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Transforming Perinatal and Infant Mental Health:

A mixed-methods evaluation of the iHV PIMH Champions Programme

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Executive Summary

The Institute of Health Visiting's (iHV) Perinatal and Infant Mental Health (PIMH) Champions Programme was developed in response to the urgent need for early identification and intervention for perinatal mental health issues. Mental health problems during the perinatal period are common and can lead to serious consequences for both parents and infants if left untreated. Despite national guidelines encouraging regular mental health screening, many families still do not receive appropriate support. Since 2013, the iHV has worked to address this gap by training multi-agency professionals to become Champions — leaders in PIMH within their local systems. This three-part evaluation incorporated the views of 2,151 participants and explored the effectiveness, scalability and system-level impact of the Programme, including its 'train-the-trainer' cascade model.

The objectives of the evaluation were to:

- Assess whether shifts in learning from Champion-led training align with those from the iHV-facilitated delivery
- Evaluate the fidelity of the cascade model
- Describe the impact on individual Champions
- Explore the broader influence of the Champion role on the PIMH system
- Identify barriers and facilitators to successful programme implementation

A mixed-methods approach was used, encompassing three workstreams:

1. Analysis of pre- and post-training data across different training formats;

2. An online survey completed by 111 Champions from across the UK;

3. Thirteen in-depth qualitative interviews supplemented by three case studies.

Key findings

- **Workstream 1:** Champions demonstrated increased knowledge, confidence and role clarity across all training formats. Overall, 98% of participants reported improved confidence in recognising perinatal mental health issues. Participants also reported a greater understanding of policy and guidelines, better awareness of local and national support, and a more holistic appreciation of the importance of parent-infant relationships. These outcomes were consistent across all training models, suggesting that the cascade format of delivery by iHV Champions can be as effective as direct delivery by the iHV training team, when training fidelity is maintained.

- **Workstream 2:** The broader impact of the Programme was examined through an online survey. Over 70% of Champions had cascaded training, with many reaching a wide range of professionals across health, early years and voluntary sectors. Reported impacts of the Programme included improved early recognition and identification of perinatal mental health concerns, the facilitation of more timely access to enhanced support for families, and referrals to community and specialist services when needed. Champions also noted personal and professional development benefits, such as increased confidence, better interdisciplinary collaboration, and involvement in service development. Enabling factors included access to iHV resources, co-facilitation with other Champions, and supportive organisational environments. However, barriers such as lack of protected time, staffing shortages, and inconsistent local leadership were noted to limit implementation.
- **Workstream 3:** Qualitative findings further highlighted the Programme's transformative effect. Champions described a profound shift in professional mindset, developing a "perinatal frame of mind". This new lens fostered more holistic, relational, and inclusive practice. Many Champions reported acting as strategic leaders, advocates and change agents within their organisations, contributing to new pathways, influencing training strategies and engaging in system-level improvement. The training helped them build confidence, lead interdisciplinary conversations and support colleagues in emotionally complex work. However, sustaining impact proved challenging in systems without structural support. Champions expressed the need for ongoing supervision, co-facilitation, and organisational alignment to maintain training quality and influence.

Across all workstreams, the evaluation suggests that the iHV PIMH **Champions Programme is a credible, effective and scalable approach to workforce development** and system transformation. The findings strongly support the Programme's Theory of Change, showing that Champions become local leaders, driving improved care through enhanced knowledge, motivation and collaborative practice.

Areas for future development:

- For the iHV, this includes improving access to updated resources, monitoring training fidelity, and enhancing support and accessibility of resources for non-health professionals.
- For organisations and service leaders, recommendations include allocating protected time for Champions to enable them to enact their role, integrating the role into job descriptions and strategic plans, and fostering a safe environment for reflective practice.
- Future research should focus on long-term family outcomes, impact on parents and families, engagement with less active Champions, and the effectiveness of training adaptations.

In conclusion, the iHV PIMH Champions Programme is a well-regarded, evidence-based intervention that improves practitioner knowledge, enhances care quality, and contributes to systemic improvements in perinatal and infant mental health support. With sustained investment, strategic alignment and ongoing support, the Programme has the potential to deliver lasting change for families and services across the UK.

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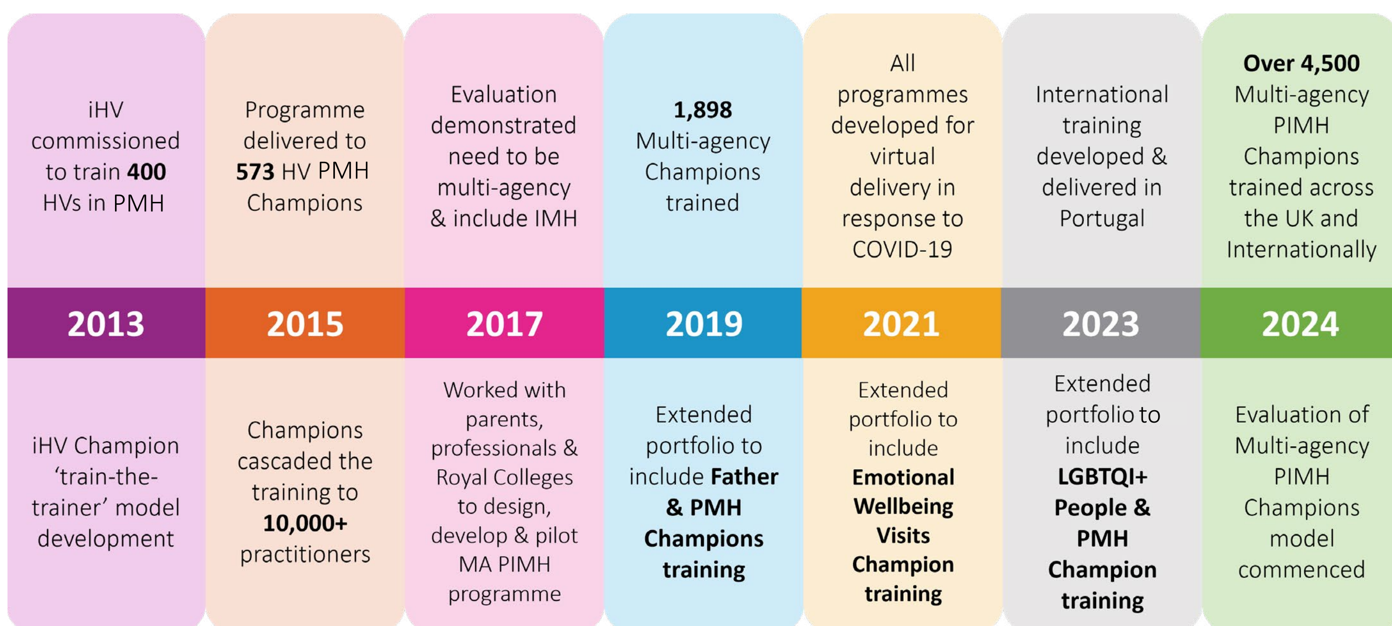
Background

