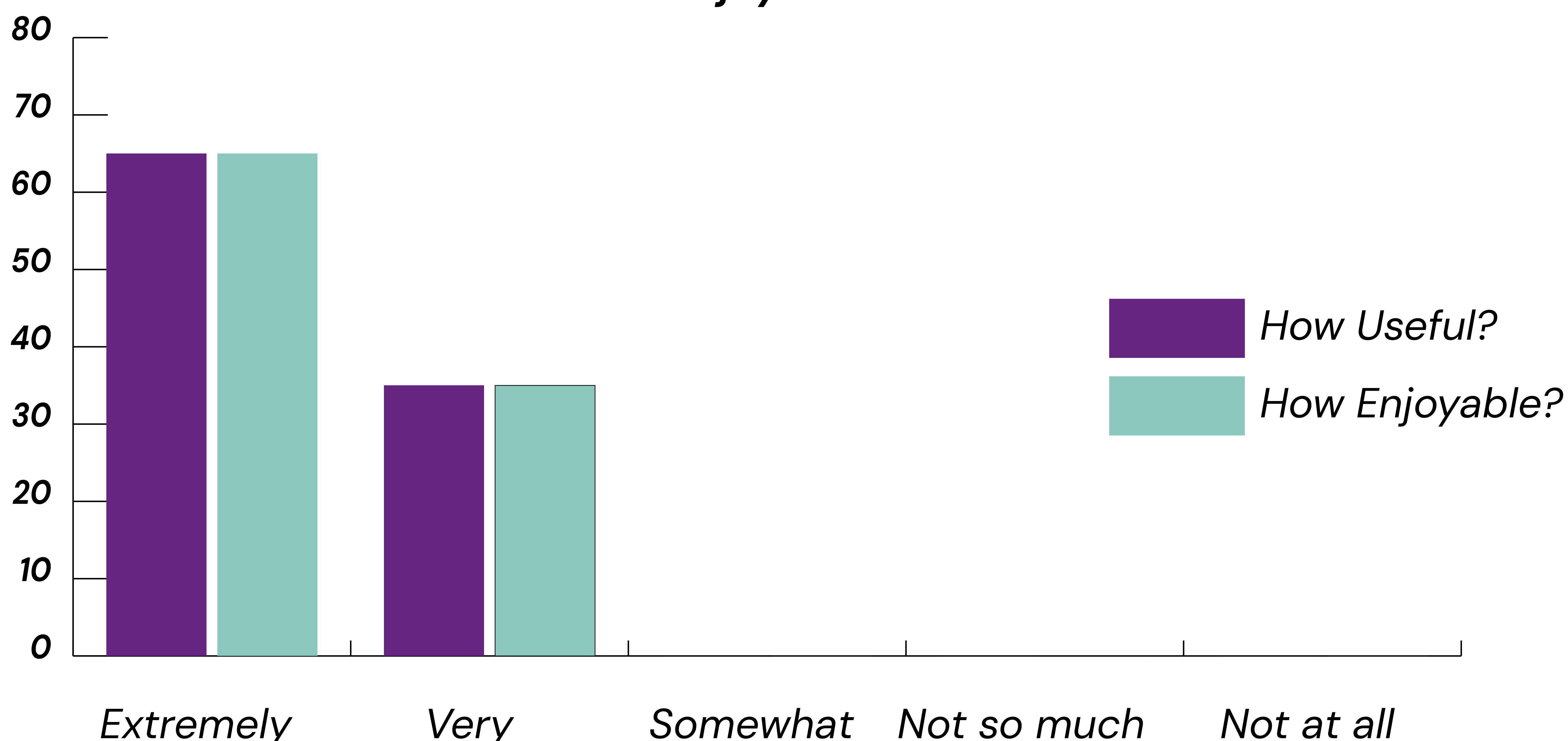


What did families think of the service?

There were two time points where feedback was formally gathered from families; after the group antenatal session and when the one-to-one/family intervention was complete and/or the family were leaving the service for other reasons e.g. geographical relocation.

Bloom Antenatal session

A survey was sent to all families who attended the antenatal group session. They were asked how useful and enjoyable the session was. Feedback is displayed in the chart below.



100% of attendees said they learnt something new and 100% said they would recommend the session to other families.

