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Exploring interprofessional collaboration during the implementation of a parent-infant mental health service: A qualitative study

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ABSTRACT

We examined interprofessional working in a newly implemented parent-infant mental health service team supporting families experiencing bonding and attachment difficulties. The aim was to identify forms of interprofessional work undertaken, barriers and facilitators of this work, and families' and healthcare professionals' perceptions of it. Semi-structured interviews were carried out with 21 stakeholders (5 parents, 4 team clinicians, 9 service referrers, 3 service commissioners) and were analyzed thematically. Interprofessional activities identified included building the service team's cohesion and shared practice, building partner networks, interagency communication, coordination of roles, and raising awareness of infant mental health and parent-infant relationship needs. Enablers and barriers to interprofessional working were broadly consistent with findings from previous studies of related services, but with additional emphasis on consultative work as an enabler. Healthcare professionals reported benefiting from the case consultations and training on infant mental health provided by the service team. Parents reported that good interprofessional working enhanced satisfaction and engagement with the service. Findings indicate the centrality of interprofessional working for parent-infant mental health teams, with implications for future service implementation, service development, and understanding of mechanisms by which such services may influence family outcomes.

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Introduction

The need for interprofessional collaboration in early intervention family support services is widely acknowledged (World Health Organization, 2010). Within the United Kingdom (UK), the government's 'The Best Start for Life' report (Department for Health and Social Care, 2021) calls for coordinated services, interdisciplinary training, and sharing of best practice in order to support families in the first 1,001 days following conception. The report also stresses the importance of services addressing parent-infant bonding and mental health. Currently there are 39 interprofessional, specialist parent-infant mental health teams across the UK providing support to parents and babies from conception up to the child's second birthday (Parent-Infant Foundation, 2021). The current paper examines interprofessional working in the implementation of a new parent-infant mental health service.

Background

Several definitions and models of interprofessional working have been developed that distinguish between interprofessional team working, collaboration, coordination, and networking based on dimensions of practice related to shared team identity, clear goals/roles, interdependence, integration, shared responsibility, and team tasks (Reeves et al., 2018). The optimum interprofessional approach, argued Reeves and colleagues (2018), depends on clinical purpose and local needs of patients. Contextual influences on collaboration were also emphasized by Schot et al. (2020), who characterized interprofessional activity as bridging gaps between healthcare professionals, negotiating overlaps in roles and tasks, and making spaces to carry this out. The extent to which these activities are performed varies by profession as well as team and network settings (Schot et al., 2020).

Interprofessional working is central to the practice of parent-infant mental health teams because they address families' needs that have traditionally been met by dichotomized services dealing with either adults or children, mental or physical health, health or social care, and are run by a variety of providers across different tiers of provision (Lee & Mee, 2015). Fragmented services can lead to families having to re-tell their story to persons at multiple agencies, becoming dissatisfied, and reducing their engagement (E. K. Olander et al., 2019); conversely, good interagency collaboration can produce better mental health outcomes (Asarnow et al., 2015). Therefore, it is critical that the interprofessional work of parent-infant mental health teams is examined in order to optimize service functioning and family outcomes.

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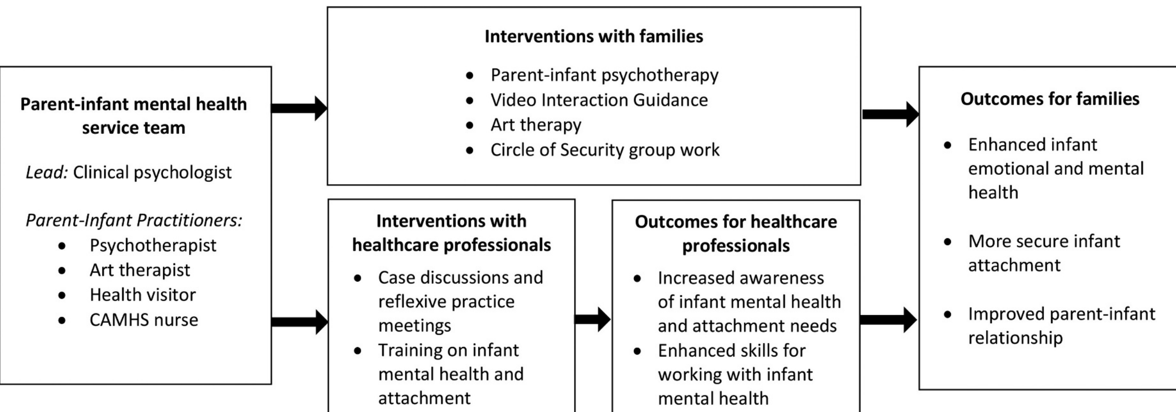

