Embedding the Baby's Voice in Children and Young People's Mental Health Services. An approach to aid prioritisation, design and delivery

1. What is the problem we are trying to address?

Babies depend on sensitive, responsive care to grow and develop healthily. But many do not get the nurturing care they need. More than one in ten babies in the UK today are living in fear, confusion and distress.

Not everyone bonds easily with their baby. Parents can be overwhelmed by trauma from their own childhood. Some are struggling with mental or physical health difficulties. Domestic abuse, homelessness and the impacts of poverty can disrupt parent-infant relationships too.

Around 15% of babies in the UK (80,000 babies every year) are estimated to be at risk of 'disorganised attachment', meaning that they have a mental health need. Yet only around 4–6% receive specialist help from a parent-infant team.

Many mental health services see only a handful of babies each year, and some do not accept referrals for babies at all. This is the *Baby Blindspot*: babies have mental health needs.

Baby voice statement

"I cannot use words to tell you I am frightened, confused or distressed. I might turn away, be very quiet or hide my needs. Please don't mistake my silence for being a 'good baby'. I am still communicating, but you need to know what to look for".

2. How to frame Infant Mental Health - start with the importance of parent-infant relationships

The easiest way for any audience to begin to understand infant mental health is to start with a baby's first relationships. Polls of the public confirm that most people instinctively understand that parent-infant relationships are important. These relationships are commonly expressed with terms like bonding and attachment. Feedback from professionals working in the sector is starting with the term infant mental health can be off-putting for some parents and fellow professionals.

3. What is Infant Mental Health and what does it look like?

The first step to embedding Baby Voice is to recognise babies have mental health needs. It is expressed through their emotional wellbeing, sense of safety, capacity to regulate, and emerging relationships. Because babies cannot use words, but communicate in other ways, their mental health is seen in:

- How they connect with caregivers (eye contact, responsiveness, seeking comfort)
- How they communicate their needs and express distress (crying patterns, withdrawal, irritability)
- Their ability to settle and be soothed (co-regulation and self-regulation)
- Their levels of curiosity, engagement and alertness

Infant mental health difficulties present differently to older children and adults. Babies and young children can experience regulation, relational, emotional, and behavioural problems. Enduring problems put children at risk of developing clinically significant mental health problems.

Infant mental health is not located within the baby alone. Because they are completely dependent on adults to meet their needs, it is formed within relationships, particularly the parent–infant relationship(s). The main influences on a baby's mental health are:

- The quality of caregiving and relationships (e.g. sensitivity and attunement, responsiveness [serve and return], emotional warmth, connection, mentalising ["thinking baby"], consistent and predictable care)
- The wider family and social environment (e.g. parental experience of trauma, adversity, mental health, poverty, housing)
- Experiences during pregnancy and early caregiving (e.g. maternal stress, nutrition, safety to explore, opportunities for early learning)

Baby Voice Statement

"My mental health needs begin before I can speak...even before I am born. I learn whether the world is safe through the grown-ups who hold me, comfort me and respond to me (including in the womb)".

4. The meaning of Baby Voice and why it should be incorporated into future mental health governance structures, frameworks and plans

Baby Voice means recognising and acting upon the perspective of babies, including those who are not accessing services.

It is crucial that Baby Voice is considered as well as the perspectives of older children, parents and families. This is because:

- Baby Voice is an acknowledgement that babies and young children have emotional and mental health needs.
- Babies have a basic developmental need for their experience to be acknowledged and acted upon by the adults around them. This provides the building blocks for emotional wellbeing and for their future development and outcomes.
- Baby Voice is fundamental for keeping babies safe. A consistent learning point from serious case reviews is that the needs and perspectives of babies have been overlooked.
- Babies, like all children and young people, have a fundamental right to be heard. This is enshrined in the United Nations Conventions on the Rights of the Child and supported in national legislation and guidance.
- 'Baby Voice' also requires formal accountability — named roles or processes to ensure babies' perspectives shape policy and governance. Taken seriously, this approach makes parent–infant relationships a core marker of quality and safety, recognising that babies' physical outcomes, emotional security and social development are inseparable from the strength of their earliest relationships.

A Baby Voice approach shifts practice towards understanding and acting on the baby's lived experience — improving early identification, targeting support more effectively, and preventing escalation. There is best practice guidance and toolkits to help do this. In specialised parent-infant relationship teams, Baby Voice is fundamental to both their purpose and approach. Furthermore, several Services have also begun to reflect on how this can be applied in their settings supported by shared national learning.

Of note, the Government's guidance – Improving the mental health of babies, children and young people: a framework of modifiable factors - recognises the importance of parent-infant relationships (a key aspect of Baby Voice) but is yet to be incorporated into mental health service frameworks and planning.