Perinatal mental health problems are common and, if untreated, can have serious consequences for parents, babies, and families. In the UK, suicide remains the leading cause of direct maternal death within a year of birth[1]. The annual societal cost of perinatal mental illness was estimated at £8.1 billion in 2014 - 72% of this cost related to perinatal mental health problems on child outcome[2]. This figure is likely to have risen in the years since. More recent analysis by the London School of Economics strengthens the economic case for investing in timely, effective perinatal mental health treatment, highlighting both unmet need and the potential for substantial savings to health and social care[3]. Poor parental mental health can affect parent–infant interactions, with lasting effects on child development[4,5]. The Centre for Mental Health's briefing, A Sound Investment, further emphasises the ethical and economic rationale for prioritising perinatal mental health in policy, commissioning, and workforce planning[6].

Early identification and support are crucial. Since 2013, the Institute of Health Visiting (iHV) has championed high-quality training for practitioners working with families during the perinatal period – delivered through its PIMH Champions Programme and a range of other PIMH initiatives. Its evolving 'train-the-trainer' PIMH Champions model remains central to promoting sustainable impact. The iHV's current portfolio includes training in multi-agency PIMH, Fathers' Perinatal Mental Health, LGBTQI+ Perinatal Mental Health, and Emotional Wellbeing Visits. Over 4,670 Champions have now been trained across all programmes in Scotland, Wales, Northern Ireland, England and Portugal (Figure 1).

Figure 1: Evolution of iHV PIMH Champions Training Programmes



This evaluation focuses on the flagship iHV PIMH Champions Training Programme, which has received national and international recognition. Awards include a commendation from the Maternal Mental Health Alliance[7], the White Swan Foundation International Education Award (Marcé Society, 2018), and finalist status in the HSJ Workforce Initiative of the Year (2021). The Programme is externally accredited by the CPD Standards Office and aligned with national competency frameworks[8,9].

The iHV Perinatal and Infant Mental Health Champions Training Programme

Grounded in ecological, human-valuing, and salutogenic principles[10], the iHV PIMH Champions Programme is informed by educational theories of partnership working[11] and psychological mindedness[12,13]. Its Theory of Change, as outlined by Beauchamp and Baldwin[14], underpins this evaluation and highlights key mechanisms of impact (Figure 2):

Figure 2: iHV PIMH Champions Programme Theory of Change (Beauchamp and Baldwin, 2025)

iHV PIMH Champions Training Programme Theory of Change

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Situation

1 in 5 women + 1 in 10 men **experience perinatal mental illness** (PMI)

Maternal suicide is the leading cause of direct maternal death occurring within a year after the end of pregnancy

PMIs cost around **£8.1 billion** per annual cohort of births in UK

72% of costs relate to adverse impacts on the child

PMIs are **treatable**

But **many are not identified** and there can be **barriers** to accessing support for those who most need it

Aim

To build advocacy for perinatal and infant mental health through access to high-quality perinatal and infant mental health training for all practitioners working with families in the perinatal period.

Evidence assessment
Research, UK policy and clinical guidelines

Inputs
- Funding for training
- Organisational support
- Time
- Resources (physical space, IT provision)
- Multi-disciplinary staff
- Voices of Lived Experience

Activities
- Champions Training programme
- Quarterly virtual Forums
- Quarterly e-Bulletins
- Web-based resources

Change mechanism
- Knowledge acquisition
- Support systems
- Skills and confidence to lead change
- Experiencing safe psychological space
- Developing a 'perinatal frame of mind'
- Feeling supported
- Feeling motivated to make a difference
- Being professionally curious
- Understanding of other professional

Outputs
- Number of Champions trained
- Increased knowledge, skills, understanding and confidence
- Strengthened networks and support systems
- Access to PIMH-related CPD

Outcomes

Short term
- Creation of place-based Champion leaders who have robust skills and knowledge of the latest evidence base relating to PIMH

Medium term
- Champions cascade awareness-level PIMH training locally

Long term
- Champions influence stakeholders and services around the needs of families, identify local gaps in services, and improve support available.
- Expanded pool of place-based Champion leaders to enable wider dissemination of programme

Impacts
- Raised parity of esteem for mental health
- Early identification and support for PIMH problems
- Improved outcomes for babies, children and families
- Strengthened local integrated PIMH care pathways
- Clinically- and cost-effective care
- Improved inter-agency working
- Reduced health inequalities

Assumptions

- Those being trained as Champions have the motivation, passion and skill to deliver the cascade training
- Champions will have protected time to develop their role and maintain knowledge, skills and competencies
- Champions will have access to robust clinical supervision
- Services will support staff to attend training

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The Programme content and formats are outlined below (see Box 1).