Families were asked ***what they wanted to remember*** from the session. Most talked about the wonder of baby development, the importance of developing a relationship from pregnancy and realising how interactive babies are when they are born:

"I want to remember how important it to be speaking to the baby whilst the baby is still in the mother's womb. I was surprised to find out how the baby recognised the fathers voice when born."

"Found it very interesting that babies can respond and communicate so early, particularly to sounds in the womb (currently creating a baby playlist) and mimicking facial expressions at birth."

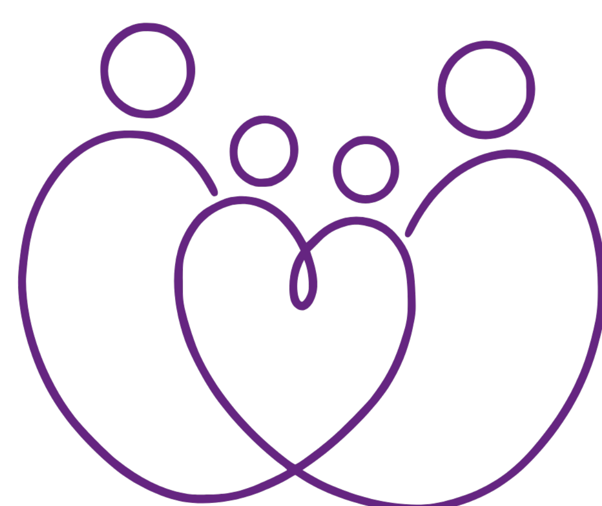
"How we as parents can respond to our child better and meet its needs."

Lots of families talked about wanting to remember to look after themselves in order to look after baby:

"Prioritising self-care and seeking support when needed."

Some of the couples who attended also talked about how the session made them think about their relationship:

"I feel like we left the session feeling closer to each other."



When asked ***what was good*** about the session most parents mentioned the creativity and interactive nature of the activities and the sense of it being a safe space:

"I liked how interactive the session was when we used the wool to symbolise neurolinks."

"We both felt comfortable to speak openly about are hopes and fears of becoming first time parents."

In terms of what could have been improved, most people said nothing, but a few mentioned the poor quality sound on one of the videos shown and one family (where they were the only ones to attend) missed the presence of peers:

"Nothing, was a very positive/empowering session."

"The sound on the computer."

"Having other people (parents) there. Although this didn't stop the class being very good."

Asking for ***other comments*** led to appreciation of the session, its accessibility and a desire to engage with the service in future:

"It has made me focus on the positive side of pregnancy and birth rather than feeling nervous about my baby all the time."

"It was amazing that it was provided through NHS GP."

"This is a great idea and would benefit many mothers and fathers to be."

"Would like to book in for a follow up appointment after birth."

Overall Experience of the Service

The CORC Adapted Parent Experience of Service Questionnaire was given to people when they finished their work with the service. The percentages of people selecting each answer are displayed in Table 3.

	Certainly True	Partly True	Not True	Don't Know
I feel that the people here listened to me.	100%			
It was easy to talk to the people here.	100%			
I was treated well by the people here.	100%			
My views and worries were taken seriously.	100%			
I feel that the people here know how to help with the problems I came for.	90%	10%		
I have been given enough explanation about the help available here.	100%			
I feel that the people here are working together to help with the problem.	90%	5%		5%
The facilities here are comfortable e.g. waiting area.	76%	24%		
The appointments are usually at a convenient time.	86%	14%		
It is quite easy to get to the place where the appointments are.	90%	10%		
If a friend needed similar help, I would recommend that he or she come here.	100%			
Overall, the help I have received here is good.	100%			

Table 3: Service Experience Questionnaire Answers

Most of the questions received the highest ratings possible from all families indicating that they felt listened to, treated well and that they would recommend the service to a friend. Some of the families (10%) were less sure that people knew how to help them and were working together. This generally applied to families in the temporary accommodation setting whose main goal was to find secure housing. There was also lower satisfaction with some practicalities, namely where and when the appointments were held.

Three qualitative questions were also asked:

What was good about your care?

Words such as 'understanding', 'care', 'trust', 'support', 'easy to talk to', 'non-judgemental' featured often and illustrated the importance of the therapeutic relationship in facilitating change:

"The relationship, bond and trust."

"We were listened to with dignity and care. And the suggestions given to help us through our difficult times were definitely successful in their outcomes."

There was an appreciation of the service being accessible and adaptable to parents' needs at different times:

"Personalised, clear, professional, actionable, caring and compassionate and accessible."

