MINDING THE BABY

QUALITATIVE FINDINGS ON IMPLEMENTATION FROM THE FIRST UK SERVICE

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May 2017
Impact and Evidence series

This report is part of the NSPCC’s Impact and Evidence series, which presents the findings of the Society’s research into its services and interventions. Many of the reports are produced by the NSPCC’s Evaluation department, but some are written by other organisations commissioned by the Society to carry out research on its behalf. The aim of the series is to contribute to the evidence base of what works in preventing cruelty to children and in reducing the harm it causes when abuse does happen.
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Summary

Minding the Baby® (MTB) is a preventative interdisciplinary parenting programme developed explicitly to promote secure parent–child attachment relationships. The programme was developed by Lois Sadler, Arietta Slade, Nancy Close and Linda Mayes through a collaboration between the Yale Child Study Center and the Yale School of Nursing, and has recently been delivered in three locations in the UK by the NSPCC. The UK project involves a two-stage implementation process, beginning with a pilot clinical service evaluated qualitatively, followed by a randomised controlled trial. This report summarises the findings from the qualitative evaluation of the first pilot cohort. The qualitative evaluation had two components, one focusing on practitioners’ experiences of using the MTB model, and the other on women’s experiences of receiving the service.

The study demonstrated both the value of the MTB programme for practitioners and parents, and the challenges and barriers that can hinder the translation of the model into practice. Practitioners underlined the central role the therapeutic relationship with mothers played for successfully engaging mothers in reflective work, reinforcing the mechanism of change as predicted by the model. Building trust between practitioners and parents was a key stepping stone to focusing on the baby. The success in building strong relationships with mothers was particularly impressive given the complexity of challenges faced by many mothers, including a history of attachment disruption and negative experiences of involvement by professionals.

Implementation of reflective work was affected by factors operating at multiple levels – including the immediate family, the family’s wider social context, local and national service factors and the wider cultural context. Sometimes, mothers struggled to think about their own mental states and those of their infant at times of crisis; practitioners’ emotional reactions to working with high-risk and high-need families sometimes interfered with their ability to hold a reflective stance, and organisational disagreements about risk sometimes disrupted the service’s ability to hold the family in mind.
These difficulties highlight the importance of creating systemic conditions that support reflective practice and supportive trusting working relationships under high-stress conditions, particularly where there are safeguarding concerns. Two factors appeared crucial in managing this: 1) The clinical-supervisory model was highly valued as it placed reflection and mentalisation at the core of supervision, and explicitly addressed practitioners’ emotional reactions to their work, leaving them feeling validated and connected with their support system and ‘held in mind’; 2) working closely in pairs with another practitioner helped contain anxiety, fostered a sense of support, reduced isolation, and improved clinical decision-making.

The feedback from parents about the programme was very positive, and suggested that engagement in MTB and the subsequent positive changes that they experienced were promoted by the individualised, flexible and collaborative nature of the programme. Building a sense of trust, openness, genuineness and understanding appeared to be vital ingredients in creating effective working partnerships between families and practitioners. Parents reported that the programme had helped with their self-confidence and wellbeing, and helped them manage their personal difficulties. It also helped them to develop their parenting skills and they enjoyed learning about child development and how to manage their child’s behaviour at different stages.

It is important to note that this report captured the views and experiences of practitioners and parents at a relatively early stage in the implementation of MTB in the UK and that with time the picture is likely to change. Furthermore, we were not able to obtain feedback from parents who disengaged from MTB, or who never engaged in the beginning, which means that the views of a very important group of parents are not represented in this report.
Introduction

Minding the Baby® (MTB) is a mentalisation-based preventative parenting programme that incorporates nurse home-visiting and infant–parent psychotherapy models, developed explicitly to promote secure parent–child attachment relationships through engaging and enhancing parental reflective functioning. The programme is targeted at disadvantaged families, where the mother is under 25 years old with additional and complex needs.

MTB is a relatively new programme, and research examining its efficacy is preliminary. The first wave of outcomes from a pilot-phase randomised controlled trial conducted in the US has demonstrated that MTB has positive effects on both health and attachment outcomes (Sadler et al, 2013). Following its initial implementation in the US, the NSPCC has worked in close collaboration with the Yale program developers and senior clinicians to implement MTB in three sites across the UK: York, Glasgow and Sheffield. This pilot UK implementation of MTB will last for five years, and will deliver two cohorts of families in each location.

The current report provides a summary of a qualitative study of the first cohort, and aims to promote learning regarding the key components of the MTB model, as realised in the UK context by the NSPCC. The focus of the study was to illuminate the following: 1) What elements of the programme effect change and produce better outcomes?; and 2) What are the challenges of implementation and barriers that can stand in the way of translating theory into practice?

Part One of the current qualitative study focuses on the challenges of translating theory into practice within the MTB model, from the perspective of the practitioners delivering the programme. Part Two focuses on engagement and the therapeutic processes of change from the perspective of the parents enrolled in the programme. The research specifically aims to address the following questions:

1. What promotes and hinders the engagement of high-risk families into the MTB model, and what are the challenges to sustaining this engagement?

2. What are the challenges of implementing the MTB model and applying reflective functioning theory in practice, and what facilitates the programme’s implementation?

3. What do parents perceive as facilitating or hindering their engagement with the programme?

4. What, if anything, do the parents see as having changed as a result of the programme and what has facilitated or hindered that change?
What is Minding the Baby?
An overview of programme elements and theory of change

MTB is grounded in both social ecology and attachment theories, with a particular emphasis on reflective functioning (Sadler et al., 2013; Slade, 2002, 2006). Attachment-based early preventative interventions have been demonstrated to be effective in enhancing both parental sensitivity and infant attachment security (Bakermans-Kranenburg et al., 2003). However, Slade (2006) argues that the success of many of these interventions derives in large part from changes in parental reflective functioning that arise as a by-product of focusing on the parent–child relationship. This enhanced reflectiveness, in turn, promotes the parent’s sensitive attunement to the child, and crucially, increases the likelihood of the child’s attachment security. Research suggests that disorganised attachment in particular is more prevalent in children experiencing multiple adversities (Carlson, 1998; Madigan et al., 2006; van IJzendoorn et al., 1999) and that insecure and disorganised attachments are associated with poorer social competence and higher rates of emotional and behavioural problems (Sroufe, 2005). Thus, the quality of parenting and the security of the mother–infant attachment relationship are an important set of early developmental processes through which social adversity may impact on child development.

There is considerable evidence that the early security of a child’s attachment is associated with a parent’s reflective functioning capacity (Fonagy et al., 1995; Slade et al., 2005). Reflective functioning describes the ability to understand that one’s own or others’ mental states influence one’s own or others’ behaviour (Fonagy et al., 2002). Several studies have indicated that parental reflective function influences parental sensitivity, which is essential in the development of a secure attachment (Slade et al., 2005; Fonagy et al., 2002; Fonagy & Target, 1997; Rosenblum et al., 2008; Slade, 2005; van IJzendoorn, 1995). Parents from disadvantaged backgrounds are more likely to have limited reflective functioning, due to their own troubled attachment experiences (Fonagy et al., 2002; Slade, 2006). It has, therefore, been argued that parenting programmes focusing on improving reflective functioning may improve the quality of attachment and facilitate children’s social and emotional development (Slade, 2006).
Until recently, home visiting programmes, which are effective in engaging and facilitating change in complex families (Heinicke et al, 1999; Kitzman et al, 2010; Lieberman et al, 1999; Olds et al, 2010), have not explicitly concentrated on the development of reflective capacity. They have also tended to focus on physical health or attachment, but not both (for example, Nurse Family Partnership, Olds et al, 2007; Infant parent psychotherapy, Lieberman et al, 1999). However, Slade and colleagues (Sadler et al, 2006; Sadler et al, 2013; Slade, 2002, 2006) have recently developed a home visiting programme, Minding the Baby® (MTB), designed to promote parental reflective functioning and secure attachment, while also addressing the family’s physical and mental health needs.

MTB is targeted at young mothers from disadvantaged backgrounds experiencing social adversity. It was developed in an inner-city community in the US and is implemented by paediatric nurse practitioners (NP) and clinical social workers (CSW). A pair of practitioners, one with a health training (a nurse or health visitor) and one with a social work training, begins visiting the mother in her third trimester of pregnancy and they provide regular home visits and other support (such as via telephone) from then until the baby is two years old. The practitioners support the mothers’ reflective parenting, promote the attachment relationship between the mother and infant, and promote development of parenting skills (Sadler et al, 2013).

The practitioners use various methods for supporting the development of reflective capacity, such as modelling a reflective stance during visits (for example, curiosity about the child’s and parent’s state of mind) and facilitating activities during which practitioners can narrate some of the feelings being experienced by both mother and infant (Sadler et al, 2013). They also have other roles (both distinct and overlapping) including providing: health education; advice on child development; various therapeutic approaches dependent on their assessment of the mother’s and child’s needs; and help with any legal or court issues (Sadler et al, 2013). These practitioners work closely with other professional involved in the family’s care, from mid-pregnancy until the child’s second birthday.
Results of the qualitative evaluation of Minding the Baby

Method

Prior to detailing the findings of the study, we begin by explaining the methods that were used and provide an overview of the circumstances and characteristics of those taking part in order for the findings to be understood in an appropriate context.