Box 1: Content and Format of iHV PIMH Training Programme

Module Content:

- Context, policy and research
- Assessment, identification and interventions
- Mental health conditions
- Parent-infant relationships and the perinatal frame of mind
- Red flags, risk of suicide and safeguarding
- Inclusive, integrated care pathways and quality assurance
- Voices of lived experience, case studies
- Practitioner wellbeing and supervision

Format 1: iHV PIMH Champions Training

Based on a 'train-the-trainer' model, the Programme aims to prepare participants to undertake a Champion role in Perinatal and Infant Mental Health (PIMH). Participants receive a 2-day virtual or in-person training, facilitated by iHV trainers, including module content, guidance on how to deliver training, top tips for successful cascades, and discussion regarding opportunities for ongoing development and networking via iHV PIMH Champions Forums, resources and Bulletins. On completion of the Programme, participants have access to all PIMH Champion resources (PowerPoint presentations, films, evaluations, certificates) to support them to deliver an awareness-level PIMH cascade to multi-agency colleagues.

Format 2: iHV PIMH Awareness Training

This format involves direct delivery of the Programme content by iHV trainers to a multi-agency audience. The aim of the Programme is to build advocacy for, and understanding of, perinatal and infant mental health (PIMH). Participants receive a 1-day or 2-day virtual or in-person training, facilitated by iHV trainers covering module content. The pace of delivery, activities and depth of discussion will vary depending on duration. No cascade of training is associated with this format.

Format 3: Champions' cascade of iHV PIMH Awareness Training

Champions trained through Format 1 deliver this awareness-level training locally to multi-agency audiences. Participants receive a 1-day or 2-day or modular cascade of the iHV PIMH Awareness training, facilitated virtually or in-person covering module content. The aim of the Programme is to build advocacy for, and understanding of, perinatal and infant mental health (PIMH).

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Rationale for this evaluation

As the PIMH Champions Programme expanded nationally and internationally across diverse professional groups and service settings, variability in implementation increased. A formal evaluation was needed to understand barriers and enablers to effective scale-up, assess the impact of adaptations on fidelity and outcomes, and explore the broader influence of the Champion role on services. Anecdotal reports suggested Champions were modifying delivery (e.g., shortening sessions), potentially undermining core content and the Programme's Theory of Change. While iHV data showed improved knowledge and confidence when training was delivered by experienced facilitators, it was unclear if similar results occurred with Champion-led sessions. Following a Scottish Government commission in 2020, over 200 Champions were trained, with NHS Education for Scotland (NES) collecting data. This provided a unique opportunity to compare outcomes and examine system-level impacts of the Programme.

Aims and objectives

Aim

To evaluate the process, impact, and outcomes of the iHV PIMH Champions Programme.

Objectives

1. Assess whether shifts in learning from Champion-led training align with those from iHV-facilitated delivery
2. Evaluate the fidelity of the cascade model
3. Describe the impact on individual Champions
4. Explore the broader influence of the Champion role on the PIMH system
5. Identify barriers and facilitators to successful Programme implementation

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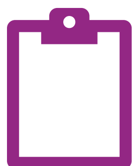
Methods

A mixed-methods approach was used to collect and analyse both quantitative and qualitative data through three workstreams. This allowed exploration of a range of perspectives and offered a better understanding of connections between the data.

Workstream 1: Existing pre- and post-training evaluation data for all three training formats were analysed to explore changes in learning, confidence, and perceptions. Comparisons were made between two training delivery models: iHV PIMH Awareness Training delivered by iHV trainers (Format 2), and Champions' cascade of iHV PIMH Awareness Training delivered by PIMH Champions trained by iHV trainers (Format 3), provided by NES. Data were analysed using descriptive statistics.



Workstream 2: An online questionnaire was co-produced by the research team in collaboration with iHV PIMH Champions from an existing practitioner advisory group. It was initially piloted with a small number of Champions to ensure clarity, relevance, and usability before wider distribution via SurveyMonkey. Questions relating to consent were included at the start of the questionnaire, providing participants with full details about the study and how their information would be used. All PIMH Champions registered on the iHV database (Salesforce) were eligible to participate and were sent a web link to the questionnaire via email. The research team collated and analysed the questionnaire results using descriptive statistics. Additionally, the questionnaire included an option for respondents to indicate their willingness to participate in a qualitative interview or contribute a case study for Workstream 3.

Workstream 3: PIMH Champions who indicated their interest in participating in an interview through the questionnaire were invited to take part. The data from Workstream 2 informed the development of a topic guide to support the interviews. Semi-structured interviews were conducted by Research Team members using the Zoom recording system, after obtaining written informed consent from each participant. Only audio files of the interviews were stored, and the recordings were transcribed by an external transcription company.
Interview data were analysed using the six phases of thematic analysis as outlined by Braun and Clarke[15]. Participants who expressed willingness to contribute a case study were provided with a template and asked to return it to the research team via email.

From this point forward, the iHV PIMH Champions Training (Format 1) will be referred to as 'Champions training'; the iHV PIMH Awareness Training delivered by iHV trainers (Format 2) will be referred to as 'Awareness training'; and the cascade of iHV PIMH Awareness Training delivered by PIMH Champions trained by iHV trainers (Format 3) will be referred to as 'Cascade training'.

Evaluation Approach and Mitigating Bias

The evaluation was conducted in-house by the iHV Innovation and Research team, enabling access to participants and alignment with the Programme goals. To minimise potential bias, interviews and data analysis were led by team members not involved in developing or delivering the PIMH Champions training. This separation supported objectivity and encouraged candid participant responses. Involving two researchers in data collection and analysis further enhanced reliability through collaborative interpretation.

The expert advisory group (EAG), comprising independent members, organisations, and practitioners, provided expert advice and oversight throughout the study. The EAG ensured adherence to the study protocol, upheld robust governance, and provided objective feedback on the draft report findings.

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Ethical approval was obtained from the School of Social Sciences Staff Review Committee, University of Kent, on 15/11/2024 (Ref:1094).

Findings

Workstream 1: Pre-and post-training evaluation

In this workstream, routine existing pre- and post-training evaluation data were analysed to explore changes in learning, confidence, and perceptions across all three training delivery models.