Figure 1. Parent-Infant Mental Health Service Model.

It is also important to know what helps or hinders interprofessional collaboration in this context. Systematic reviews of perinatal maternal mental health (Myors et al., 2013), midwifery and health visiting (Aquino et al., 2016), and child and adolescent mental health services (CAMHS; Cooper et al., 2016) have generally agreed that enablers of interprofessional working involve good communication, respect, shared vision, aims and goals, clear roles, joint action, liaison staff, collaboration protocols, adequate resources, joint training, and colocation. Barriers involve the opposite, such as poor communication and understanding of roles, lack of respect, geographic distance, inadequate resourcing, divergent professional cultures, and poor information sharing. Some of these factors are more pertinent to the work of healthcare professionals within particular contexts. Cooper et al. (2016), for example, suggested that interagency collaboration within CAMHS places more emphasis on joint training and understanding of each other's professional perspectives and less emphasis on role demarcation. How far these factors apply to the interprofessional practice of parent-infant mental health teams working with very young children is unknown (Hunter et al., 2020) and may differ from that of CAMHS or services that typically work with older children.

Our aims were to understand how interprofessional practice occurs during implementation of a new parent-infant mental health service and to identify what helps or hinders interprofessional working. We examined various stakeholders' perspectives: the service team comprised of clinical practitioners providing the service; service referrers, that is, professionals referring families into the service; and service commissioners responsible for the planning and public funding of the service. In addition, families' perspectives of interprofessional practice were examined. It is hoped that this study will inform future service development, implementation strategies, and optimize conditions necessary for successful interprofessional practice and outcomes for families.

Method

This study forms part of a mixed methods evaluation of a parent-infant mental health service, henceforth referred to as "the service." The evaluation was carried out in 2020–2021 by an experienced team of four healthcare researchers and a clinical psychologist (E.K. Olander et al., 2021). We focus here specifically on interprofessional practice and qualitative findings.

Setting

The service was set up in May 2019 to provide a therapeutic service supporting the emotional and mental health needs of the baby, infant attachment, and parent-infant bonding in one county in England. The National Health Service (NHS) provided the service, which was commissioned by a consortium of seven clinical commissioning groups and two local government bodies. The service was delivered by a lead clinical psychologist and team of five parent-infant practitioners, henceforth referred to as "practitioners." The practitioners' diverse professional backgrounds included psychoanalytic psychotherapy, art therapy, CAMHS nursing, and health visiting or public health nursing as termed outside of the UK.

The team offers therapeutic interventions to families with complex needs, providing individual parent-infant psychotherapy, art therapy, Video Interaction Guidance (Kennedy et al., 2010), and Circle of Security group work (Marvin et al., 2002). They also act as *system champions*, raising awareness of infant mental health and attachment across early years services through provision of online interprofessional training for midwives, health visitors, family support workers, and mental health practitioners. The team's system champions work is also carried out through provision of consultations with other agencies via reflective practice meetings and casework discussions aimed at influencing other healthcare professionals' practice with families. Figure 1 illustrates the service model.