Participants

Part One: All practitioners who were delivering MTB across the three UK sites were invited to take part in the study. There was the equivalent of four full time practitioners at each site. In several of the sites, there were a number of part-time staff, resulting in a total of 18 members of staff altogether. Four practitioners left their posts before being invited to participate in the research. Therefore, a total of 14 practitioners were invited, all of whom subsequently agreed to participate. One practitioner was not able to attend the scheduled interview due to a crisis with one of her families, resulting in a total of 13 practitioners interviewed.

Part Two: Parents were recruited from the three MTB UK pilot sites through their MTB practitioners. Sixteen mothers and three fathers participated. These parents had been enrolled in the programme for an average of 21 months (range = 16 to 26 months).

The mothers ranged in age from 17 to 23 years (M=21; SD=2) and their babies ranged in age from 9 to 19 months old (M=14; SD=3). Two of the three fathers involved were aged 21 and the third was 23 years old. All of the participants described their ethnicity as White British. Eleven were co-habiting, and two of the couples had additional children (the fathers’ children) who lived with the couple some of the time. Of the remaining five, two mothers were married and the other three were living alone with their baby and described themselves as single. Eleven of the mothers and all three fathers had GCSE level qualifications; three of the mothers had attended some secondary school but had not achieved GCSE level or any other academic qualifications. Two mothers were currently in college. All participants were unemployed at the time of the interview apart from one father.
It is important to note that although the parents who participated were diverse in some ways, they also lacked diversity in potentially important areas, such as their ethnicity and level of engagement in the programme (for example, all of the participants were generally engaged in the programme). In addition, participants were recruited from the first cohort of parents taking part in the MTB pilot. This first cohort seemed to have high need and significant input from social services; however, it is likely that the second cohort will be more balanced in terms of their level of need and involvement with social services.

Procedure

Part One: MTB is delivered three months prior to the child’s birth and continues until the infant is two years old. In order to capture the challenges of implementing the model with mothers as they navigate the different developmental tasks across this age range, as well as capturing the challenges of delivering the programme at different intensities (for example, weekly compared with fortnightly visits) and while undertaking different therapeutic tasks (for example, engagement through to endings), practitioners were interviewed when they were at different stages across the programme. They were sent an email containing information about the project, and were invited to contact the researcher if they wished to participate. Interested practitioners were contacted via telephone or email and were given further information on the study. A time to conduct the research interview was also arranged. All interviews were conducted at NSPCC offices. Participants were assured that the research team was independent from their employers (the NSPCC), and that the NSPCC would not have access to any of the interview recordings or transcripts. Furthermore, participants were informed that if they were worried that they could be identified by the information they provided, they could request that sections of the interview be excluded from the analysis.

Part Two: Parents were invited to take part in the study by their practitioners. Although deemed to be the most appropriate method of recruitment, recruiting through practitioners is likely to have had impact on the diversity of the participants (for example, as mentioned above, the participants were generally engaged in the programme).
Those parents who expressed an interest in participating were contacted by telephone by the researcher, in order to discuss the research further, confirm the parents’ wish to participate and arrange a day and time to carry out the interview. Written consent was obtained before the interview began and parents were assured of confidentiality and reminded that the interviewer was independent of the NSPCC who ran the MTB programme. A debriefing period was included at the end of each interview to discuss how participants felt about the interview and any strong emotions elicited.

Interviews

Semi-structured interview schedules were developed specifically for this study based on established guidelines (Smith, 1995).

Part One (Practitioners): The interview consisted of four broad areas of questions: (1) practitioners’ experiences of engaging families; (2) maintaining relationships with families; (3) applying reflective functioning theory in practice; and (4) supervision. Practitioners were encouraged to elaborate and give specific examples throughout, and to describe the context for any challenges they encountered. Interviews lasted for approximately two hours and were audio-recorded.

Part Two (Parents): The interview schedule focused on four broad areas of questions: (1) parents’ views of their engagement in the program and what hindered or facilitated this; (2) parents’ relationships with their practitioners and what hindered or facilitated these; (3) parents’ relationship with each of their practitioners; and (4) parents’ views of programme outcomes. Prompts and follow-up questions were used to enable elaboration of participants’ experiences or views. Interviews were conducted in the parents’ homes. The interviews with each mother (or couple) lasted approximately 40 minutes (range: 20–76 minutes) and were audio-recorded. In all three cases where a father was involved in the interview, the mother and father were interviewed together.
Qualitative analysis

Verbatim transcripts of the interviews were analysed thematically (Braun & Clarke, 2006). Thematic analysis is a flexible approach to qualitative analysis that aims to identify key ideas or patterns within the data: to describe complex data sets in terms of the central themes and was conducted in an iterative fashion. The first phase of analysis, “familiarisation”, involved reading each transcript and listening to a selection of the recordings in order to become immersed in the data. Key ideas and recurrent themes were then noted down. Following this, a subset of transcripts was selected on the basis that they provided the richest and fullest accounts. These transcripts were examined in detail, and key ideas were identified and noted.

During the second phase of analysis, a summary list of the key ideas identified in each of the initial set of transcripts was produced. These summaries were then compared and contrasted, and similar ideas and topics of interest were grouped together into initial themes, and these were rechecked against the raw interview material.

Following this, the remaining transcripts were examined against these initial themes. Again, key ideas were recorded, and the initial list of themes was edited, adjusted and added to accordingly.

The next phase of analysis involved grouping the initial themes into potential domains in order to provide an organising thematic framework. Each transcript was then revisited a final time to ensure that the proposed themes and domains were evident in individual accounts, and to collate illustrative quotations to provide evidence for each theme.

This final examination of each transcript also allowed each theme to be further refined, and to ensure that relevant contradictions, nuances and exceptions were captured. In the case of the interviews with parents, respondent validation was also used (Pope & Mays, 2000). This involved a one-page, shortened summary of the themes and subthemes being sent to all of the participants. They were invited to provide their feedback on the accuracy of the themes; four participants replied and all of them were happy with the summary.
Results

Part One: Practitioners

The analysis generated nine categories of themes, grouped into two domains: “The challenges of translating theory into practice” and “The essential components” of the programme. The first domain concerns the barriers to implementation of the model, while the second domain reflects the components of MTB that practitioners identified as being crucial in building relationships with mothers and engaging them in reflective work.

Domain 1: The challenges of translating theory into practice

When practitioners spoke about the challenges they faced implementing this mentalisation-based model, it was clear that although some of the challenges lay in the immediate therapeutic context (for example, involving the mother and the MTB practitioner), the wider context within which the reflective work took place was also extremely important.

Challenges were identified at many different levels – from practitioners’ relationship with mothers, to the complex relationships between organisations. Figure 1 illustrates the different systems in which challenges were identified, drawing on Bronfenbrenner’s (1979) ecological-systems model as an organising framework.
Factors at each level came together and interacted to create challenges unique to each family. The importance of identifying and understanding the barriers to engagement for each mother, given her individual circumstances and presentation, was described as essential in formulating how to intervene. Table 1 summarises the categories and themes in this domain.
Table 1: Categories and themes in Part One: Practitioners – Domain 1: The challenges of translating theory into practice

<table>
<thead>
<tr>
<th>Category</th>
<th>Themes and sub-themes</th>
</tr>
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<tbody>
<tr>
<td>1.1 Mothers</td>
<td>1.1.1 Mothers’ own unique histories brings challenges</td>
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<tr>
<td></td>
<td>Previous relationship history: trauma, neglect and abuse</td>
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<tr>
<td></td>
<td>Mothers’ attachment style</td>
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<td></td>
<td>Previous experience of professionals</td>
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<td></td>
<td>1.1.2 Mothers’ motivations for engaging in Minding the Baby</td>
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<td></td>
<td>1.1.3 Minding the Baby is not for everyone</td>
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<tr>
<td>1.2 Family context</td>
<td>1.2.1 Grandmothers</td>
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<td></td>
<td>1.2.2 Fathers</td>
</tr>
<tr>
<td>1.3 The environment</td>
<td>1.3.1 The physical environment</td>
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<td></td>
<td>1.3.2 Crises and chaos</td>
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<tr>
<td>1.4 MTB practitioners</td>
<td>1.4.1 Anxiety about getting reflective functioning right</td>
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<td></td>
<td>1.4.2 Emotional impact of the work</td>
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<td></td>
<td>1.4.3 Vague boundaries of the role</td>
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<td>1.5 Organisational level</td>
<td>1.5.1 Internal systems and requirements can shut down reflection</td>
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<td></td>
<td>Internal reporting systems</td>
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<td></td>
<td>Supervision</td>
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<td></td>
<td>Technology and resources</td>
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<td></td>
<td>1.5.2 Social care involvement</td>
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<td></td>
<td>Shuts down mothers’ ability to be open and to reflect</td>
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<td></td>
<td>Challenges the voluntary nature of the programme</td>
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<td></td>
<td>Raises “ethical” concerns for practitioners</td>
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<td>1.6 Wider culture</td>
<td>1.6.1 Common attitudes</td>
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<td></td>
<td>1.6.2 Cultural perception of agencies</td>
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In the sections below, each of the themes identified in the practitioners’ narratives is described in detail.
1.1 Mothers

The mothers enrolled in MTB often presented with complex needs and difficulties, which frequently created challenges to reflective work. In particular, mothers’ relationship and attachment histories, and their motivations for engaging in the programme, were described by practitioners as being important factors to consider when working with mothers, and were also important potential barriers to effective intervention. In addition, cases where mothers had significant difficulties engaging in reflective work led practitioners to wonder whether MTB was suitable for everyone.