The table below summarises participant numbers, session delivery and questionnaire completion across the three training formats.

Table 1: Participant numbers, session delivery and questionnaire completions across the three training formats

Training Format	Delivery Period	Participants Engaged	Pre-Training Completed	Post-Training Completed
Champions Training (Format 1)	Jan 2021 – May 2024	929	878	776
Awareness Training (Format 2)	Mar 2022 – Jul 202	698	599	499
Champion-delivered Cascade Training (Format 3)	Feb 2022 – Aug 2024	Not Known (based on questionnaire completions)	550	370

Pre-training questionnaire completion rates were consistently higher than post-training across all training formats, reflecting common patterns in participant engagement.
Champions represented local authorities, NHS staff, and the Voluntary, Community and Social Enterprise (VCSE) sector across all four UK nations. Feedback indicated that participants highly valued the opportunity to learn about local services available to families, with many expressing an intention to collaborate with colleagues across sectors to adopt a multi-agency approach to perinatal care:

"The diverse groups of professionals on the training increased my knowledge of the services available in different areas."

(Champion Training in England, March 2021)

Knowledge Gain and Confidence in Key Areas

Shift in Understanding of Perinatal Wellbeing and Infant Mental Health

One of the key objectives of the Programme is to enable participants to confidently articulate why good parental mental health is vital for infant development and long-term health outcomes. Feedback indicated that participants' understanding of the importance of parental mental health and its impact on infant mental health increased following training, across all three formats (see Table 2).

Table 2: Participants' understanding of the importance of parental and infant mental health during the perinatal period, pre- and post-training

Training Format	Champions training (Format 1)	Awareness Training (Format 2)	Champion-delivered Cascade Training (Format 3)
Good understanding, pre-training	25%	60%	49%
Good understanding, post-training	78%	80%	60%

Additional qualitative comments from participants showed that many were motivated by a strong commitment to advocate for parental and infant mental health, focusing on bonding, attachment, and long-term family wellbeing.

Recognising the most common perinatal mental health conditions

The Programme also aimed to help participants recognise the clinical features of perinatal mental illness. Confidence levels rose significantly, from just 12% of Champions' training participants feeling confident pre-training to 60% post-training (Format 1). Overall, 98% of participants agreed or strongly agreed that they could recognise key symptoms after completing the training. Participants particularly valued learning how to use open-ended, non-judgmental questions and stressed the importance of building trusting relationships when eliciting and addressing sensitive issues like self-harm and eating disorders.

"There are lots of different symptoms, but the relationship is the important part to help recognise the condition."

(Participant, PIMH Champions Training Wales, January 2021)

"I now understand how these [mental health conditions] present and the importance of asking open questions to assess and refer families to the right support."

(Participant, PIMH Champions Training, England, November 2023)

Figures 3 and 4 show similar training outcomes across delivery formats. Although Cascade training (Format 3) had slightly higher pre-training confidence, about 97% of participants in both Awareness (Format 2) and Cascade (Format 3) post-training agreed or strongly agreed they felt confident recognising common perinatal mental health conditions.

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Figure 3: Awareness training (Format 2): Participant confidence in recognising the clinical features of the most common perinatal mental health conditions

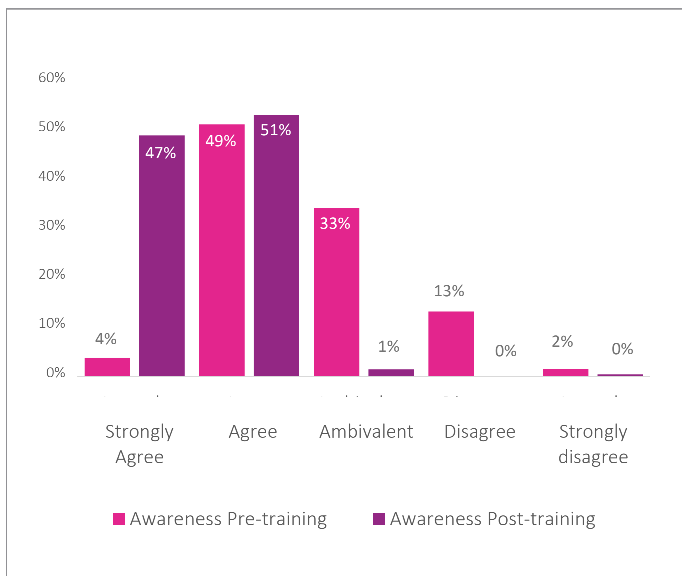
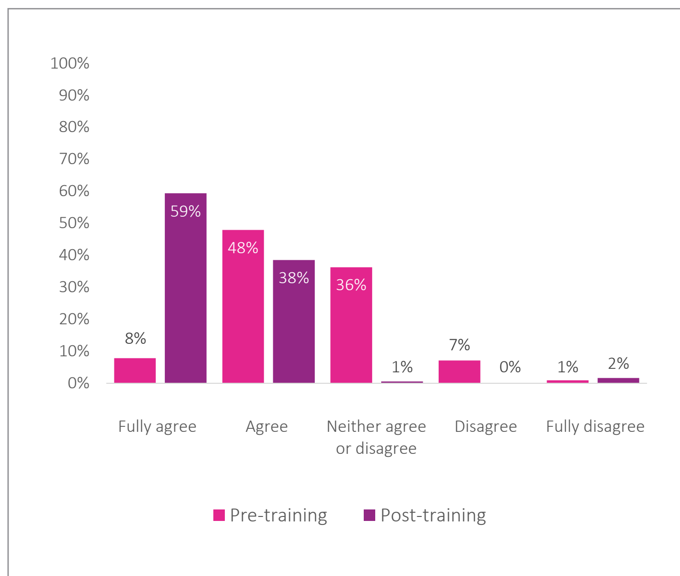


Figure 4: Cascade training (Format 3): Participants can recognise the clinical features of common perinatal mental health conditions



Understanding of Policy and Resources

In Champions training (Format 1), confidence in explaining key infant mental health concepts rose from 42% pre-training to 96% post-training. Similarly, in Awareness (Format 2) and Cascade (Format 3) trainings, prior to the training, over 25% disagreed they understood related policies and research, which dropped to less than 1% after training. The comparable shifts across formats (Figures 5 and 6) demonstrate the training's effectiveness in enhancing understanding of infant mental health and its long-term impact.