Participants and recruitment

Multiple stakeholders were recruited, including service commissioners, referrers to the service, the service team practitioners, and families using the service. The service commissioners approached were those directly involved in the commissioning consortium; referrers were eligible if they had referred families into the service or had contacted the

service but had yet to refer. Recruitment of service commissioners and referrers was initiated by the service implementation manager who requested written consent for sharing contact details with the evaluation team. Those who consented were contacted by a member of the evaluation team and invited to a telephone interview. For recruitment of service team practitioners, the service's clinical lead sent them invitations to take part. If interested, they contacted the evaluation team who then arranged telephone interviews. The service team informed current parent service users about the study if they were not currently in crisis and regardless of the duration of their involvement with the service. If interested, parents gave permission for their contact details to be passed to the evaluation team, who then arranged a telephone interview if parents consented. The recruitment process produced a total sample of 21 participants, described in the findings.

Data collection

Telephone interviews were carried out between June 2020 and February 2021 using a semi-structured interview schedule and were audio-recorded. Interviews lasted 33 minutes on average, ranging from 12 minutes to 80 minutes (excluding introductions and consent procedures). The focus of interviews for commissioners, referrers, and service team practitioners was on service implementation and process issues including interprofessional working. The service team practitioners were interviewed twice, 4 months apart, using different interview schedules capturing initial implementation and subsequent implementation changes. Interview guides were informed by previous literature on implementation and interprofessional communication. For families, the focus of interviews was their experience of the service from referral to date and drew on concepts from the theoretical framework of acceptability (Sekhon et al., 2017). See Online supplement for sample interview guides.

Data analysis

Interviews were transcribed by a professional transcription company. Transcripts were deidentified and analyzed using Braun and Clarke's (2006) thematic analysis approach, using Nvivo (12 Plus) software. Three members of the evaluation team read the transcripts for familiarization. Two of the three then carried out initial coding of transcripts independently, developing and clustered codes into themes, comparing themes across transcripts, and refining them in an iterative process. Theme development based on the service team's, commissioners', and referrers' transcripts was carried out initially inductively, leading to identification of areas of interprofessional activity and then deductively, with barriers and facilitators identified. The broader three-member evaluation team (including the two coders) then compared the coders' initial codes and mapped themes for areas of convergence and divergence, and a final set of themes was derived through discussion. Parents' transcripts were analyzed separately from other stakeholders, and coding reflected perceptions of interprofessional practice.

In addition to independent initial coding, trustworthiness was enhanced through triangulation of data involving comparisons of different stakeholders' accounts (i.e., commissioners, referrers, service team, parents). Although the focus of interviews varied for each stakeholder group, all participants were asked about their perceptions of the service. Thus, it was possible to compare different stakeholders' perceptions across common themes and examine convergence of views. To enhance credibility, a summary of themes with illustrative quotations were read by the service team lead who agreed with the themes and interpretations. Verbatim quotations are reported to evidence the themes derived, with some shortened as indicated by [...].

Ethical considerations and approval

Ethical approval for the study was granted by the authors' faculty ethics committee (Reference ETH1920-0823) and by the Health Research Authority (HRA; PR REC 20/NE/0237) for parent interviews as well as by the service NHS Trust Research and Development department for the service team and parent interviews. The study adhered to ethical standards in the UK Policy Framework for Health and Social Care Research (Health Research Authority, 2020). Participants were informed verbally and in writing that participation was voluntary and that their choice to participate or not would not affect their treatment. Informed consent was gained from all participants prior to interview, including consent for audio-recording interviews. Consent was obtained verbally rather than written due to COVID restrictions.

Findings

The description of participants is followed by presentation of themes from participants' interviews. The first five themes represent areas of interprofessional practice derived from healthcare professionals' interviews, and one final theme captures perceptions of interprofessional practice from parents' perspectives. Themes are listed in Table 1.

Table 1. Themes: Healthcare Professionals' Areas of Interprofessional Working and Parents' Perceptions.