Theme 1.1.1 Mothers’ own unique history brings challenges

“We’ve had a few girls who have grown up in care, who have had all sorts of abuses happen and they don’t have family support…a number of them, I think, have been so traumatised and so damaged that they’re not…able to think about things…They’re just not there and they’re so hurt and so defended that to even open up that little space would be so painful for them that they’re just not able to.”

Each mother’s unique history created a range of challenges in implementing MTB. Many practitioners spoke in terms of continuums, explaining that the mothers they were working with often fell at the extreme ends of various ranges, such as their level of “avoidance” or “dependence”, all of which influenced their ability to trust others, form relationships and tolerate attention as well as impacting on their capacity to reflect. Practitioners saw mothers’ abilities in these areas as related to their experience of being in relationships with others in the past. Previous relationships with professionals, and mothers’ attachment and relationship histories were seen as being particularly important.

By the very nature of the inclusion criteria for MTB, the majority of the mothers had previously experienced maltreatment while growing up. Practitioners described many mothers as having “horrible histories”, and having experienced severe neglect and abuse. Mothers’ histories had a great impact on practitioners’ efforts to engage them in reflective work. Indeed, they noted that it often felt as if mothers’ heads were “so full of their own history and experiences” that there was just “no room” for anything else. Similarly, previous experiences of abusive or neglectful others resulted in mothers experiencing practitioners’ attempts to form a caring relationship as “intrusive” and “threatening”.
Moreover, practitioners discussed the ways mothers’ attachment styles, in particular “avoidant mums” posed further challenges; these mothers found any direct attempts to encourage reflection about their feelings intolerable and often withdrew or avoided any such conversations. Although working with “avoidant mums” was the predominant challenge discussed by practitioners, some also acknowledged that working with “pre-occupied” mothers created other difficulties as they often inundated practitioners with demands, and required so much support that it was often “impossible” to get to any reflective work.

Finally, many of the mothers enrolled in MTB had “long histories” of being involved with services. Practitioners explained that for these mothers, the common narrative about professionals was often a negative one. Furthermore, it was noted that some of the mothers and their families (and often the wider community) shared a “mistrust” of professionals; practitioners explained that there was often a family story about professionals “interfering” and being “out to steal your children”.

Theme 1.1.2  Mothers’ motivations for engaging in MTB

“It is a really intense programme…and it’s a massive commitment…I think they’ve really got to want to do it, they’ve got to see the benefit to it. And I think for those girls, they are the ones that really go for it and open up and trust you, and form a really good relationship with you.”

Practitioners described a great deal of variation in mothers’ level of motivation to engage in MTB. This greatly impacted mothers’ ability to open up and form a relationship with MTB clinicians. Practitioners noticed a difference between the mothers who “really wanted it” and were committed to the full aims of the programme and had a desire to reflect, and those who had signed up for other reasons (such as pressure from social care, or a desire for practical support). They noted that mothers really needed to be committed to the programme and to want a “better life for themselves and their babies”. These were the mothers who would “really go for it” and “form a really good relationship” with practitioners.

Practitioners also acknowledged that it was very hard for some mothers to imagine something better, largely because of their own histories and current circumstances. This made doing any reflective work difficult. Practitioners recognised that for some families, they had ‘sold’ the programme as something that would provide practical help and promote child development, and did not explicitly discuss
the level of therapeutic work or extent to which mothers’ own histories and experiences would be explored. This raised the question of whether this had led some families to disengage when their own experiences were explored, as this was not what they had expected or signed up for.

**Theme 1.1.3 MTB is not for everyone**

“I don’t think the girls are able to do it [reflective functioning], the majority of them just can’t. I think there are a lot of girls who are really, really traumatised from their own past…a lot of them have been in the care system and they’ve had all sorts of abuse in their backgrounds and they just don’t know how to talk about it or to think about it, and they close down any conversation…I suppose my feelings are that it doesn’t work with your very traumatised mums…who just don’t seem to be able to open any semblance of that little way in.”

Practitioners questioned whether MTB was suitable for all of the mothers they were working with, as they saw considerable variation in the level of mothers’ reflective capacities and their ability to think about their own experiences and those of their child. Practitioners felt that many of their mothers had notably low reflective functioning at the start of the programme, and for a subset of these mothers, capacities for reflection were “non-existent.” These mothers were described as having had “so much trauma in their lives” that they were either not able to tolerate any reflectiveness, or simply did not have the capacity to do so.

Many practitioners felt that in these cases they had seen little improvement over the course of the intervention, and wondered whether they were effecting any change – there was the sense that they were “asking [mothers] to do the impossible”. Practitioners felt that these mothers were able to engage with many aspects of the practical and emotional support offered, but were not able to access the central mentalisation component of the intervention. This led many practitioners to conclude that MTB might not be suitable for these mothers.
1.2 Family context

Practitioners spoke in detail about how mothers were often very isolated, with very few sources of social support. Many of the mothers enrolled in the programme did not have contact with their families, a significant number having been taken into care as children. Those who did have contact often had difficult relationships as a consequence of their experiences growing up. Family relationships – notably with maternal grandmothers and the father of the baby – had dramatically different impacts on the programme in different families. Sometimes, these relationships were identified as a great source of support, which acted to foster mothers’ reflective capacities and enhance mothers’ ability to open up – giving them “permission to talk”. However, family relationships were sometimes described as being a significant barrier to MTB, hindering mothers’ ability to engage in the programme.

Theme 1.2.1 Grandmothers

“I think that some of the girls that we’ve had and we’ve lost, it’s been down to their mothers (the grandmothers)...[if you think about] the backgrounds of these young girls, and [then think of] their mothers’ experiences...because they had their children young, and it hasn’t been great...and then when we come in they see us...They put us in there. It’s, like, ghosts in the nursery, you know. They see their experiences again and they think that’s what’s going to happen.”

Many grandmothers were described as suspicious of MTB and of any involvement with social workers, and as such often discouraged their daughters from engaging in the programme. It was noted that due to the young age and level of vulnerability of many of the mothers, the opinions of their parents had a considerable influence on their decision-making. One practitioner in particular noted the importance of needing to not just consider the mother’s history, but also her family’s history, when trying to formulate barriers to engagement. Often, grandmothers had very difficult experiences of parenting their own children, many received social care involvement, and many had had children removed. As a result, these “ghosts in the nursery” continued to have influence on MTB participation, as grandparents often brought their own worries and beliefs about professionals and about parenting, which significantly impacted their daughters’ views.
Theme 1.2.2 Fathers

“Certainly here in this city, dads are co-parenting [and] doing all the same tasks as mums in terms of baby care, which brings potentially some risk issues if there are risk issues around dads. But also brings, you know, some real strengths and benefits and can blend some of the difficulties that mums may have because they bring another dynamic.”

Many mothers were in relationships, often co-habiting, with the fathers of their babies. This meant that fathers often played a significant role in caring for the babies, and were described as “equally as good, and equally as challenging” as the mothers enrolled in the programme. Several practitioners spoke about working jointly with both parents, feeling that MTB could not exclusively be for mothers. However, other practitioners spoke about having to carefully negotiate boundaries, and feeling the tension between not wanting to exclude fathers, while being mindful that the programme was principally for mothers.

Many advantages of fathers being involved were noted. In particular, practitioners explained that “some of the dads have more capacity to do mentalisation and reflective functioning than [the] mums”, suggesting that fathers’ abilities and confidence often helped to scaffold mothers’ skills. Similarly, fathers often circumvented other challenges – for example, for very “avoidant” mothers, having another person present often took the focus of attention away from them and lessened the intensity of the interaction. It also enabled practitioners to “model” reflectiveness with fathers, while not placing any pressure on mothers to respond.

Fathers also brought challenges, and some were described as being “obstructive”, and of having “no interest” in the programme. They often seemed scared of being judged and suspicious of professionals, leading them to – like mothers – struggle with engagement. A major challenge of fathers’ involvement within MTB was the risk they could bring. It simply was not safe for mothers to “think or speak freely” or reflect on their feelings when domestic violence was ongoing, or suspected. In cases of suspected domestic violence, practitioners also found it difficult to hold on to their own reflective stance as they felt they were always looking out for risk.
1.3 The environment

The physical environment families were living in, alongside the interaction of many factors within those environments (such as crises involving finances or housing), were identified as the source of many challenges when trying to deliver the programme.

Theme 1.3.1 The physical environment

“Recognising that the mums need to be in a certain state of mind before they can be reflective...if they’re sitting worrying because they don’t have any heating, and they are cold...to try then to engage them into a meaningful discussion to develop some mentalisation isn’t going to work.”

The environments that some of the mothers lived in were described by practitioners as “oppressive” and “neglected”, “dark and depressing”. Naturally, this could be a significant barrier to initially engaging families, as mothers were often reluctant to let any professional through the front door. The home environment often seemed to have a significant impact on mothers’ mood, with one practitioner explaining that it was “hard to have many feelings beyond depression when you’re there.”

Another practitioner explained that for several of her mothers with low mood, the environment often “mirrors their mind”. The home environment was also described as having a significant impact on mothers’ reflective capacity: mothers had to shut their mind off to “avoid the horribleness” of their situation. Changing the environment (for example, taking the mother out to a cafe or play centre) often uncovered previously hidden reflective abilities, sometimes to the surprise of those working with them.