"Vital support throughout our entire parental journey from prenatal all the way through to postnatal."

A reoccurring theme was around parents' developing identity...

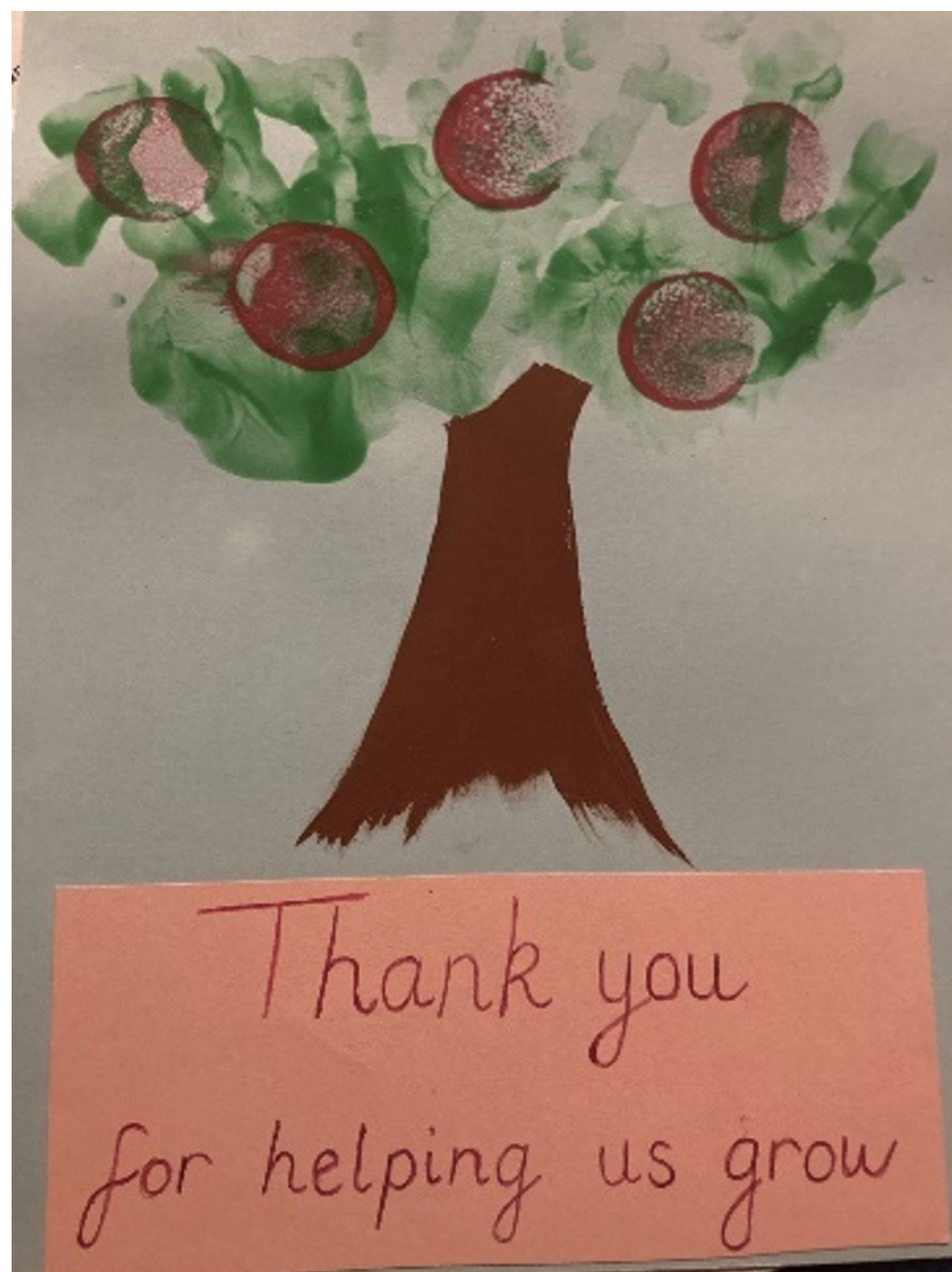
"It has changed my life and outlook on myself and motherhood."

"I have learnt so much I become a better mother through her care. And more importantly I recognise I can be a good mother."

...and positive changes within couple relationships:

"When I say we wouldn't be the strong parent team today without this, I really mean it."