Healthcare professionals' themes: Areas of interprofessional working
1: Developing team cohesion and shared practice
2: Building partner links
3: Developing interprofessional communication
4: Coordinating professional roles
5: Building awareness of infant mental health and parent-infant relationship needs
Parents' theme
1: Perceptions of interprofessional working

Participants

Among professional stakeholders, seven commissioners were approached to share their contact details with the evaluation team. Of the four who agreed to share contact details, three consented to be interviewed. The three worked in different areas of the region that the service covered. Among referrers, 14 were approached to be interviewed, and 9 agreed to take part. They worked in a variety of services spread across the county. Their professional roles were: health visitor (3), perinatal mental health nurse (1), adult mental health nurse (1), occupational therapist (1), social worker (1), Family Nurse Partnership worker (1), and a chief executive of a voluntary sector organization (1). Among the service team, the clinical lead and three of the five team practitioners took part. All professional interviewees were female.

Contact details of seven parents were sent to the evaluation team, and five agreed to take part. All of the parents were mothers whose initial contact with the service began while pregnant in one case, while their baby was under 12 months old in three cases, and when their child was between 1 and 2 years old for one mother. Two parents were first time mothers, and all were cohabiting/married. Participants' demographic profiles were representative of service users' profiles (E. K. Olander et al., 2021).

Healthcare professionals' perceptions of interprofessional practice

Five themes were derived from the healthcare professionals' interviews that reflected the foci of the service team's interprofessional activities (Table 1). Each interprofessional area identified by healthcare professionals through evaluation of the service model is further described in connection to barriers and facilitators to interprofessional working. Service team practitioners are referred to as practitioners throughout for brevity.

Theme 1: Developing Team Cohesion and Shared Practice

Although the interprofessional composition of the service team offered a flexible intervention approach, it could also be a barrier to interprofessional team working due to different opinions within the team as to the best treatment approaches to apply: "One member of the team might identify how an approach could really help that mum or dad with their confidence, say around parenting, whereas another practitioner might be very much interested in their relational history" (Practitioner 2).

To overcome team differences and offer a potentially more consistent approach, the team strove to develop shared interprofessional understanding of different clinical interventions while also recognizing each other's unique professional contribution:

> We all come to this work with our own kind of underpinning theoretical knowledge and understanding. [. . .] We are trying to sort of build a shared language of intervention that we bring our own kind of understanding to that intervention. But there is a sort of core set of principles that we are all striving towards having at the root of our practice. (Practitioner 4)

Facilitators of shared interprofessional understanding included undertaking clinical trainings together to develop a common approach and team cohesion, which took considerable investment of time and finance during initial implementation. Bridging interprofessional differences was also aided by strong team leadership and a shared commitment to parent-infant work: "I think we are all incredibly passionate about the work [. . .] and I think [team leader] has been really helpful" (Practitioner 1).

Weekly team meetings also provided a formal space for building a common approach through discussion of family cases and additionally provided an informal space for building team cohesion. The importance of informal bonding time became even more evident when team meetings had to take place via video following COVID-19 lockdown and informal contact was diminished: "All our team meetings are virtual, but yeah, like I say we do miss that [informal contact] because it's the bits like when you're going to get your lunch and you have your little chat" (Practitioner 3).

Theme 2: Building Partner Links

All interviewees saw building relationships with partner organizations as critical to successful implementation of the service, particularly for generating referrals to the service and onward referral. Building relationships involved identifying and establishing links from primary care to tertiary care services across multiple sectors and took up much of the team's time: " . . . initially, it was a lot of networking, going out, meeting different services, telling them about our service, getting copies of the referral form" (Practitioner 3).

A barrier to building partner networks was the sheer number of partners to connect with and their differing geographic boundaries, which challenged the logistics of providing joined-up system-wide family support in each locality:

> There is a geographical challenge due to the sort of fragmentation of all of the kind of services that are within the NHS and social care, and education, and all the different Clinical Commissioning Groups, and it is really difficult to create a coherent sense of team around children and families. (Practitioner 4)

The service team's concerns about building networks across providers were echoed by referrers to the service: "That [geographic spread] must make it much harder for them [the service team] to build that local contact and build that relationship with different professionals because, you know, where do you start?" (Referrer 9).