Theme 1.3.2 Crises and chaos

“I think if people are in crisis, particularly around housing, it's very difficult to do this work. You could say that is the work, but if people are in such an anxious state about housing, about money...I wonder if they can do the depth of work that’s needed because...those things are basics aren't they really? And maybe we're wanting them to go much deeper around thinking about their baby, you know, the basics being in place that they have got a roof over their head, and I think the other basics about food and money is pretty significant, or heating. If our work is about helping the relationship, there's got to be room for it.”
Practitioners described often finding a “massive mess to unpick” each time they visited families; issues with housing, benefits, finances and relationships were “relentless”, leading practitioners to feel that they were “fire-fighting” and solving crisis after crisis. Many practitioners said that this often shut down the possibility of working towards developing maternal reflective functioning, explaining that “you can’t really just get your manual out and start looking at reflective functioning [when a family is about to get evicted]”.

However, not all practitioners agreed that the chaos was a barrier to doing reflective work – some felt that crises could be key in getting to reflective functioning as it led to more natural conversations about mothers’ feelings and worries, and encouraged wondering about babies’ experience of what was happening.

1.4 MTB practitioners

Practitioners also spoke about having ‘hangovers’ from previous roles, explaining that it could be difficult to let go of the way they had previously done things and to give up their previous professional identities and responsibilities. They spoke about the impact the MTB role had on them, both personally and professionally, and reflected on the impact this, in turn, had on the way they were able to work with families.

Theme 1.4.1 Anxiety about getting reflective functioning right

“...I think sometimes it’s made me think ‘Do I know what I’m doing? Am I doing it?’ I think on a certain level, at first, it can be quite deskilling.”

Learning about reflective functioning was described by some practitioners as putting “new language” to existing skills. However, other practitioners described it as being an entirely new experience. Considerable anxiety was expressed about whether they were “doing it right”. Practitioners sometimes became so “preoccupied” by this anxiety that they were unable to think clearly. By reflecting internally about mothers’ experiences and wondering about how everything they said and did was going to be received, practitioners could feel “paralyse[d]” and “frozen” in the moment. However, once they had learnt to stop trying so hard and to “tune in to” their own feelings to guide interactions, the reflective stance came more naturally. Practitioners also realised that their fears about “doing RF right” were often mirrored in the organisation; they explained that since this was the first time MTB was being implemented in the UK, the NSPCC were also anxious about getting it correct and “impressing” the programme’s developers.
Theme 1.4.2 Emotional impact of the work

“I’ve never had my head so full of people before, where you take them home with you. You can’t switch off…you’re really, just holding so much, horrible difficult information, and really feeling that for a lot of our girls that they haven’t got anyone else really, we are their main source of support and the first place they turn to if they have problems, and that’s really hard. That’s hard to, it’s just hard to have that responsibility sometimes, it’s intense.”

Working with traumatised, isolated families living in poverty could often be a very emotional and difficult experience for practitioners, especially given the intense nature of the relationships they had built with many of the mothers. They spoke about knowing that they (alongside their paired practitioner) were at times the only people in these mothers’ lives, leading to feelings of sadness and a sense of “overwhelming” responsibility. Some practitioners found it very difficult to switch off from work, feeling that they were always “carrying” their families with them. The emotional impact intensified in instances when the programme was not going well. At these times they sometimes felt like a personal and professional “failure”, taking considerable responsibility when parents were not progressing in the programme. These cases were described as “overwhelming”, leaving practitioners feeling “depressed and disheartened”.

Theme 1.4.3 Vague boundaries of the role

“I feel I’m just never sure where my work ends. There are so many things that I can do that sometimes I feel absolutely quite scattered really, I mean, from re-homing a cat just, you know that was causing havoc, to taking somebody to housing…getting somebody some carpet…looking at furniture, trying to find some funding for them to get a washing machine, a fridge, freezer. Just the breadth of work is quite big really in practical ways…”

Practitioners’ roles often felt vague and undefined. They explained that because there were such high levels of need in the families they were working with, it sometimes felt like the practical tasks were endless, risking the reflective work of MTB being entirely missed. Disagreements between different managers and supervisors regarding the scope of the role were also described – where some managers or supervisors encouraged practitioners to help mothers with a wide range of practical tasks in order to facilitate engagement, others encouraged practitioners to be more boundaried in their approach. These different recommendations often left practitioners confused about their responsibilities.
The undefined role was also said to impact their relationships with other professionals. Some practitioners described feeling “powerless”, explaining that their concerns and opinions were “not taken seriously” or “valued” because no one (including themselves) really knew what it was that they did, what they provided, or what their remit was. However, practitioners also spoke about the benefits of having a less defined role, as it afforded them the flexibility to be present with mothers and “be whatever they need” them to be. This was seen as very useful when engaging families.

1.5 Organisational level

Because MTB was situated between and within agencies with divergent aims and responsibilities (for example, NSPCC, Social Care), practitioners experienced tensions between these organisations. One particular tension was in regards to risk. Whereas practitioners felt that MTB was designed to hold the risk and work to reduce it, they felt the NSPCC was quick to communicate concerns to statutory agencies. For practitioners, this could often damage relationships with mothers and make it harder to effectively work with the risk. A lack of integration between agencies and management structures with regards to managing risk created a very difficult context for practitioners to work in.

Although positive working relationships with other organisations had been built in many instances, when there were disagreements about roles and responsibilities – particularly around risk assessment and management – practitioners experienced a battle between organisations. As a result, it sometimes felt that the experience of mothers and babies were forgotten about while organisations debated processes.

Theme 1.5.1 Internal systems and requirements can shut down reflection

“[It] absolutely [has an impact on the way I work] and I don’t even think it’s subtle. I think that because I’m so conscious about what I need to write on my recording, I sometimes think within my sessions about how I’m going to record certain things rather than just enjoying the moment of being in the session and, therefore, losing probably some of the reflectiveness because I’m not probably as focused…I don’t think it’s subtle, I think it’s like a brick, in some instances, that that recording is always in the back of your mind…”
Practitioners spoke very positively about the organisation they worked for and their managers; however, they also acknowledged that some of the structures within the organisation were in conflict with the ethos of MTB at times. This had an impact on practitioners’ work with families and their ability to sustain a reflective stance. In particular, reporting and recording policies and the volume of supervision were seen as particularly challenging, alongside issues with access to technology and resources.

Significant issues were raised regarding the level of bureaucracy, as practitioners felt that there was a conflict between certain “stringent” organisational policies and procedures and the “flexibility” of the MTB program. Although it was widely acknowledged that recording was vital, especially around safeguarding, there was a sense that the level and type of recording was not helpful to practitioners, rather it was there to enable their manager to monitor their work.

Practitioners reported that they felt “scrutinised”, “judged”, and “over-monitored”. The level of bureaucracy significantly impacted the way in which practitioners worked with families; for example, several practitioners explained that at times in sessions they became aware that they were going through mental checklists of how they were going to record certain information rather than being present in the moment. The level of reporting also left them with little time to reflect, and no “space in [their] head to think”. Practitioners described struggling to hold their families in mind, as instead of reflecting on the content and quality of a session, they were rushing back to the office to record the factual events of the session.

Nearly all practitioners expressed the view that the quantity of supervision was overwhelming. At times, this led some practitioners to feel “deskilled” with “little room for autonomy”. Practitioners also voiced concerns that repeating mothers’ stories and their own experience of mothers so frequently detracted from them being “real” with mothers in the moment, explaining that it ended up feeling like a rehearsed script.

There were mixed views regarding group supervision, with some practitioners speaking very positively about the experience, while others reflected that their head felt “too full of [their] own cases to hear about other people’s”. Interestingly, the language used to explain what this felt like (such as “my head is too full”, “no room for reflection”, “I just switch off”) was very similar to the language used by practitioners when explaining what it was like for mothers who were asked to reflect at a time when they were unable to do so.
Practitioners also explained that some types of supervision were more helpful than others. There was a sense that the most useful supervisions were those in which practitioners felt they had a strong relationship with their supervisor and felt safe to share their experiences and talk deeply about cases – where they felt “held in mind”, while supervision that was less focused on the relationship was sometimes described to feel more like a “tick-box” exercise.

Finally, several practitioners described that not having access to suitable working technology or resources (such as for video work) meant that they were not able to provide MTB according to the manual. The stress of trying to get technology to work often led practitioners to become engrossed and preoccupied by the technical difficulties, thus reducing their ability to be present or reflect in the moment.

**Theme 1.5.2 Social care involvement**

“You’re asking people to be open and sometimes they’ll have some negative thoughts… sometimes they’ll get really fed up with their baby…but how open can they be when they know that you are going to be going back to a case conference or core group and giving an update? It probably perpetuates a feeling that at any time a child could be removed, so how open can they be about sharing? They’ve got to have a distance emotionally in their relationship that they’ve got with the child. How reflective can they be if that’s what they’re having to do?"

Statutory child welfare services (social care) were often involved with many of the families that practitioners were working with, and the significant challenges this brought were frequently detailed.

Practitioners felt that social care involvement often shut down openness, as the safe space that had been created for reflection became a potential source of judgement for mothers. Practitioners noted the tension between the aims of MTB and mothers’ beliefs about social care involvement. MTB aimed to encourage mothers to reflect on their feelings and experience.

However, if mothers felt judged or believed their child was going to be taken away from them, they were less able to be open, particularly about times they were finding difficult (despite the normalcy of these feelings). Many believed that anything they said would be shared with social care. Practitioners wondered whether the threat of losing their child made thinking about their own feelings and those of their child too threatening, resulting in many mothers “shutting off”.
Social care teams were often involved with families at the point of enrolment in MTB, and in many cases were the referrer; practitioners detailed numerous instances when participation in MTB was included on child protection plans prior to birth.