In addition to the formal feedback, families have shared their thoughts and experiences in other creative ways such as pictures and messages written from the baby's voice:



Thank you for being so kind to my Mummy.

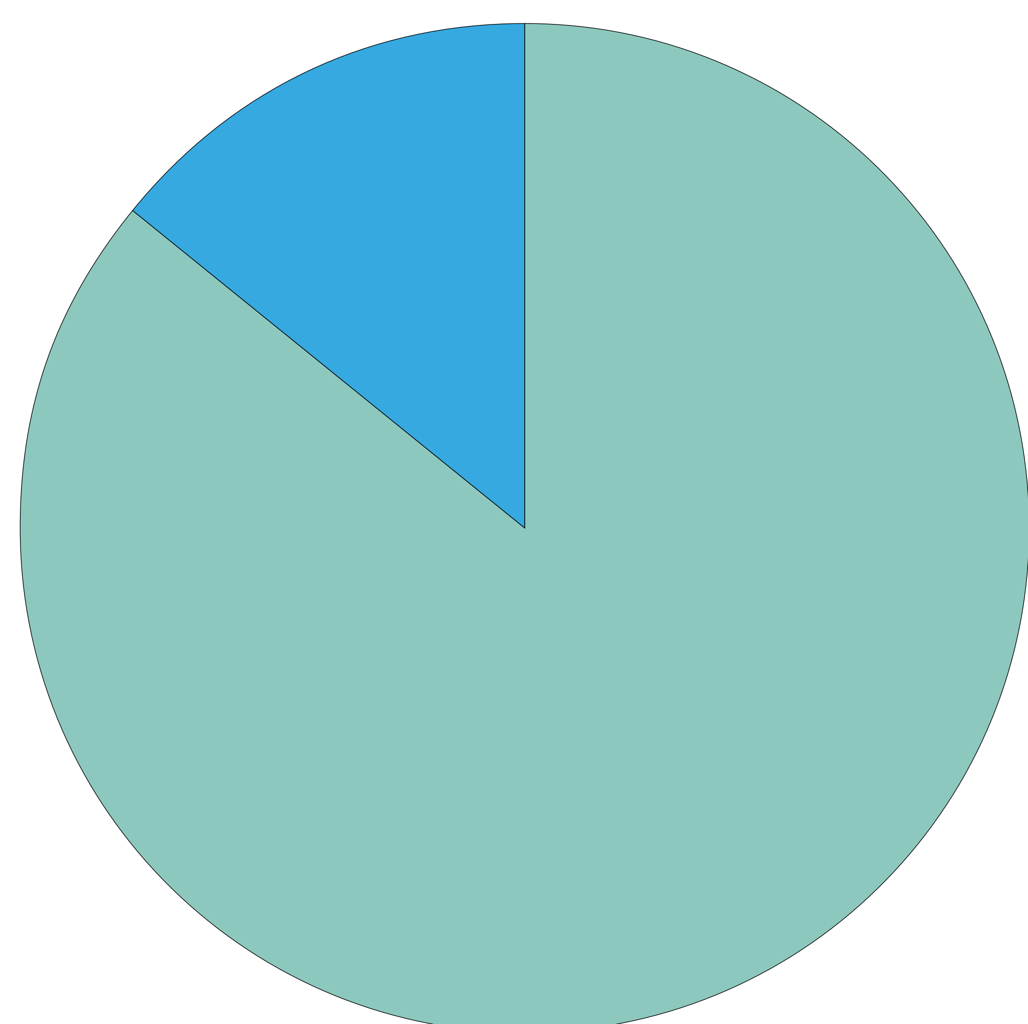
You have helped her be more compassionate and more patient, and now I feel more loved than ever before.

Thanks to you I have a new mummy – who I know will love me, even when I cry (in the middle of the night)