Another obstacle to building networks with partners was organizational change within services experiencing restructuring, staff shortages, or high staff turnover. As staff in other services changed, the team had to re-build professional links to continue promoting the service and cement referral routes. Referrals from services such as health visiting were particularly likely to be affected by organizational change "because [when] mums don't have regular contact with one health visitor, they are very unlikely to disclose to a person that they don't know very well that they are having difficulties with their baby" (Practitioner 3).

Key facilitators for building partner links included allocating responsibility for developing partnerships in specific

regions to individual team members with local knowledge and prior professional links within that locality. In addition, it was helpful that the service commissioners recognized the developmental trajectory of the service, allowing time to "take it [relationship building] slow, be deliberate, be planned and that's fine" (Commissioner 1). In practice this approach permitted the team to soft launch the service, identifying partners and building up interprofessional links gradually.

Theme 3: Developing Interprofessional Communication

Effective interprofessional communication was integral to building and sustaining links within and between services. A potential barrier to such communication was the geographic distance between the service team's base and early years services in other regions, making in-person meetings difficult: "there was a huge amount of driving. It is a very rural location" (Practitioner 1). As a means of overcoming geographic spread and enabling better interprofessional communication, the team initially developed colocation working in centers such as family hubs. However, the COVID-19 pandemic curtailed colocation and led to greater use of virtual networking and video consultations. This switch to remote digital working facilitated interprofessional communication and saved time on travel across regions. Overall, the use of remote technologies was seen by most interviewees as advantageous for interprofessional working: "the digital approach really supports reaching a wide range of people quite quickly" (Commissioner 1).

An additional barrier to communication was the lack of a common information technology (IT) system for sharing case notes with other services: "if there's something that's noteworthy, there's that concern that maybe it could get lost [. . .] I think that is a weakness because it's obviously so useful if they can click and see our notes and we can see theirs" (Referrer 5). Among services with a shared IT system, information exchange was reportedly smoother and less time consuming.

Interviewees reported that good communication between professionals contributed to greater professional trust and better coordination of roles in cases requiring joint care:

> There's pretty good communication between health visitors and [the service], so I don't feel like, or probably up to now I didn't have this kind of feeling that I needed to do joint visits because I fully trust them. Because, as I said, I only got really good feedback on the service and they worked really well with me, and they've been really useful and kept updating me about families. (Referrer 2)

Theme 4: Coordinating Professional Roles

Coordination of professional roles became increasingly important as the number of families requiring multiple agency support grew over time. Without such interprofessional coordination, families could become overwhelmed by multiagency involvement: "how do we do that in collaboration with everyone else so that this poor mum wasn't overwhelmed with having people knocking on her door, turning up like buses all together?" (Practitioner 3). During initial service implementation, a barrier to developing multiagency coordination was lack of knowledge among potential referrers about the team's interprofessional composition and roles: "I don't know what else they offer [. . .] I've only really had contact from the psychology side of things. My guess is that there are consultants and nurses and hopefully occupational therapists as well" (Referrer 5). As the service developed more partner links over time, referrers gained greater understanding of the service aims and professional roles, which facilitated role coordination. Such coordination was important for carrying out joint needs assessment and care planning and was facilitated by interprofessional meetings and joint family visits to ensure that families were receiving support from the most appropriate service in a timely manner: "I know that there have been a few [cases] where we've [perinatal mental health service] jointly worked and in that kind of instance, it's more about making sure we've got clear care plans of who does what" (Referrer 1).