Practitioners suspected that this led many mothers to feel that participation in MTB was mandatory or at least necessary in order to keep social services “off their back”, and as such were often not fully signed up to the aims of the programme. These mothers’ engagement was said to feel more “superficial”, and practitioners described them as being “guarded” towards professionals, thus preventing them from building meaningful therapeutic relationships.

Because practitioners spent considerable time with families and developed trusting and strong relationships with mothers, they were often in the unique position of being privy to identify safeguarding issues. They encouraged mothers to discuss potential concerns, that might otherwise have gone unnoticed, such as domestic violence. Practitioners explained that this created an “ethical” tension; they spent considerable time trying to build trust so that mothers felt safe to open up, but at the same time knew that if they were successful in doing so, they might then have to break that trust if concerns were identified. As a result, mothers could often feel betrayed and let down.

Practitioners also explained that once a safeguarding concern had been raised, they were often recruited to assist with parenting assessments by social care, which entirely changed the essence of their role and often led mothers to become very suspicious, believing practitioners were “spying” for social workers.

Practitioners reflected that their relationship with mothers was key in overcoming these challenges: if they had managed to develop a strong and trusting relationship with families, mothers could hear and recognise their concerns more readily. In addition, wondering with mothers about what it must be like for them to have social care and MTB involved in a really open and honest way was being extremely valuable.

1.6 Wider culture

Practitioners acknowledged that attitudes and beliefs commonly held within the wider community often had a significant impact on both the families they were working with, and the therapeutic work they were doing.
Theme 1.6.1 Common attitudes

“And I think culturally, where we are, it’s quite a harsh environment, where the general communication tends to be much more negative, people struggle to name anything positive about themselves or others. And that’s very much [what it’s like here], we don’t tend to say positives. The terms of endearment are negative, and I don’t know if that’s the case across other parts of the UK, but it’s certainly the case here. So here, where you’re trying to feedback positives, even when the feelings are more hopeful and positive, they can still be portrayed as being more negative.”

Practitioners explained that it was unusual for people in the communities they were working in to speak in positive terms. As a result, encouraging mothers to be positive in their interactions with their babies was very unfamiliar and did not fit with mothers’ experiences.

Similarly, practitioners felt that the culture in which their families lived did not promote thinking about feelings: this was not valued, and was probably discouraged by both their families and the wider community. Again, this had a significant impact on mothers’ ability and willingness to reflect, and also meant that any positive changes that were achieved were likely to be challenged by others.

Theme 1.6.2 Cultural perception of agencies

“The perception, or the image could be that you get involved in cases that people talk about child cruelty. So the perception often can be that actually you’re assuming they have the potential to be cruel to their child, rather than you coming from the assumption about they could be a good parent and you want to help them be a better parent.”

Many practitioners spoke about the public’s perception of the NSPCC, and noted the impact that national advertising campaigns had on beliefs that the NSPCC targets families who abuse their children, which was in contrast to the aims of the preventative nature of MTB. This belief was felt to be commonly held by mothers, and many other members of their communities. The stigma of NSPCC involvement was thought to have prevented some families from engaging with the programme.
Domain 2: The essential components

Practitioners felt that the actual nature of the reflective work involved with “minding the babies” was not problematic; rather, the challenges centred around getting to a point where that work was possible. They identified several essential components of MTB that enabled them to engage mothers and facilitate reflective work. These are summarised in Table 2 below.

Table 2: Categories and themes in Part One: Practitioners – Domain 2: The essential components

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2.1 Relationships are key

“What we’re doing wouldn’t work if you didn’t have that relationship, you couldn’t go in and start talking about reflective functioning and their feelings and their emotions and their history if you didn’t have a really solid relationship with them, a trusting relationship, they just wouldn’t…”

Practitioners consistently explained that the most vital part of the programme was their relationships with the mothers; without a “solid foundation”, it was not possible to engage them in any reflective work. “Trust” and a feeling of relational “safety” were said to be necessary for mothers to feel able to begin to explore their own experiences, thoughts and feelings, and to contemplate those of their child.
**Theme 2.1.1 Importance of building relationships early**

“I think that once the baby is here, I think it’s much more difficult to go back. So, that initial assessment time, where you need to get to know them. If you go in and start probing and asking about their family history and their life line, in the first couple of visits, then you’re the social worker, and most of them have had social workers and other professionals and it’s not a new experience for them to do that kind of work.”

Practitioners spoke about the importance of having the time to build these relationships early in the programme: they had noticed that the “strongest” relationships they had with families were the ones where they had a long and gentle early engagement period. The opportunity to help with practical issues (such as housing), and make important improvements alongside being able to give mothers a positive sense of what a relationship with MTB practitioners would be like, helped to develop strong and trusting relationships.

Practitioners noticed a qualitative difference between the mothers they felt they had spent enough time with in the early engagement phase, and those who had been referred much later; the latter were felt to be more likely to disengage from the programme, and their relationships were described as more “superficial”, more focused on practical issues, and lacking trust. Without enough time in the early engagement phase, it became harder to go back and get to know mothers, which in turn made it harder to tailor the intervention to their individual needs.

Using a “gentle”, “paced”, “non-pressured” approach to early engagement was described to have a very positive impact on building early relationships with mothers. Practitioners described the importance of informing mothers that MTB was a voluntary programme, and then acting in a manner that reflected that: ensuring the approach taken was never “pushy”, empowered mothers to decide what they wanted for themselves and their baby. A flexible approach was identified as essential; as each mother needed something different during the early engagement period, it was important to be able to adapt the approach, such as its intensity, formality and directness.

The “solid [relational] foundation” achieved by such flexible and gentle engagement allowed practitioners to overcome other challenges as they arose throughout the programme; it enabled them to challenge mothers when needed, navigate difficult and often very painful conversations about mothers’ own histories, and discuss concerns and risks in a way that resulted in mothers being able to hear those concerns.
Theme 2.1.2 Giving mothers a different experience of relationships

“For a lot of young people it’s different to be asked what they think about something and how it makes them feel. I think for a lot of [our mums] don’t have a lot of experience of being asked that. Or feel anybody else is interested in how they feel, what they think.”

Despite the many barriers and challenges to building relationships, there were factors that allowed practitioners to forge meaningful connections with mothers and their families. For one, practitioners were providing mothers with a different experience of being with others. For instance, descriptions of the qualities of practitioners’ relationships with mothers were often contrasted with mothers’ previous experiences with both personal and professional relationships that had often been characterised by the absence of these qualities.

There were several recurring ideas about the relational qualities that practitioners felt were particularly relevant. Mothers often discussed with practitioners the importance of knowing that they would “keep coming back”, and “wont give up” on them. Practitioners spoke about the importance of understanding mothers’ attachment histories and recognising that it was likely these mothers would try to push others away. Many of the mothers they worked with often wanted to keep professionals “at arm’s length” and tried to “put them off”, frequently with great success. Practitioners described the importance of consistently being there for mothers and repairing relationships when ruptures or disengagements occurred, demonstrating to mothers that they were not going to give up on them.

Practitioners emphasised how important they felt the programme’s focus on reflective functioning was. Although practitioners explained that a “solid relationship” was necessary to engage mothers in reflective work, they also spoke about the central role reflective functioning played in building those relationships. “Wondering out loud” about mothers’ worries and fears and helping them to name their dilemmas or conflicts (for example, wanting to open up and talk, but being scared of what the practitioner might think or do) were described as especially important during the engagement phase.

Constantly reflecting about mothers’ experience and showing genuine interest and curiosity about what they thought and felt was described to foster “deep” relationships and give mothers an experience of being “valued”, “cared for”, and having someone “interested” in them.
This could be contrasted with examples of mothers’ experiences of more directive approaches regularly taken by professionals, which were explained to be focused on “instructing”, “teaching” or giving mothers information, often leading mothers to feel judged or powerless.

Theme 2.3.1 “My other half”: Paired practitioners’ working relationships

“I think a lot of our cases have been quite hectic, chaotic, difficult to be around, having another person that goes in there just as regularly as you do to see what you’re seeing and feel what you might be feeling is really useful. Because sometimes trying to articulate to somebody who’s not been in there, what it’s like, is difficult.”

Working closely with another professional was a very new way of working, and practitioners described the important benefits it brought. Many of these benefits were practical, such as the sharing of workloads. However, the “essential” part of working in a pair was described by nearly all of the practitioners to be about the relationship. They often referred to their pair as their “other half” and described the partnership as “invaluable” and as an essential “sounding board”, where both partners knew the family equally as well and could, therefore, offer meaningful insights into their challenges and strengths. This also afforded practitioners the opportunity to check out their feelings with someone who genuinely understood the context. Having a partner who really knew the family reduced the level of “uncertainty” or “unease” practitioners felt when trying to make sense of complex situations, which reduced anxiety and felt “containing”.

The level of “trust” practitioners had with their partner was emphasised, with practitioners explaining that it felt safe to reflect and ‘wonder’ about families within their partnership, and to share their own feelings and frustrations. Several practitioners spoke about how it sometimes felt that “other people don’t want to listen to how awful” some of the situations they encountered could be, but that their pair was always there to listen to their feelings and help make sense of them. This was described as very supportive, like their pair was “holding [them] in mind” and always tuned into how they might be feeling.
2.2 “Minding mums”

Practitioners explained that each family had their own set of unique strengths and challenges, and a “route to reflective functioning” needed to be formulated for each mother. Mentalisation was spoken about as being the core component of MTB that enabled this; practitioners explained that reflection was crucial when trying to engage mothers, build relationships and do the reflective work.