Figure 5: Awareness training (Format 2): participant understanding of current policy and research relating to perinatal mental health, current practice and service development

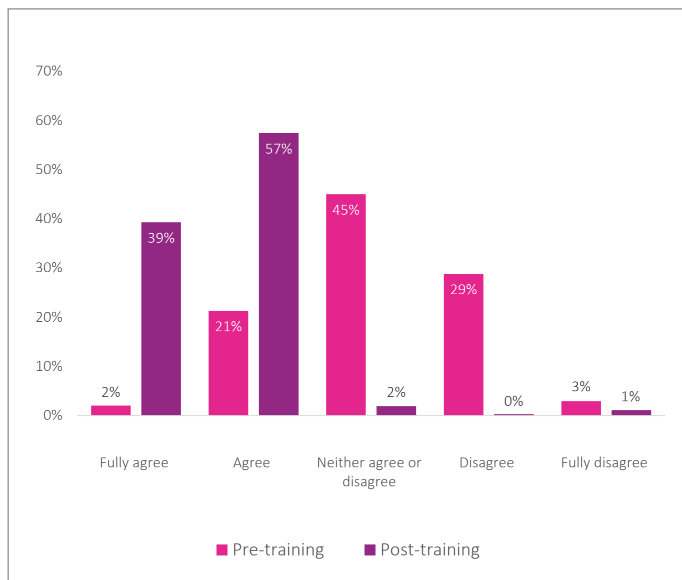
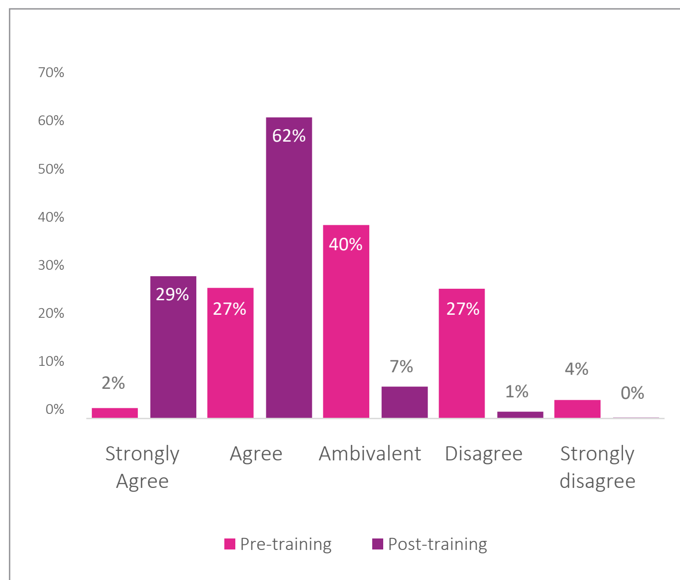


Figure 6: Cascade training (Format 3): Participants are aware of key policies and research evidence relating to perinatal and infant mental health and know how to access these



Training significantly improved participants' familiarity with and understanding of key clinical guidelines (NICE CG192, SIGN 127/169), with over 90% of Cascade and nearly 90% of Awareness training participants recognising their importance post-training. Pre-training, about 40% of participants were unaware of these guidelines. Post-training, 53% of Cascade training (Format 3) participants strongly agreed they were familiar with SIGN Guidelines, compared to under 30% in the Awareness training (Format 2) group, likely due to differences in question framing. Overall, 87% of Awareness and 92% of Cascade participants agreed or strongly agreed they understood the importance of clinical guidelines for perinatal and infant mental health after training.

Confidence in Accessing Support

When asked about their confidence in accessing support for mothers and families, a marked improvement was observed. The table below illustrates the shift in confidence before and after the Champion training (format 1):

Table 3: Participant confidence in accessing support for mothers and families

Response	Champion (Format 1) Pre-training	Champion (Format 1) Post-training
Strongly Agree	12%	59%
Agree	62%	39%
Ambivalent	20%	0%
Disagree	5%	0%

Through all methods, the training had a positive effect on participants' knowledge of the support available for mothers and families. The data show a significant reduction in uncertainty from around 25% to around 1% for each group and from around 10% disagreement to none. There is a marked increase in strong agreement. The Cascade training (Format 3) cohort suggests a greater shift in those strongly agreeing from 5% to 62% compared with those in the Awareness training (Format 2) cohort from 8% to 48%. In both cases, the findings indicate that the training was successful in significantly enhancing participants' understanding of the available help and support systems for families in need.

Participants' Engagement with Services and Role Clarity

Participants were asked about the impact of the training on their role clarity and empowerment (Figure 7), and motivation to improve outcomes for women and families (Figure 8). Responses indicated a greater understanding of their role following the training. In post-training surveys, 57% of Champions training (Format 1) participants strongly agreed that they understood their role and felt empowered to contribute effectively to multi-agency efforts.