Theme 5: Building Awareness of Infant Mental Health and Parent-Infant Relationship Needs

The service team's role as system champions meant raising awareness of infant mental health among other healthcare practitioners, which could also facilitate referrals to the service. A potential barrier to system champions work was the relatively under-acknowledged or unseen mental health needs of infants. Interviewees agreed that healthcare professionals were more likely to identify parental mental health needs rather than those of infants:

> I don't think the infant as a focus would have been picked up. I think the parent, or the caregiver, probably would have come into adult services with whatever struggles they [parent] were having, and their difficulties may have been addressed. (Commissioner 2)

Raising awareness of infant mental health and parent-infant relationship needs among potential referrers were facilitated by the team's consultation model of interprofessional collaboration. In addition to raising awareness of these needs, the team aimed to use cross-agency consultations to increase and improve referrals, to build a network of joined-up professionals around the family, and to develop the skills of other family practitioners. Team members framed consultation work as:

> . . . empowering professionals to sort of think about the parent - infant relationship in quite sort of radical ways compared to the way that is has been thought about over some years. [. . .] it is about transforming the way we think about and deliver the infant-parent services across the region. (Practitioner 4)

The team's consultative work was especially valued by referrers in cases where parent-infant bonding issues were present but lay outside the referrers' own area of expertise: "For me that was very reassuring that there wasn't an omission that was occurring because of my lack of training in a particular area" (Referrer 5). Such consultations appeared to strengthen confidence among other professionals about their own practice, while also deepening their practice by promoting a relational, psychological approach to working with families:

> I think because of the psychological approach for their team, they [the service team] really helped me slow down and they really helped me widen that perspective a bit and think about the whole family I think and the impact on each other and those kind of relational things that are happening. (Referrer 1)

In addition to consultations, the team's provision of free interprofessional online training aimed to raise awareness of the importance of the parent-infant relationship and infant mental health. Provision of such training was welcomed by referrers who benefited from the gain in specialist knowledge, which influenced their own practice with families:

> If we [health visitors] can take on board some of the things that they're [the service team] able to share, then we can kind of help disseminate that information. So, it will be useful, it may not necessarily be quite as good as having the service, but if it's not available it will be the next best thing. (Referrer 8)

Parents' Perspectives of Interprofessional Working

Analysis of parents' perceptions of interprofessional working indicated that prior to the involvement of the service, multiagency contact could feel overwhelming, as this mother indicated when contacting her health visitor for support:

> I like called up one [health visiting] service, had a couple of assessments and I suddenly had three people on my doorstep, and I had zero explanation as to who they are. [. . .] So that whole thing was, you know, at the beginning was quite overwhelming. (Mother 2)

However, once the parent-infant mental health service became involved, the parent-infant practitioner successfully managed to coordinate interprofessional care, which the mother positively reflected on as "astonishing." Moderation of the number and frequency of services visiting helped restore the mother's sense of control after the initial feeling of multiagency overinvolvement:

> I eventually called up and said, "Well I think we need to cancel all of this because I just need one person." [. . .] She [parent-infant practitioner] put the control back in my hands so I didn't feel like I was being watched. (Mother 2)

Another mother revealed that she typically dropped out of services, but was committed to attending sessions with this service team:

> There's been times when I've done other therapy where I kind of cancelled it last minute, and you know, done quite a few things where I've just dropped out or opted out of stuff and that, but I never have with her [parent-infant practitioner], it's quite nice. (Mother 1)

She attributed her past dropping out to the frustration of having to re-tell her story when previous healthcare professionals failing to share information about her: "I just spend a huge amount of my time repeating myself over and over and wondering why nobody actually communicates." She further explained that she had committed to this service's sessions precisely because of the practitioner's ability to gather information effectively from other healthcare professionals and pass information on to other services, thereby avoiding her repeating her story:

> But [parent-infant practitioner] just done [her] research [. . .] and she went out of her way, as far as I'm concerned, it was out of her way, because I don't believe that this is part of her job role necessarily, but she phoned them [adult mental health team] and asked how she could help them. (Mother 1)

Mothers were made aware that healthcare professionals were sharing their information, and were generally pleased about it: "Sharing that information helped. If you go back to your General Practitioner and they can see what you've been doing elsewhere, it's useful because you don't have to sit and talk through it all again" (Mother 5). However, one parent had reservations about information sharing between agencies:

> They could all see what each other had written, so before I had my appointment they would look back at each other's notes. [. . .] I didn't overly like the fact [. . .] Everyone kind of knows what's going on and are they all talking about me? (Mother 3)

Overall, the feedback from mothers indicates that the service was for the most part helpful in coordination of care with other services, which other services had not necessarily succeeded in prior to the involvement of this service.