5. A Baby Voice approach: a framework for services

The published guidelines and toolkits tend to set out four essential components for embedding Baby Voice. A useful framework is the Lundy model of participation, which includes:

A. SPACE – Baby-friendly environments

- Services create physical and emotional environments where babies can safely communicate
- This includes reducing overstimulation, allowing movement, and creating calm, attuned interactions

In practice this could look like:

- Settings adapted (lighting, noise, layout)
- Professionals positioned at the baby's level
- Time and space built in for observation

B. VOICE – Capturing infant communication

- Babies communicate through behaviour, gaze, movement, and emotional response
- Services actively observe, interpret, and reflect on this

In practice this could look like:

- Structured observation of parent–infant interaction
- Practitioners narrate and "wonder aloud" about the baby's experience
- Parent support is focused on recognising and responding to cues

C. AUDIENCE – Someone with the power to take decisions listens

- The baby's communication is explicitly recognised and brought into professional thinking

In practice this could look like:

- Case discussions include: *"What is the baby telling us?"*
- Professionals acknowledge and respond directly to the baby in sessions
- Infant experience is made visible across the system (i.e. all services that support them)

D. INFLUENCE – Decisions change as a result

- The baby's perspective shape decisions about care, intervention, and service design

In practice this could look like:

- Decisions are documented with the infant's perspective included
- Intervention plans reflect relational and developmental needs
- Services adapt based on what babies' experiences reveal

What this enables

Embedding a Baby Voice approach leads to:

- Better prioritisation
  → Identifying relational risk earlier, not just at crisis points
- More effective interventions
  → Targeting parent–infant relationships, not just symptoms
- Improved outcomes
  → Supporting emotional development, relationships, and long-term mental health

The key issue - Most services currently stop at "VOICE" (if that).

- Observation may happen but it is less commonly:
  - Brought into decision-making
  - Used to prioritise support
  - Embedded in service design

Baby voice statement

"I show my needs in different ways to older children. I need you and other grown-ups to look, listen and act on my needs. If you don't, I have no other way to ask for help".

6. Best Practice Service Models – prioritising Baby Voice & addressing the Baby Blind-Spot

Current service models in the perinatal period have traditionally prioritised adult mental health presentations and crises. This means that Baby Voice, including early relational and developmental needs and risks can be overlooked. Furthermore, mental health needs of babies and young children can be overlooked by the wider workforce and system who are not adequately trained to identify presentations of infant mental health difficulties.

This section includes several best practice examples for Baby Voice related to mental health. The first set of examples are from a strategic and governance perspective, the second show the everyday clinical practice of specialised parent-infant relationship teams:

A. Baby Voice included in national, regional and local mental health strategies and governance structures

- *Baby Voice part of the Wales Ten-Year Mental Health and Wellbeing Strategy (2025-35)*

The mental health strategy in Wales includes babies, alongside children and young people. It includes a case study written from the perspective of the baby. This was inspired by the Pledge for Babies in Wales developed by the Children's Rights in the Early Years Network (CREYN) with input from the Parent-Infant Foundation.

- *Baby Voice incorporated into the Governance Structures of Black Country Mental Health Services*

In 2024, the Black Country's Children and Young People's Mental Health Board actively sought to include the perspective of the babies and the importance of parent-infant relationships. The Board was renamed - the Baby, Children and Young People's Mental Health Board and the Terms of Reference were updated to reflect this new focus on babies and young children. A Parent-Infant Emotional Wellbeing steering group (a multi-agency practitioner group) was taken on as an official advisory group to formally report to the Mental Health Programme Board.

- *Baby Voice central to Blackpool's Five-Year Parent-Infant and Early Years Relationship Strategy (2025-2030)*

The strategy features case studies written from the perspective of babies and young children (including an unborn baby), and focuses on data related to babies and young children facing the greatest health inequalities:

B. Baby Voice at the heart of clinical practice in Specialised Parent-Infant Relationship Teams

Recognising and acting upon the perspective of the baby and infant mental health is central to how specialised parent-infant relationship teams work:

- **Assessments, treatments, outcome measures and clinical documentation consider Baby Voice**

A parent-infant team in Lanarkshire developed the Lanarkshire Infant Mental Health Team Observational Indicator Set - which places the perspective of the baby at the heart of assessment and treatment. Fife Infant Mental Health Team uses the Lanarkshire Infant Mental Health Observation Indicator Set and has a voice of the infant template to support observation and language to describe what infants may be conveying.

The Little Minds Matter (parent-infant team in Bradford) use 'voice of the child' statements in their notes, letters and other communications with other professionals. Babies are also involved in the staff recruitment process. 'We have introduced a parent-infant panel as part of recruitment, with the parent rating how they experienced the candidate's interactions with both them and their baby, and how they thought their baby experienced the candidate. This is an opportunity for service user involvement and ensuring that the experiences of babies are given a platform to be noticed.'

The Bradford Oldham Early Attachment Service is trialing a goal-based measure for babies which involves helping parents to identify what their babies' goals might be.

Lothian PAIRS team reported that the team are all trained in observational tools. This enables them to keep the baby's perspective in mind in reflective practice and in consultation and team meetings.

- **Parent-Infant Teams training the wider workforce**

Parent-Infant Teams support the wider workforce to recognise and elevate Baby Voice in their work.

Little Minds Matter (LMM) in Bradford build capacity in the wider workforce through training and consultation support to professionals, volunteers and students who support families with babies and young children. The training helps attendees understand the importance of the first 1001 days and reflect on how to incorporate the perspective of the baby and parent-infant relationship interventions into their work.

LMM also works with professionals involved with babies and their families by supporting them to consider the voice/perspective of the most vulnerable babies. This work is further supported by the involvement of LMM in meetings such as pre-birth panels and child protection core groups. In the last year, 320 consultation sessions were facilitated with professionals.

More information

The following reports and links provide more information on baby voice, and specialised parent-infant relationship teams who support disrupted early relationships and infant mental health.

Why Babies' First Relationships Matter – Centre for Mental Health
Who is holding the Baby? – Parent-Infant Foundation
Voice of the infant videos - NSPCC expert insights