Figure 7: Format 1 Champions training: Participant clarity and empowerment in their professional role to maximise their contribution to improving outcomes for women and families

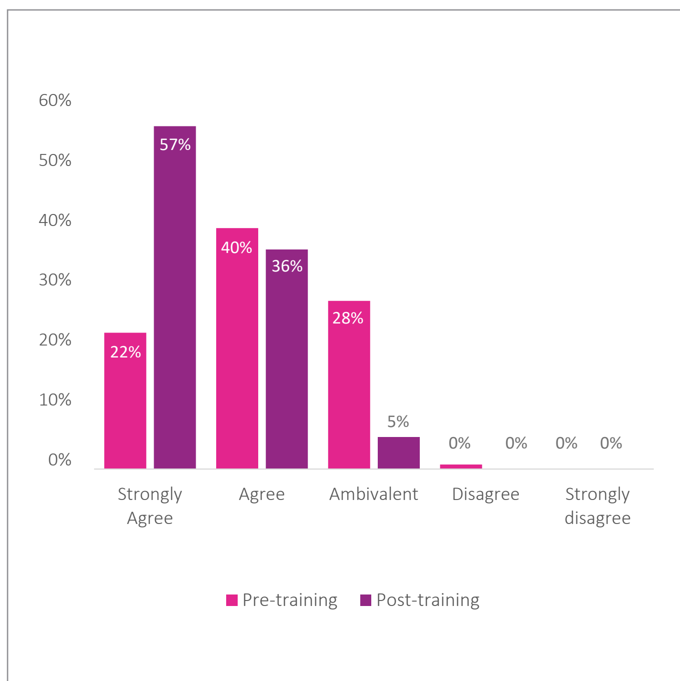
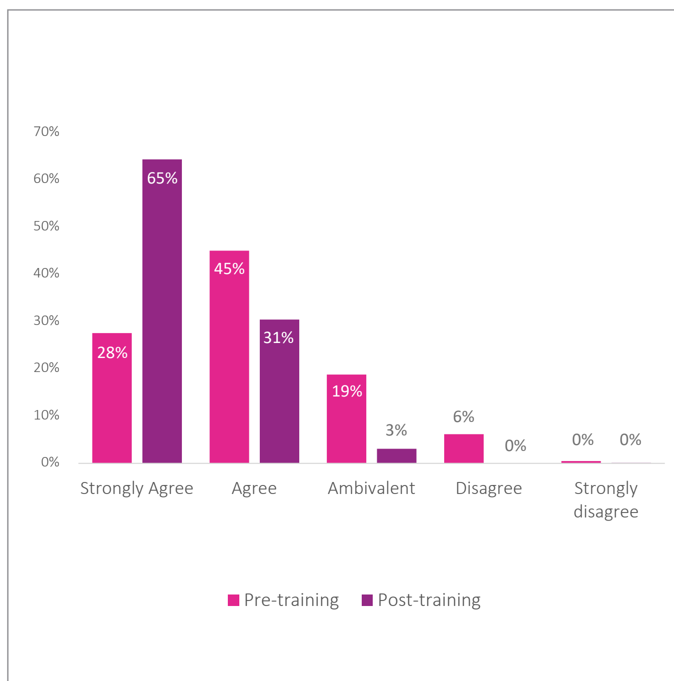
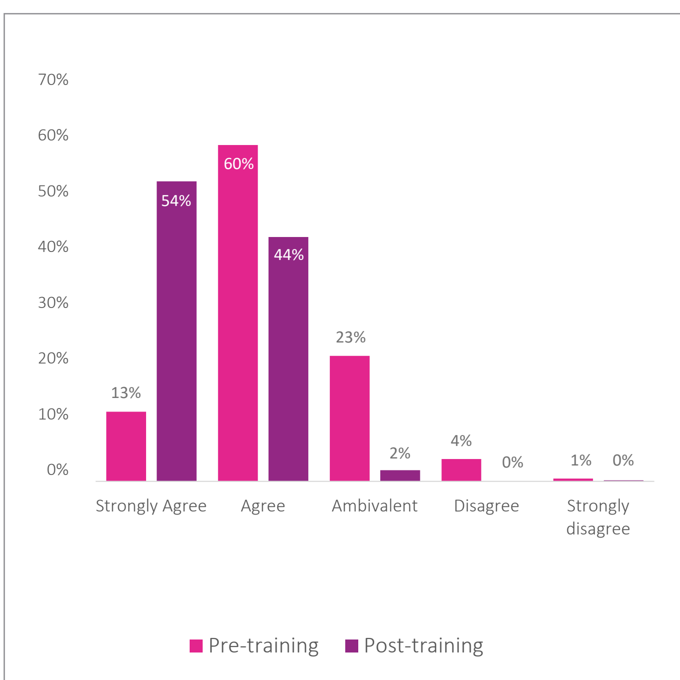


Figure 8: Format 1 Champions training: Participant clarity on iHV Champion role and motivation to improve outcomes for women and families in their local area



This question was not asked when the Cascade training data was collected, and therefore, comparable information was unavailable. However, the results from the Awareness data (Format 2) reflect a similar shift in knowledge to that discussed above, with 53% of participants post-training strongly agreeing compared with 12% before training (see Figure 9).

Figure 9: Format 2 Awareness training: Participant clarity and empowerment in their professional role to maximise their contribution to improving outcomes for women and families



Qualitative responses indicate that participants intended to improve local service pathways, particularly around infant–parent bonding and attachment. Post-training comments suggest the training motivated participants to advocate for better access to perinatal mental health services and actively contribute to service improvement.