Discussion

Our findings provide insight into the forms of interprofessional working involved in the implementation of a new parent-infant mental health service. Findings also provide insight into the differences that the service's interprofessional working can make to parents and other healthcare professionals.

The implementation of the service required the service team to engage in several forms of interprofessional working as defined by Reeves et al.'s (2018) typology. Interprofessional teamwork was undertaken to develop team cohesion and shared practice. Interprofessional networking was required to build partner links and referral pathways and in raising awareness of the service itself as well as infant mental health and parent-infant bonding. Interprofessional collaboration was carried out in coordinating roles with other practitioners supporting families, reinforced by good interprofessional communication. The findings also resonate with Schot et al.'s (2020) classification of interprofessional activities. Building bridges occurred between service team members in developing team identity and with external agencies in development of professional networks for referral and for increasing awareness of infant mental health and parent-infant bonding. Negotiating overlaps took place in coordination of care for families with multiple needs, while creating spaces occurred to a lesser extent, consistent with Schot and colleagues' findings, in activities such as adopting remote working technology when colocation was no longer possible. A picture emerges from these findings of a highly skilled team engaged in complex interprofessional work.

The facilitators and barriers to interprofessional working identified in the context of this service largely concur with those identified previously in reviews in related areas (Aquino et al., 2016; Myors et al., 2013). However, in comparison to Cooper et al.'s (2016) findings regarding CAMHS teams, we found a greater emphasis on consultative work as a mode of interagency working, reflected in the fifth theme concerning building awareness of infant mental health and parent-infant relationship needs. Such consultations reflect the specific role of parent-infant mental health services as system champions for infant mental health and parent-infant relationship needs (Bateson et al., 2019). Although some

CAMHS teams work with children under 2 years of age, many do not, and raising awareness of infant mental health and bonding remains a significant undertaking for parent-infant mental health teams through interagency consultation and training (Hunter et al., 2020; Lee & Mee, 2015). Feedback regarding consultations also indicates the benefits of this interprofessional activity in upskilling other healthcare professionals. Cross-agency reflective consultation and supervision have been shown to be effective means of supporting practitioners' use of evidence-based treatments in the context of parent-infant intervention work (Noroña & Acker, 2016).

From the perspective of parents, good interprofessional communication and care planning influenced their decision to engage with the service. This is an important finding because parents can sometimes feel stigmatized and mistrustful of family services, reducing their willingness to engage (Megnin-Viggars et al., 2015). It was also evident that parents' previous experience of multiagency involvement had at times felt intrusive, highlighting the need for practitioners to attend carefully to coordination of timing and frequency of services' involvement.

The impact of interprofessional working on families can be understood from a systems psychodynamic perspective, involving parallel processes whereby dynamics occurring in one interpersonal arena are replicated in another (Sarnat, 2019). For both families and practitioners, Moore (2017) suggested that, "parallel processes operate at all levels of the chain of relationships and services, so that our capacity to relate to others is supported or undermined by the quality of our own support relationships" (p. 11). Bion (1962) posited that supportive relationships facilitate *containment*, involving transfer of problematic feelings to the container from the contained. In the professional context, containment allows the contained individual/group to perform more optimally (Ruch, 2007), which possibly reflects the way the service team's consultations functioned for healthcare professionals. Indeed, interprofessional collaboration may represent a "circle of containment" (Goldsmith et al., 2018, p. 84). Thus, healthcare professionals experiencing containment may – in a parallel process – bring containment to their clients through the therapeutic relationship (Malone & Dayton, 2015). Containing a parent's difficult feelings allows containment of their infant's feelings, thereby enabling development of a secure parent-infant bond and infant attachment (Bion, 1962). Seen through this systems theoretical lens, effective interprofessional working is key to achieving positive outcomes for parent-infant relationships.