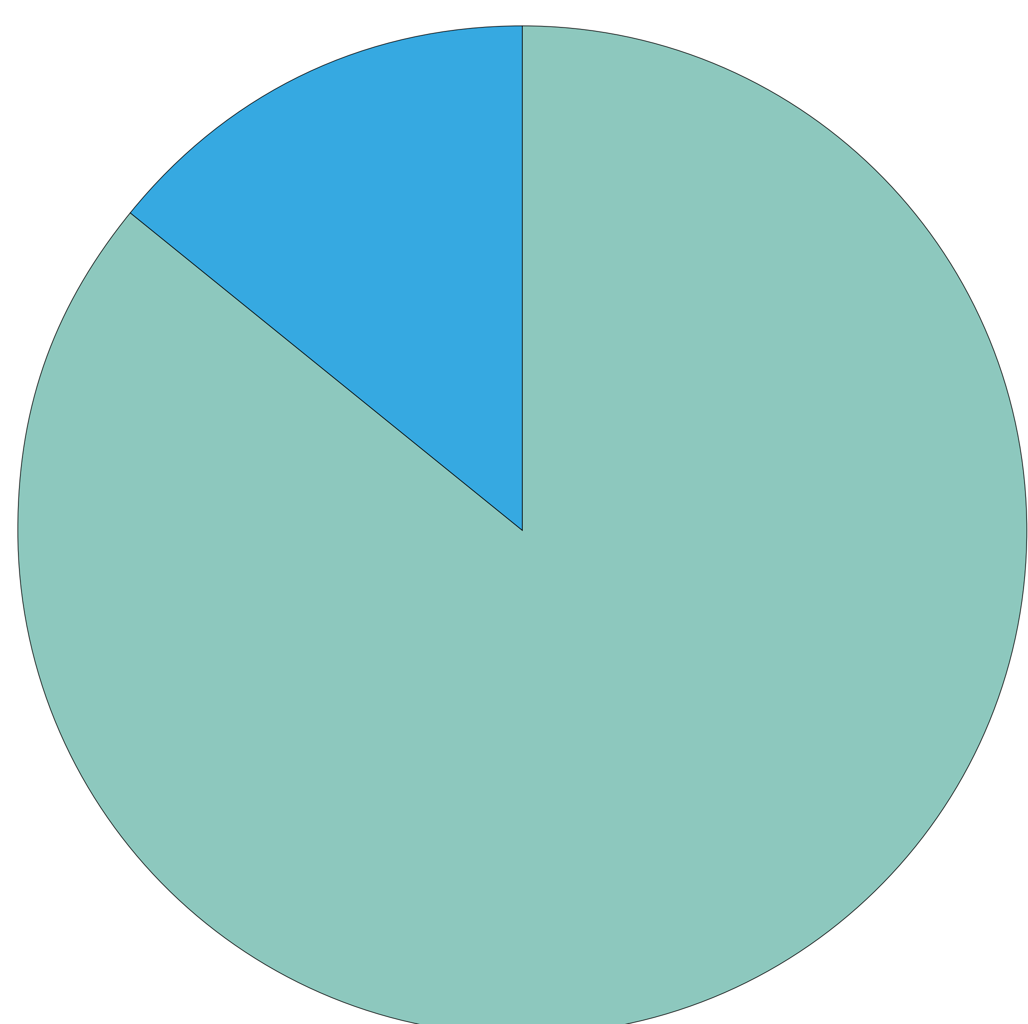
What did staff think of the service?

Staff in the GP and temporary accommodation (TA) setting were asked about their experiences of the service and how useful it was for them and the families. Twenty-one staff responded to the anonymous questionnaire, 14 from the GPs, 7 from the TA setting. In both GP and TA settings, 86% of staff said it was extremely useful for them and 14 % said it was very useful. The same percentage ratings were given when asked about how useful they thought the service was for families.

How useful is the Service for GP/TA Staff?



How useful is the Service for Families?



In terms of ***what worked well*** about the service, staff in the ***GPs*** spoke about the helpfulness of being co-located in terms of accessibility and timeliness of support for both families and staff:

"Being able to work closely with (psychologist) – particularly being in the same building works really well. Sometimes just a quick chat for advice can be enough."

"Being based in practice to be on hand to support our patients."

"Responsive service providing timely care and input."

They spoke about the benefits of the training/consultation work the service does:

"It has been great to utilise the service to gather professional opinion and insight for any patient concerns or queries experienced during practice."

"Raised awareness of the importance of the first 1,001 days and helped the team better support patients. Helped the team present a more trauma-informed approach to patients and build communication and relational skills."

The direct work with families around mental health and parent-infant relationships was mentioned...

"Really useful to be able to give struggling parents somewhere to go/someone to go to. They feel supported, heard and understood."

"Wonderful service for those with post-natal depression – they are seen quickly and have avoided anti-depressants in some."

"Helped bonding and creating connections."

...as were the group sessions building communities of support:

"Helped families come together."

"The stay and play sessions are brilliant."