Summary of Workstream 1 Findings

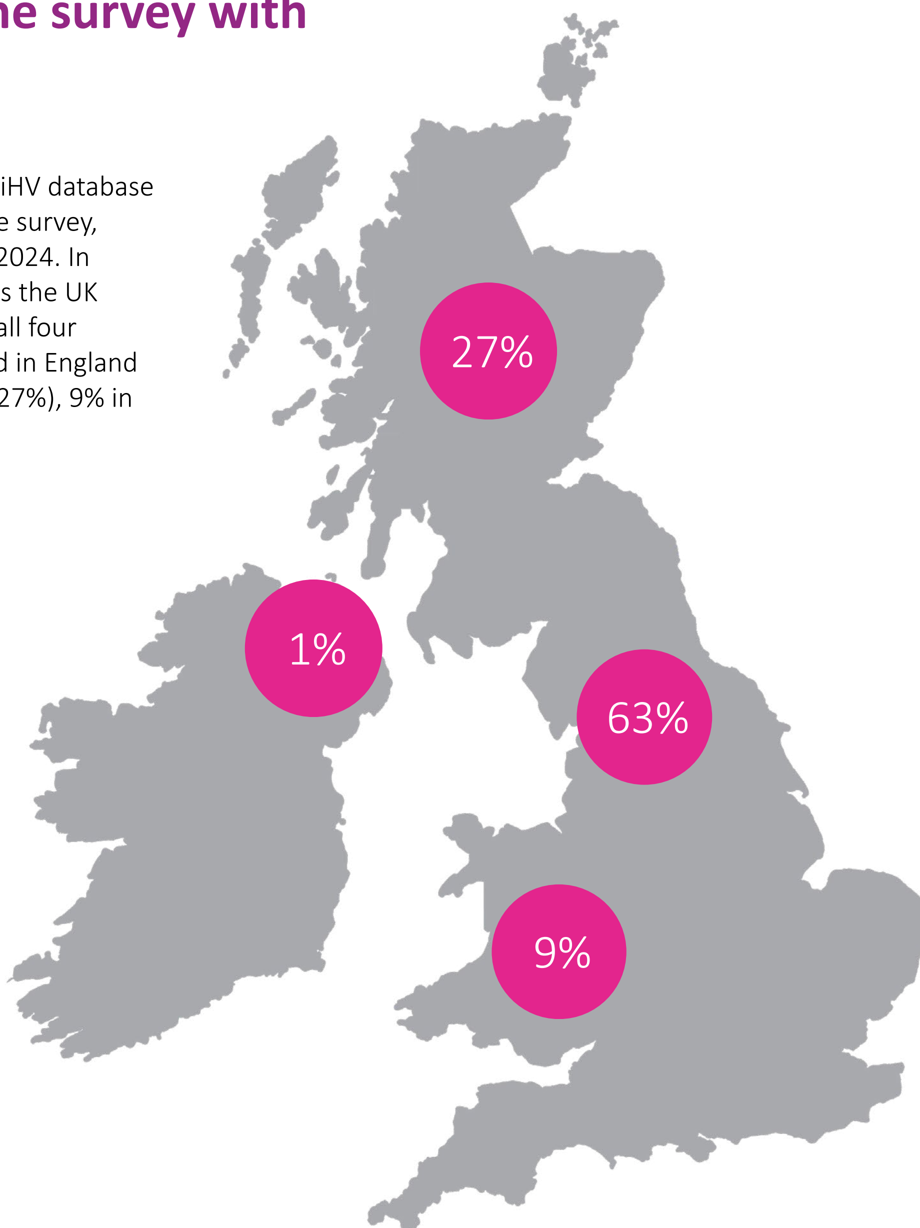
The iHV PIMH Training Programmes have demonstrated significant success in increasing knowledge, confidence, and understanding among participants, regardless of which format was used and whether the training was delivered by iHV trainers or cascaded by Champions. All three programmes have had a notable impact on practitioners' ability to recognise perinatal mental health conditions, understand infant mental health, and access appropriate support for families. This workstream aimed to determine whether the learning shifts from training delivered by Champions were consistent with those delivered by iHV facilitators, and the findings suggest that they were.

The Champion's role has positively contributed to local service improvements and empowered professionals to actively engage in multi-agency approaches to perinatal care. The consistency of outcomes across different facilitators suggests that the training model is robust and scalable, supporting the ongoing success and expansion of the Programme.

Overall, the findings highlight the Programme's broader impact in enhancing the knowledge and skills of professionals working with children and families, thereby promoting better long-term mental health outcomes for mothers, infants, and families.

Workstream 2: Online survey with PIMH Champions

All PIMH Champions registered on the iHV database were invited to participate in the online survey, which was disseminated in December 2024. In total, 111 PIMH Champions from across the UK responded. Respondents represented all four nations of the UK: over half were based in England (63%), just over a quarter in Scotland (27%), 9% in Wales, and 1% in Northern Ireland.

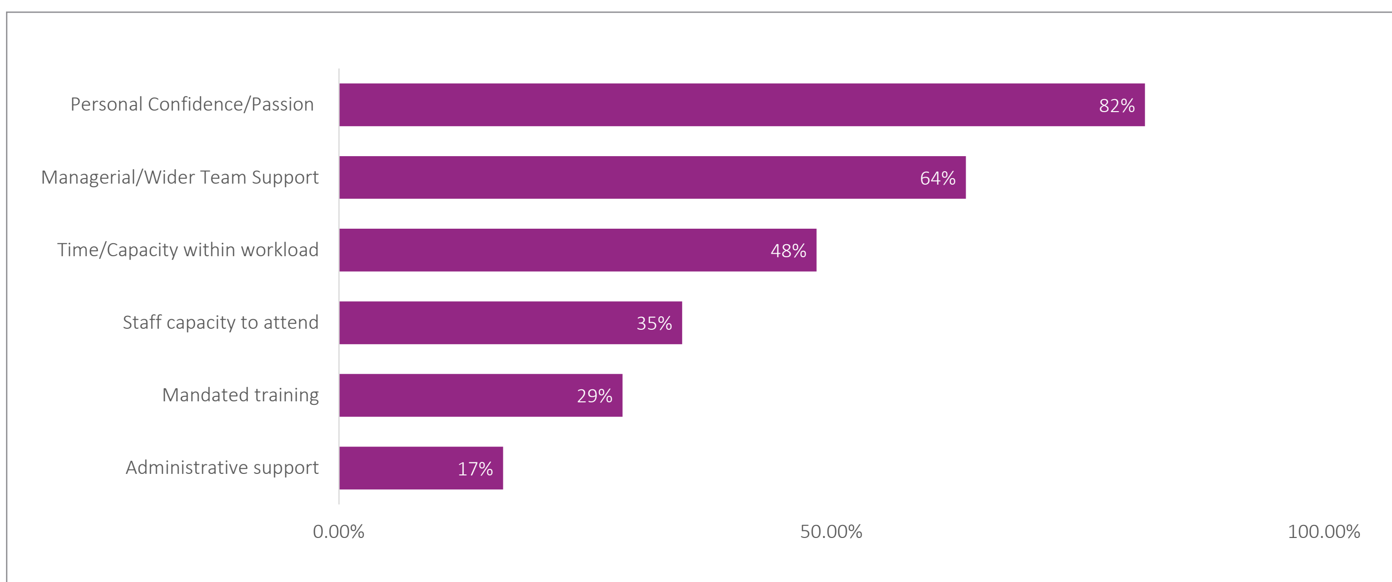


Cascading Training: Barriers and Facilitators

Positively, 71% of respondents had already cascaded the training, and 9% had planned to do so within the following twelve months. This was particularly encouraging, given that only 38% worked in areas where PIMH Awareness training (Format 2) was mandated.