Theme 2.2.1 Keeping mothers in mind

“If you’ve guessed what’s going on in her head she knows you understand her...I think for her it makes her think, ‘Oh, they do understand how I feel and what’s going on’. And it also gives her permission, a lot of the times they speak and say what she thinks.”

Many examples of useful practice with regards to building relationships with mothers and engaging them in reflective work were detailed; however, there was not a ‘one size fits all’ list of what worked. From the examples provided, it was clear that each mother brought a complex set of unique challenges and strengths. It was, therefore, important to identify these and tailor the approach for that particular family accordingly. Practitioners explained that the programme was often more about “minding mums” – really knowing and understanding mothers, their history, their attachment style, their beliefs and ways of making sense of the world, and using this information to formulate how best to intervene.

Practitioners described constantly mentalising about mothers’ experience; these reflections were not necessarily shared with mothers, but helped practitioners to understand their presentation and behaviour and in turn formulate what they needed to do to help. They emphasised the importance of being tuned into mothers’ reactions, wondering to themselves about how mothers might be experiencing the situation or the intervention, and adjusting their approach accordingly.

Examples of this happening at the micro-level were often given; practitioners explained that before asking a question, or making a comment they would already be wondering about how that particular mother was likely to experience or interpret what they were saying. This skill was said to take a long time to develop, and required practitioners to have confidence in their own reflective abilities. Supervision was described as being essential in supporting the development of these skills and abilities.
Theme 2.2.2 “Start where mums are at”

“I think the main part is just going from where the mum is on that day, and not from the past, just taking the present as a real starting point, from when they are answering the door. Really recognising their physical presentation and their mood. Recognising those things. I think that’s probably the crucial part.”

Practitioners noted the importance of respecting where mothers were at, both in the moment and more generally, and tailoring the programme to their needs and capabilities. In one sense, this required practitioners to recognise what mothers needed each time they met them at the front door, and adjust their session accordingly, irrespective of any plans or ideas they might have had for the session. In a more general sense, with regards to reflective functioning, this reflected the importance of identifying what mothers’ skills and capacity were, and working at that level, rather than having any expectations about where mothers should be at.

Practitioners gave an abundance of examples illustrating the intricate ways they had learnt to tailor the programme on the basis of what they felt each mother needed at any given time. They had observed the “biggest shifts” when the programme was tailored in this way. For example, with mothers who were described as “avoidant”, practitioners found that considering their own history and reflecting on their own experience was often too threatening and caused them to withdraw or “shut down”.

However, practitioners had learnt that for many of these mothers thinking about their baby and reflecting on what they might be thinking or feeling was much more tolerable, and, therefore, a much more appropriate place to begin the reflective work. Similarly, for some mothers even this was too distressing, and practitioners had learnt that using video clips of other dyads and helping mothers to begin to consider what might be going on in the minds of the mothers and babies in the film was a much more tolerable experience, and allowed mothers to stay within a reflective space.
2.3 Supervision

Clinical supervision was described to be essential in helping practitioners to implement MTB and engage mothers in reflective work. Interestingly, the language used by practitioners to describe their experience of supervision was strikingly similar to the language used to describe their perception of mothers’ experience of the programme.

Theme 2.3.1 Essential components of clinical supervision

“I think sometimes it can make you make sense of the feelings that you’ve got, or they can just clarify that the feelings that you’ve got are all right, because sometimes they can be negative feelings, you know, like that family is really frustrating, I find it really difficult going there…And I think having that supervision can be like, okay, let’s unpick that…and I think you can come away and you feel a bit more like it’s making sense again.”

Practitioners felt that “everyone [was] keeping everyone in mind”, explaining that their relationship with their supervisor felt like a mirror of their relationship with mothers, which in turn mirrored the mothers’ relationship with their baby. Practitioners’ needs were being kept in mind by their supervisors, who would adjust supervision to cater to what they needed at different times – essentially “starting where they are at” on any given day. Being held in mind by their supervisor in such a way left practitioners feeling supported and valued.

Practitioners also felt they were given “permission” to feel what they felt: their emotional reactions to families and situations were “validated” by their supervisors – it was “okay” to feel that way. This was beneficial for several reasons. In some instances, having someone acknowledge how difficult and distressing some of the situations they experienced with families were felt to be “containing” and “reassuring” – practitioners felt “heard” by their supervisors.

Discussing their feelings about a case also allowed exploration of these feelings, which helped practitioners to make sense of them. This was described as particularly useful in instances where there were a lot of concerns; practitioners felt that gaining some understanding and insight into their own feelings and how this connected with mothers’ experiences helped to “contain” and “hold” their worries. Finally, understanding how their feelings linked with mothers’ experiences allowed practitioners to rely on their feelings more in sessions, and gave them the confidence to start to share and reflect on their experience in the moment with families.
Feeling “held in mind”, alongside exploration of their own emotional experience, helped practitioners to mentalise and ‘wonder’ about mothers’ experiences. “Constantly mentalising about mums” in order to make sense of the complexity and gain insight into what might be needed to help was described as the essential component of supervision. Gaining these rich understandings about mothers in supervision enabled “routes out of the chaos” towards focusing on reflective functioning to be identified.

Having a better understanding of mothers and a good formulation of their presentation meant that practitioners were better able to anticipate setbacks and make sense of mothers’ decisions, particularly when they appeared not to be in their best interest (for example, returning to an abusive partner). This increased insight lessened the emotional impact and confusion when setbacks occurred, and helped practitioners to better understand the challenges they were facing and to adjust their expectations accordingly.

**Theme 2.3.2 Experience of supervision mirrors relationship with mothers**

“You feel a bit embarrassed by it all, it’s like everyone is expecting you to talk about your feelings…and it’s not something you’ve ever done before…I mean, is a completely new experience for me, and if I’m being really honest, you know to start with it was a bit like ‘Oh… I don’t know if I’m really comfortable with this. I don’t want to tell you how I feel, or anything like that’. And there still are times where it can feel a bit [scary].”

Practitioners explained that their relationship with supervisors often felt like a template for their relationships with mothers, and the words that they used to describe their experience of supervision were strikingly similar to those they used to describe mothers’ experience of the programme.

Practitioners used several phrases repeatedly to capture their experience of being supervised, explaining that this type of supervision was an “entirely new experience”, where previously they had not had a space “just for them”, were not used to talking about their own feelings and had “never had the interest [from another professional] in [them], and [their] feelings”. At first they had worried about being “judged” and “struggled to trust” their supervisor, who was often described as a very impressive expert.
Practitioners found it very difficult in the beginning to openly name what they really thought or felt, and worried that doing so would invite criticism. These descriptions shared many similarities with the ways in which practitioners spoke about how they supposed mothers felt about them during early engagement. Practitioners also noted the importance of their relationship with their supervisor, explaining that feeling comfortable and safe to be open was essential for reflection and exploration.

Interestingly, one practitioner explained that having lots of time early on in supervision, before she had any cases to discuss, was crucial in building a solid and trusting relationship with her supervisor, and for allowing the supervisor to get to “know where they are at”. This practitioner went on to reflect that this was “how it must feel for mums”.
Part Two: Parents’ perspectives

The analysis produced 10 central themes (each of which included several sub-themes), organised into three domains (see Table 3 below). The first domain describes the parents’ perception of any changes brought about by their involvement in the MTB programme. The second and third domains describe the aspects of the MTB programme and characteristics of the practitioners, which helped parents to engage with the programme and helped to bring about change.

The perceived changes (the first domain) are presented first, as they provide the context for parents’ perceptions of what facilitated these changes.

The themes represent the views expressed during the 16 interviews, which include the three interviews with couples.

Table 3: Themes and Sub-themes for Part Two: Mothers

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Impact and Evidence series
Domain 1: Perceived changes

Involvement in the MTB programme produced an experience of change for almost all of the parents. Participants spoke about the development of their parenting skills, mainly reporting increased knowledge of how babies develop and how to manage specific behaviour their babies exhibited. They also identified positive changes in how they felt, both about themselves and about caring for their baby.

Theme 1.1 Changes in parenting skills

Nearly all parents mentioned some changes in their parenting skills. Through the developmental reviews completed by the practitioners, as well as the general information and guidance provided, parents described learning more about the stages of development for their baby and learned skills to encourage and support this development.

“They, like, encourage her [baby’s] development, they will, like, say when she is pointing to stuff for me to say what it is to help her talk. So if she [baby] is pointing outside to a tree [the practitioners told me] to say ‘Are you pointing to a tree’ and stuff like that.”

In the example above, the mother noticed how the practitioner was ‘speaking for the baby’, a core part of the programme in terms of supporting reflective functioning; however, the mother interpreted this more concretely, as the practitioner labelling things for her baby to learn, thereby supporting their development.

Through their provision of relevant information and guidance, the practitioners supported participants in learning skills to manage their children’s behaviours. This included managing sleeping problems (for example, moving the child to their own bedroom) and tantrums.

“A few things they have suggested; when she [baby] was 3 months old she just wanted to sleep in bed with us all the time. To try and get her out of it I had to leave her in the cot to cry or not talk to her when I went in the bedroom, or not pick her up, and it did work.”