There was also mention of supporting holistic care within the practice for vulnerable patients:

"Encourages new mothers to register babies asap so we can ensure they are receiving the best care. Helps to build a relationship and trust with our families."

"Checking in with patients who miss appointments."

In terms of ***what could be improved*** most ***GP staff*** said nothing or would have liked more of the service in one way or another:

"Nothing, it is a brilliant service and every GP surgery needs access."

"Having a service similar around all practices in Manchester would be fantastic."

"Make it bigger – more staff, wider range."

"More community activities/baby group sessions."

This included establishing more opportunities for collaboration:

"Maybe we could have a meeting to discuss the current case load and any issues that would be helpful to get GP input on or to feedback."

Similar feedback emerged from the staff in the ***TA settings***. When asked ***what worked well***, they commented on both the direct work with families and the staff training/consultation:

"Provides excellent support to our mothers and babies here… Provided practical support continuously and also conducted staff upskilling/informative sessions which have broadened our understanding and enabled us to be more psychologically aware of issues faced by our families."

There was a particular appreciation of the service supporting the building of relationships between vulnerable families and the TA staff/other organisations.

"Helped build a trusting relationship."

"It helps get some residents who are more reluctant to engage to feel safe to engage, as the approach is more holistic and I feel people feel a little more understood."

"Brought families and organisations together."

When asked ***what could be improved, TA staff*** said 'nothing' or asked for an extension of the service:

"Additional days, as many as possible."

"Come to different TA's."

Findings

The evaluation indicates that the service was effective in meeting its aims – engaging with the most disadvantaged families across the perinatal period and achieving positive outcomes in terms of improved parent-infant relationships, parental mental health and family functioning.

The main ingredients in the success of this model appear to be:

1. Positioning the service in primary care and offering it universally
2. Offering access to different interventions as and when needed within one service
3. Including family networks and group interventions

Stigma and fear are some of the main barriers that prevent people from accessing infant-parent and perinatal mental health services. Offering the service within the GPs where people could self-refer or be immediately referred by their GP/other health professional resulted in positive rates of engagement and is in line with recommendations to reach families experiencing the most disadvantage such as those that are ehtnically minoritised[24]. Having the option to self-refer and access different interventions as and when needed all within one service is in line with attachment-informed practice[25]. This conceptualises mental health services as 'organisational caregivers' aiming to avoid the fragmentation that comes from multiple referrals across specialist teams and instead promotes consistent therapeutic relationships that promote person-centred care and includes family networks.

Typically, someone requiring support in the perinatal period would have to access different services for baby loss, difficulties around conception, parent-infant relationship work, parental mental health support, couples/family work. The Together Service was able to offer families support throughout, holding them and linking in with other specialist services as required. This appeared to be particularly important for the homeless families who would struggle to access care due to instability in their living circumstances. In addition to the fear and stigma that such services present, families would face practical challenges such as not having access to resources to attend appointments (either in person or online), being moved suddenly 'out of area' for services and also referrals being declined due to concerns from professionals that parents were not in a stable enough place to engage in therapeutic work. Families often found themselves lost in the system.