Implications for interprofessional practice in parent-infant mental health services

Our findings suggest that, in addition to clinical skills, the ability to move between different forms of interprofessional working including internal team building, interagency networking, coordination, and consultation are key skills for parent-infant mental health practitioners as they are for other healthcare practitioners (Schot et al., 2020). Such interprofessional skills have implications for criteria for staff recruitment, job design, potential delineation of roles within teams, and performance indicators. Particularly challenging for this team, as highlighted by several participants, was interprofessional networking across a large geographic area involving many services. Dow et al. (2017) highlighted the "large, heterogeneous and dynamic" (p. 677) nature of networks within healthcare and called for interprofessional training competencies that reflect the challenge of working with such complex networks. Our findings suggest that training for enhancement of interprofessional working in addition to clinical practice may be important for parent-infant mental health teams given the centrality of interprofessional relational work to their aims.

The findings also suggest that the balance between different forms of interprofessional activities may shift over time as a service develops. In the present example, internal team training was adopted to establish a shared approach at the team's initial inception. However, more professionally homogenous teams may require less time building bridges internally, as implied by Cain et al.'s (2019) longitudinal study of professional identities. Similarly, there may be increasing need for negotiating overlaps with other professionals if families with high support needs are taken on because more dynamic joint care planning and coordination of roles may be required (Schot et al., 2020). Therefore, the developmental trajectory of services and the time required to develop interprofessional practice need to be understood and supported. Such development in interprofessional practice over time has implications for those commissioning and implementing similar early intervention services, thus informing choice of implementation strategies. Findings may also inform the development of logic models to aid understanding of the mechanisms and outcomes of interprofessional working for families and healthcare professionals (Sheaff et al., 2018,) and aid evaluation of parent-infant services.

Limitations and future research

This study was carried out during the COVID-19 pandemic, which affected how the service team worked with each other, other healthcare professionals, and families. Hence, findings may not be transferable to other teams when COVID distancing restrictions are reduced, although there is some evidence that family services may continue to adopt remote systems of working (Burbach & Pote, 2021). Also, the present investigation represents only a snapshot of initial implementation, and the balance of types of collaborative practice may change as the service becomes more established. Further investigation of collaborative practice at a later date may be required to assess how the mix of interprofessional working may have developed. A benefit of repeated interviewing with the service team was that it allowed for observation of the development of interprofessional activities over time, and we recommend a similar design and longitudinal studies to capture interprofessional changes and associated outcomes (Reeves et al., 2017).

Importantly, we included parents' views, although involving a relatively small sample of self-selected mothers and cannot claim to be representative of service users' views more broadly. As there are relatively few studies that incorporate parents' views of interprofessional working (Myors et al., 2013), further research is required that reports on their perspectives. Future researchers studying parent-infant mental health services also

need to consider ways in which interprofessional activity may influence clinical outcomes for families and economic outcomes for such services.

Conclusions

This study indicates that implementation of a new parent-infant mental health service involves development of multiple forms of interprofessional working comprising internal team building alongside external partner networking, communication, coordination, consultation, and training. The diversity of interprofessional working in part reflects the breadth of role of parent-infant mental health services as systems champions and their position in straddling multiple service divisions in the context of unintegrated family services. Our study also indicates that a team's interprofessional working is dynamic and changing as a new service develops, suggesting the need for careful consideration of an implementation approach and monitoring of interprofessional working across time. Such interprofessional working has implications for recruitment and training of staff in parent-infant mental health service teams and for job and service design, and if carried out successfully, has the potential to benefit families' engagement with services.

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