“Baby is now past one [year old] and she does have [tantrums] and I have no idea how to react to them...[the practitioners] say ‘Look, you just have to distract her’ and that is what I do now, it’s really easy actually.”
An improved understanding of their baby and his/her behaviour was alluded to in the parents’ descriptions of learning skills to encourage their baby’s development and to manage their behaviour.

Two participants gave more explicit accounts of understanding their baby.

“I just think it’s been a bit easier like learning that sometimes he’ll [baby will] cry for no reason and that he can have night terrors and stuff.”

“Like before I was a bit set back and I didn’t know what I was doing [with baby]. I didn’t really think about things as much but now everything I do I think ‘Right if I do that [what will it mean for baby?]’.”

The latter quotation also demonstrates how the mother felt that practitioners supported her to feel more confident in relation to caring for her baby. This sub-theme is described further in the next section.

**Theme 1.2 Changes in self**

Half of the parents described changes in themselves. For some of these parents, a key area of change was in their confidence, particularly in relation to caring for their baby. They described feeling more like they were being good parents who were providing their babies with appropriate care. Parents attributed changes in their confidence to their relationships with the MTB practitioners, particularly referring to the reassurance and support practitioners provided (see Domain 3; Theme 3.2). Some of the parents felt that these positive aspects of their relationships with MTB practitioners were not present in the relationships they had with other people, such as family members.

“We feel a bit more confident in what we do [now] because we know we have them backing us up and in our corner…that’s nice because we don’t always get that from our family.”

“She sort of helped me relax with that [baby’s health], so now if baby has a cold I know it’s just a normal cold…whereas before if he had a cold I would be panicking and would probably rush him to hospital. I used to be really bad and she has helped me calm down a lot with that.”
Personal wellbeing, and managing personal difficulties, was a second area that some participants found to have improved through their experience with MTB. They appreciated the time and attention practitioners gave to their difficulties, either providing the support themselves or helping participants to access appropriate services (such as supporting a mother to attend GP appointments). Some parents (as demonstrated by the quotations below) felt that the practitioners supported them in how they were thinking about themselves and their baby, helping them to manage negative or unhelpful thoughts they were having about themselves or their babies.

“Just coming out of the pregnancy, I blamed myself for being poorly and for baby being premature, because my body didn’t agree with it. [I thought] it’s my fault that he came out small, but [also] other things out of my little family to the big picture of the family; she [the practitioner] has helped me a lot with that.”

“I just suffer from depression at the moment so [the practitioner] has been helping me go to the doctor appointments and stuff like that… I like also getting information about anxiety…and then talking through that [with the practitioner].”
Domain 2: Characteristics of the programme

The parents described specific aspects of the programme that had encouraged their engagement in it and facilitated the changes described above. The programme’s flexible, individualised, informative and collaborative approach made parents feel like their particular needs were being attended to and met, and that they were fully supported. Some of the parents spoke of wariness about participating in the programme due to their perceptions of the NSPCC and/or their experiences of professionals; however, all of these parents reported that, once they met their practitioners and spent time with them, they were no longer concerned.

Theme 2.1 Flexible and tailored to individual needs

All parents valued the flexible nature of the programme and how it was tailored to their individual needs. They spoke of practitioners being there for them when they needed them and supporting them in the ways they required. This included fitting visits around parents’ availability and preferences, and also being available by telephone between visits.

“Just knowing that they are there for you if you need any help, if you have any questions or anything...they are quite flexible as well, they might just give me a phone if they are sometimes even in the area [and then] they can just pop up or whatever...If I have any questions I need to ask...I can just phone them and ask and they will be there for me.”

“[The practitioners are] there if you ever need a chat or anything...if I need to talk to anyone and I can’t talk to my partner, then I have them to talk.”

Some parents particularly appreciated the support that MTB had provided before the baby was born, in terms of preparation for the birth and training in basic skills required to care for the baby. These mothers also appreciated the MTB practitioners visiting while they were in hospital having their baby, and implied that they felt practitioners really cared and were willing to put in the extra effort to support them and their baby.
“When I was pregnant…any fear or concerns we had about the baby…you know like they helped me write a birthing plan and things like that…explained a lot of stuff, showed me how to bath a baby, how to breastfeed…they came and visited me in hospital…they didn’t have to do that, it was really nice having them.”

Theme 2.2 Collaborative

Many parents appreciated the collaborative nature of the programme, particularly in relation to setting goals. Practitioners helped them to set goals, mainly related to what they wanted to achieve in their parenting, and then supported them to fulfil these goals. Parents found it satisfying to achieve these goals, which enhanced the development of their parenting skills.

“Last time…I was speaking to her [the practitioner] about baby because she was still in the cot in the bedroom with us and I set a goal for getting baby into her own room and getting her off bottles…through the night. So when they [the practitioners] came up yesterday I had got her into her room the night before, so I said ‘The next time I see you I will have her in her own room’ and I done it.”

Another area of collaboration that parents found useful was the way the practitioners encouraged and facilitated the interaction between them and their baby. Parents especially highlighted their enjoyment of the activities the programme facilitated (such as going to the park, painting and creating a scrapbook) to enable this interaction. Participants felt that this was different to their experience of other services who were interested in either them, or their baby, rather than the interaction between them and their baby.

“It [MTB] is all about me and my baby, not about meetings I have to go to or if baby is alright. It is all about [the] fun and activities me and her can bond [over] and what we can do together, so she can stay focused and what not. It is all basically around our relationship and nothing else and that is what I like.”

The importance of this collaborative style was demonstrated by one mother’s experience of its absence. In the interview she expressed anger and confusion about one of her practitioners not working together with her and her baby; she felt that the practitioner just focused on the baby and did not talk to, or include, her.
"[The other practitioner] does more, [this practitioner] just doesn’t. I’m wanting to get her [the baby] to benefit out of it [MTB], not just get her to sit there and play all the time… when they were both in [coming to visit together] she [the practitioner] didn’t talk [to me] it was just [the other practitioner] talking, going through everything and I was going ‘Why are you here if you don’t want to talk?’.”

**Theme 2.3 Information and guidance**

Nearly all parents valued the information, direction and advice provided to them by their practitioners. This included advice about cooking and what to feed their babies, as well as a lot of support with the health needs of their babies. Parents spoke of being able to ask one of their practitioners (the paediatric nurse practitioner/health visitor) anything about the health of their baby (such as about nappy rash, coughs or colds) and knowing that they would get useful advice or information back from that practitioner.

“She’s helpful, she knows a lot about everything to do with babies and their health… feels like more or less anything you ask her about baby’s wellbeing… she’ll know and answer.”

“If we… have got any questions about baby’s health or nappy rash or something like that then [we] can always ask [the practitioner] for, like, information about it and [the] best advice [about how] to get through it.”

Some parents also talked about valuing the advice and information provided by the programme for more personal issues, such as their relationships.

“They helped me see the bad things [in a previous relationship], at the time I didn’t realise, I was, like, whatever but… they made me realise and obviously they helped in my relationship I am currently in now… they will explain things to me. They are really helpful when it comes to my relationships.”

The development reviews carried out by the practitioners were considered very useful by many of the parents. They felt that these reviews helped them to learn about the development stages of babies, and how babies can develop different skills at different times or rates. This reassured parents that their baby was normal and supported them in promoting their baby’s development.
“We [the practitioners and I] have done a development thing where they have asked me questions about what certain things she [the baby] can or can’t do, things like that, and ways to work on it and improve in a certain area if [baby] struggling a little.”

“I talk to them about her [the baby] development…I can sometimes get a bit worried about how she is developing and they reassure me that she is doing good.”

Theme 2.4 Practical help

The practical help provided by the practitioners was important to some of the participants, in particular those experiencing housing problems, or difficulties providing their baby with food, clothing and safety equipment (such as safety gates). The parents appreciated the help, which they described as very effective, that the practitioners had provided in resolving their particular practical issues.

“Just before we met them we was [sic] living at my parents’ house and we didn’t have nowhere to go or anything like that… They automatically helped us to get a place with the council… They helped us to move in our stuff and everything. When I was in hospital, they helped us to clean the flat and everything, make it safe for her [the baby] too.”

Some participants also found the practitioners helpful in assisting with their financial difficulties, such as debt resolution.

“She will be assertive to the CAB [citizens advice bureau] to try and get them to talk to people. Last time we did it [debt resolution] through CAB and only managed to get the interest to stop for a month but this time it’s stopped for good until we have paid it all off…so I think [the practitioner] has been more assertive, like they need to listen and to stop the interest.”

“She does most of the talking [at CAB meetings], she knows more about my debts than what I know…I feel a lot more comfortable going to the CAB with her than without her…she tones it down from CAB talk to my lingo.”
Domain 3: Characteristics and qualities of the practitioners

A crucial feature of the programme for many of the parents was the relationship between them and their practitioners. Participants spoke of the characteristics and qualities that they valued in their practitioners, and which combined to create the close relationships they felt with them. These close relationships, alongside the parents’ positive experience of certain characteristics of the programme, seemed to facilitate the participants’ engagement in the programme and led to the changes that parents reported to have occurred.

Theme 3.1 Mutual trust

For most of the participants, trust was an important feature of their relationship with their practitioners. Around half of the parents spoke of appreciating the trust that their practitioners placed in them. They felt that practitioners trusted them to make their own decisions, providing guidance and advice rather than just telling them what to do. This went side-by-side with the collaborative nature of the programme described above.