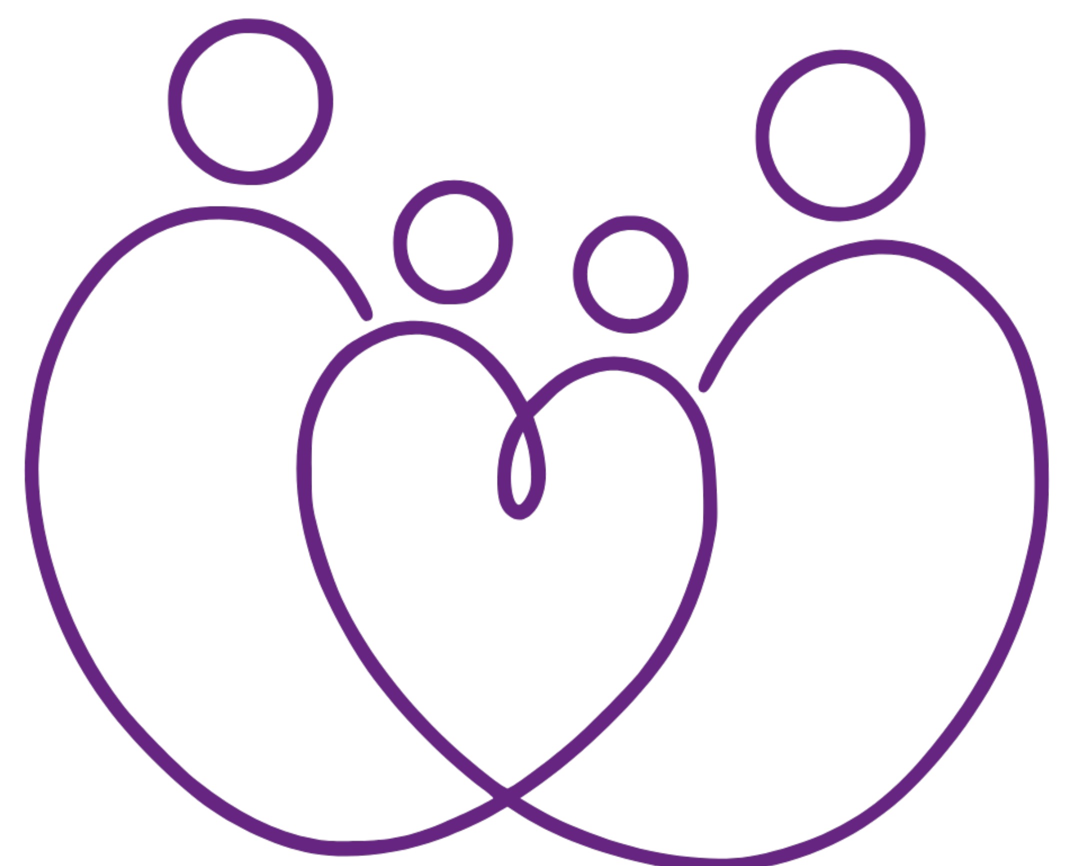
> *"...attachment theory may offer a promising framework to drive systemic change in mental health by emphasising secure emotional bonds at both the organisational and individual level. Within an attachment-informed culture, services may act as 'organisational caregivers' that promote continuity of care, independence and stronger clinical relationships. In turn, this may foster more inclusive, responsive and resilient mental healthcare systems that prioritise patients' needs and empowerment." (Salmoiraghi & Zarotti, 2025)*

The immediacy of the Together Service model using outreach work into the temporary accommodation setting and offering no waiting lists within primary care allowed us to meet people where they were, when they needed it most. Having a consistent and visible presence in both settings was key. The evidence around the cost-effectiveness and benefits of locating clinical psychologists in primary care is growing[26]. Clinical Psychologists are trained to offer mental health support across the lifespan and for different mental health presentations as well as being able to offer training and support that increases staff knowledge and reduces staff burnout[27]. These benefits were reflected in the positive feedback The Together Service received and in the engagement rates of families who often fall between the gaps in services.

> *"I believe every parent wants the best for their child, it is just that some people have been offered less support, faced more injustice, experienced more trauma or have less resources to do this. By being in the GPs we can offer ALL families support that is tailored to their need. We are less scary and easier to access than other services and we remain available for them throughout the perinatal period."*
> *(Clinical Psychologist. The Together Service)*

In terms of engagement, the benefits of having a universal offering with a self-referral option were apparent and where there was a more targeted approach the importance of there being a conversation with a health professional as part of that referral was highlighted. A striking finding was that all the men referred to the service engaged. Men are currently underserved in the perinatal period and yet we know the need and cost of not supporting dads is high[28]. The Together Service model highlights the readiness of dads to engage if the service is offered to them.

Another reflection from this five-year review is the importance of developing services in collaboration with the people that use them. Our work into the TA settings led to the development of 'stay and play' groups which were shaped by the families. The groups were particularly well attended by parents from Black African communities and offered a holistic approach to wellbeing with shared food, music, craft and stories. Within this space infant-parent and parental mental health work took place in a framework honouring community and peer support in line with recommendations on engaging minoritised groups[29].



A final important thing to note is that, although the service demonstrated impressive outcomes, it does not provide a complete solution. Mental health problems and challenges within the infant parent relationship continued for some of the significantly disadvantaged group that engaged with The Together Service. There was also relatively less satisfaction reported by some of the homeless families around the service being able to work with others to help with the problems they faced, namely finding stable accommodation. This reflects the reality of challenge in people's lives. Addressing inequality at a societal level is crucial. It also underlines the importance of flexibility in the service and being able to conduct transition visits when families moved out of area to ensure they were linked in with appropriate services and support.