“There’s such a level of trust there that, unless there is something immediate that needs dealing with, she will kind of leave us to devise our own kind of plans with it and she will be like ‘Call us if you need us’.”

Parents also found their practitioners trustworthy; they described feeling able to talk openly with them about most things, such as difficulties they were having personally or with their baby. Some parents also noted how they usually found it difficult to trust others but had been able to build a trusting relationship with their MTB practitioners. They explained that this was due to the positive way in which practitioners related to them.

“I have been through quite a lot with baby’s dad and I tell them everything about it and just rant to them about it sometimes. So yeah, I do really trust them because I know I can speak to them and it will just stay between us unless it’s something dangerous but no, I can definitely trust them.”

“[The practitioner] has always been really nice and genuine towards us and she has built that level of trust up with us, I mean me and my partner do find it very difficult to trust anyone.”
However, one mother felt she could not fully trust one of her practitioners, and did speak of feeling judged by her. This perception contributed to the mother’s wish to have only one practitioner, highlighting the importance of trust, and acceptance, in the parents’ relationships with their practitioners.

“[I] can trust one of them but not the other one really...because of my age I think she thinks I am wrong, that’s how I feel. I feel like she looks at me as if to say ‘You don’t understand the world because you are a so and so’...the only thing I would change [about the programme], [would be to have] just one [practitioner].”

**Theme 3.2 Non-judgemental and supportive**

The non-judgemental and supportive stance of the practitioners was important to many participants. They described this in terms of how the practitioners understood and accepted their particular difficulties and needs.

“I’ve spoken to her about stuff before and she’s not judged.”

“...they [the practitioners] really understand everything like the situation between me and the baby’s father, like they get it...I can talk to them about it all and they will understand it.”

“[I] feel like they just accept me for who I am, for definite.”

Related to the practitioners’ understanding and acceptance, most of the parents felt that their concerns about parenting, about their baby, and about their own health and wellbeing were helpfully supported through the practitioners’ reassurance and guidance. They felt reassured by the support and positive feedback practitioners gave them regarding their parenting and by hearing that there were other mothers who had similar experiences to them (for example, they were not alone in their struggles).

“Baby was in an incubator for six hours, which doesn’t sound like a lot but...I felt like I wasn’t going to bond with him...[The practitioners] really supported me through that [telling me that] there will still be that bond and [now I feel that] there will always be that bond.”

“[The practitioners have] been saying that we have been really good parents towards him [the baby] and they can see it in his stages of development and how he is progressing...she [the practitioner] always tells us to relax and that.”
Theme 3.3 Relaxed and open

For many participants, the relaxed and open nature of the relationship with their practitioners was crucial in helping them to feel comfortable and at ease. Participants reported that they often felt this way very early on in the relationship due to the positive way practitioners related to them right from the beginning. Parents likened the relaxed relationship they had with their practitioners to relationships with friends and family.

“Feels like they are kind of family now...I can actually just lie back, relax and be honest.”

“I have gotten used to them coming round now, like having family or friends visiting... [the practitioners] sit down and talk to me as if we are some sort of friend so that [is] nice. I feel comfortable around them.”

In relation to this, participants felt that practitioners were easy to talk to, enabling them to talk openly with them, sometimes about topics that they found difficult to discuss with others. Some of the participants spoke of feeling more comfortable talking to their MTB practitioners than to other professionals.

“I have talked to them about things that I’ve not even spoken to my husband about and they have helped me out with them and helped with some understanding of them as well.”

“It [the MTB programme] is just a better environment [than with other professionals] and stuff I would prefer talking to them than anybody like a doctor and that.”

A number of the participants also talked about their relationships with the practitioners as being humorous and fun. They described how this helped them to feel relaxed in their company and to enjoy their visits.

“She is funny [and] has a laugh all the time...not boring, if she was boring I don’t think I’d like to see her that much but she isn’t, she is [really] funny.”

Theme 3.4 Personal experience of parenthood

The practitioner’s own experience of being a mother was considered to be important by some parents. Two mothers felt that their practitioner having personal experience of being a parent meant that she could better understand what it was like to parent and, hence, what they were feeling.
“Obviously with her having kids and she understands parts of what I feel...she understands when I overreact about stuff.”

“She knows what it’s like, how they [children] can do your head in.”

For some of the parents, the practitioner’s experience of being a parent meant that they could get personal (as well as professional) views and advice on what they should be doing with their child. They found this personal opinion helpful as a supplement to the professional advice and information they were gaining from their practitioners.

“She can give me her opinion on things with her [the baby] using stuff from her kids so she can talk about her own kids and give me the experience she has had with certain things, she can recommend certain products or certain childcare for college and stuff like that, quite handy because she is a nurse and had her own kids.”

“I can talk to [the practitioner] about most things to do with baby that I have no idea about. She will say her personal view as well because she has children, she will say ‘This is what I did’, so that is really good as well.”
Conclusions

Practitioners’ accounts demonstrated the complex and diverse presentation of families enrolled in MTB, and highlighted the wide range of factors that can hinder the translation of the model into practice. Despite these considerable challenges, practitioners were able to engage families in both the programme and reflective work, and found the work rewarding. Practitioners’ accounts indicated the central role their therapeutic relationship with mothers played, both in responding to some of the challenges identified, but also in being able to engage mothers in reflective work. Building such therapeutic relationships with disadvantaged mothers whose own histories were characterised by attachment disruptions and previous negative experiences of professional involvement is particularly impressive.

The qualitative accounts made it evident that the challenges of delivering MTB do not exclusively fall within the immediate therapeutic context involving mothers and practitioners, but that the implementation of reflective work is impacted by factors situated within multiple systems – including the immediate family system, the family’s wider social context, local and national service settings, and the wider cultural context. The results of the current study demonstrate not only the complexity of situations that many families involved in MTB experience (past and present), but also the complexity of the context in which the work is being delivered – barriers at various levels of context impacted the success to which practitioners were able to implement the programme and achieve their desired clinical outcomes.

Some of the challenges identified can be conceptualised as failures to mentalise throughout different systems: mothers struggled to contemplate their own mental states and those of their infant at times of crisis; practitioners’ emotional reactions to working with high-risk and high-need families sometimes interfered with their ability to hold a reflective stance; and organisational disagreements about risk sometimes disrupted the service’s ability to hold the family in mind. These difficulties highlight the importance of creating systemic conditions that support reflective practice and strong working relationships under sometimes high-stress conditions.

Being faced with considerable complexity and risk, practitioners reported experiencing high levels of professional anxiety and stress at times. Working with high-need, multi-problem families can challenge even the most experienced professional, especially where there are safeguarding concerns, and often results in a breakdown of mentalisation and reliance on ‘action’ rather than ‘reflection’. The practitioners in this programme were of course new to Minding the Baby and were still very much learning about the model through
training, supervision and their direct experience working with families. In that context, the clinical–supervisory model was highly valued as it placed reflection and mentalisation at the core of supervision, and explicitly addressed practitioners’ emotional reactions to their work, leaving them feeling validated and connected with their support system and ‘held in mind’.

In addition, working closely in pairs with another worker brought benefits with regards to containing practitioners’ anxiety, fostering a sense of support, reducing isolation, and improving clinical decision making. It was evident in the qualitative accounts that the quality of professional relationships played a crucial role in supporting practitioners’ capacity to deliver reflective interventions.

Practitioners’ accounts supported the predicted MTB mechanisms of change (Sadler et al, 2006; Slade, 2006; Slade et al, 2005) by highlighting the importance of the therapeutic relationship; the reflective work involved in MTB was perceived as depending upon the strong and trusting relationships practitioners managed to build with mothers. The gentle, responsive, non-pressured approach to engagement and building relationships taken in MTB was perceived to be especially important for families whose histories have often been characterised by trauma and neglect, and who have frequently had negative experiences of professionals.

It is also important to note that some practitioners felt that there were mothers in the programme whose capacity for reflective function, given their circumstances and history, meant that they might not be ready for MTB. However, it is also vital to keep in mind that the practitioners were reflecting on their experiences mid-way through the first cycle of MTB, and hence had limited opportunity to see mothers’ journeys through to the end of the programme. It may be that some mothers engage with the reflective aspects of MTB more gradually than others.

The perceptions of the parents in this study were very positive, and suggest that engagement and subsequent change in MTB is promoted by the individualised, flexible and collaborative nature of the programme. The focus on the mother–baby dyad was experienced as helpful and different from other services in the past, which parents had sometimes felt either focused on them or their baby, rather than on them as a dyad. Parents reported feeling that their practitioners were trusting of them, trustworthy, understanding, reassuring, relaxed and open; indeed, these characteristics were deemed crucial for their forming close and trusting relationships with their practitioners.
Parents also said that the programme had helped them with their sense of self-confidence and wellbeing, including helping them to manage their personal difficulties. Crucially, given the aims of the programme, many parents said that MTB helped them develop their parenting skills and that they enjoyed learning about their child’s development and about how to manage their child’s behaviour at different stages.

It is important to note that the parents who contributed to this report were generally engaged in the programme, so it is difficult to extend these findings to families who were less engaged, and of course we are unable to comment on how families who chose not to take part perceived the programme. These are important limitations.

Furthermore, it is critical to appreciate that this evaluation took place during an initial implementation phase of MTB in the UK, and hence practitioners were still in the process of learning and adapting to the model and style of working, and indeed the NSPCC itself was also undergoing a process of learning about how to accommodate and support a programme of this nature. The findings of this report should be interpreted with that in mind, and may not all be applicable to a more established service.
References