Next Steps for The Together Service

The main aim now is to replicate the Together Service in another GP setting and evaluate the impact. This will include evaluating how the service reduces pressure in other systems. Within the current service families will be asked specifically what helped them to engage. This information will be used to shape future leaflets and videos promoting the service. The drive to be as inclusive as possible continues and there will be a more concerted effort to reach out to dads, transgender people, people in same sex relationships, people who have experienced loss and those who are struggling pre-conception. Part of this will involve re-working our promotional materials, talking to professionals about the referrals they make and co-creating activities and interventions that meet the needs of people currently underrepresented.

After the success of the 'stay and play' and 'peer support' groups more will be planned, and a regular slot at the GPs clinical meeting will be offered to discuss the work of the Together Service and how the team can best collaborate to support the families.

Summary

In a stretched NHS system, a clinical psychology-led infant-parent service based in primary-care appears to be a good use of resources. It benefits families, staff within GPs and wider communities. By being placed in neighbourhoods of high deprivation and reaching out to the community, people with the greatest need are able to access, make use of and contribute to the development of interventions that really make a difference for babies, families and mental health.

About the Shared Health Foundation

Shared Health Foundation is a not-for-profit organisation working to reduce the impact poverty has on health. We are led by clinicians whose expertise and experience of best practice informs the development of our projects.

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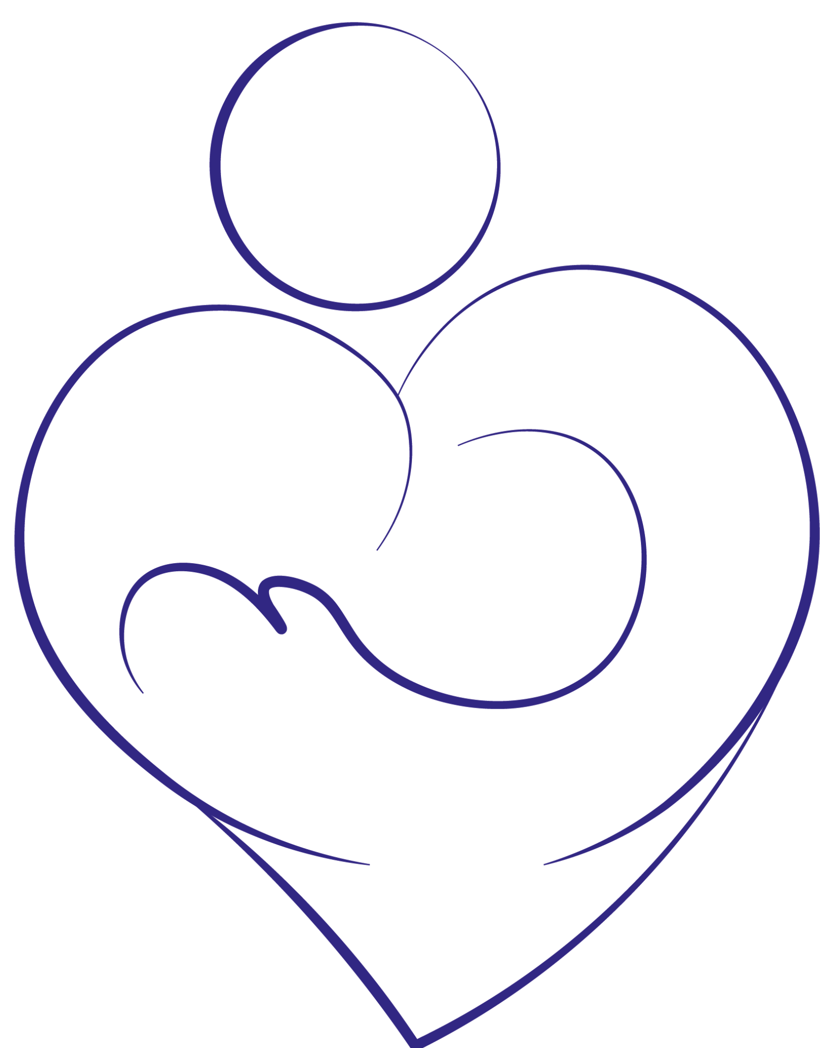

THE TOGETHER SERVICE

The Together Service was developed by Dr Jen Davies, Clinical Psychologist, in collaboration with the families who access the service and placement trainees.

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