Figure 10 below shows that survey respondents identified key facilitators for cascading training, including personal confidence and passion, managerial support, capacity, staff availability, and administrative support. Additionally, several respondents highlighted funding, the quality of the iHV PIMH Champions training resources and materials, and support from other local PIMH Champions or training “buddies” as factors that supported their ability to cascade the training.

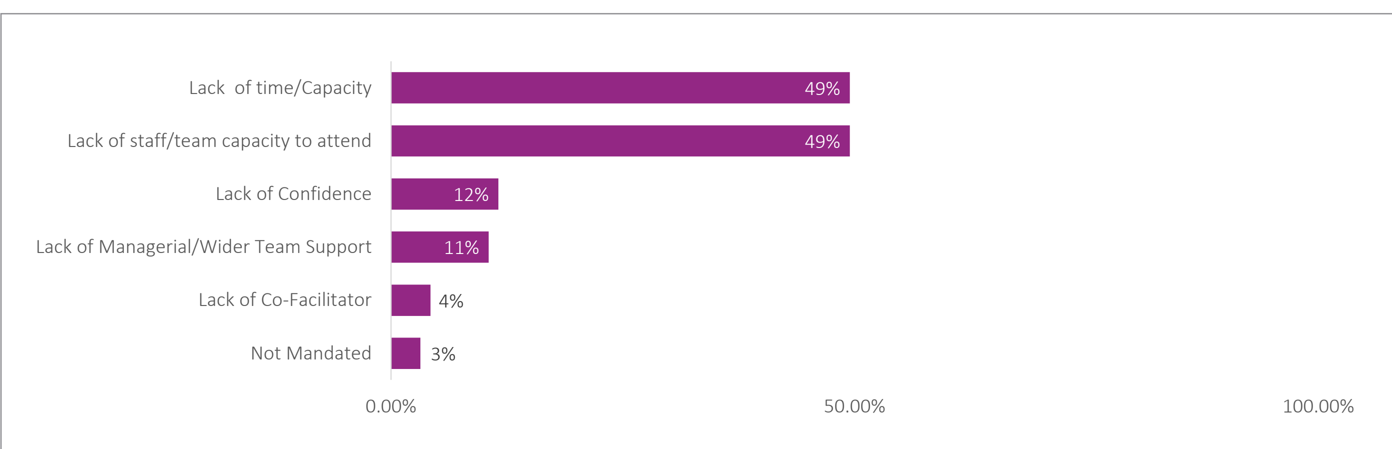
Figure 10: Key facilitators that support cascade training



Among respondents who had cascaded the training, 77% reported co-facilitating with another iHV PIMH Champion, while 8% did so with a co-facilitator who was not a Champion. Despite iHV’s recommendation that training be delivered by two facilitators - primarily to ensure participant safety and emotional support — 16% reported delivering the training alone.

Respondents were asked to identify barriers that had prevented or made it difficult to cascade the training. Figure 11 below outlines the main challenges cited.

Figure 11: Key Barriers to Cascading Training



Additional barriers included prolonged staff absences, being new or recently in post (3%), difficulty securing suitable training rooms (2%), and lack of funding for venues or refreshments (1%). A few respondents (3%) noted that non-mandatory training is often deprioritised by staff. Two iHV-specific barriers were also highlighted: one respondent felt the two-day format was too long and suggested a reminder of alternative delivery options, while another was unclear about the target audience and recommended a mapping exercise to identify those who would benefit most.

Reach and Format of Training

To assess the Programme's reach, respondents were asked how many participants they had cascaded the training to. Thirty-two percent of respondents cascaded training to 1-20 participants, while nearly a quarter reached over 100. Over 80% delivered training within health visiting teams (including health visitors, specialist health visitors, and skill mix staff), and almost half had trained students (pre-registration nurses, midwives, and health visitors). Many also reached midwives (27%) and practitioners in early years settings, family hubs, and children's centres (29%). Others included allied health professionals, social workers, mental health practitioners, and staff from the voluntary and charity sectors, with fewer involving psychologists and psychotherapists. Some extended training to obstetricians, GPs, Family Nurse Partnership nurses, emergency services, and health and social care students. This broad reach highlights the Programme's multi-agency relevance and systemic focus. Most training was delivered face-to-face in a one-day format (62%), with 27% delivered virtually and just over a quarter delivered face-to-face over two days.

Quality and Adaptation of Training Materials

The iHV PIMH Champion Training slides and resources are updated regularly in line with research and policy, and are available for Champions to download from the iHV website. Almost all respondents who cascaded the training were satisfied with the content and quality of the materials and resources provided (98%) and felt they were inclusive and accessible to all participants (95%).

More than 80% of respondents reported making adaptations to the training materials. The most common adaptation was adding information about local services and pathways, as encouraged by the iHV to enhance relevance. Thirty percent of respondents removed or reordered slides or changed participant activities. One participant simplified wording to improve accessibility for their non-health professional participants.

When asked about additional iHV Champion resources, respondents confirmed widespread use (trainer note PDFs – 70%, attendance certificates – 67%, and pre- and post-evaluation forms - 61%). Just under half utilised participant handouts, the film library of lived experience, and lesson plans.

Impact on Practice and Family Wellbeing

Respondents who cascaded the training largely reported a significant shift in participant knowledge across four of the five key learning outcomes (Figure 12). Several noted increased staff awareness, knowledge, and confidence. However, 17% did not use post-training evaluations.

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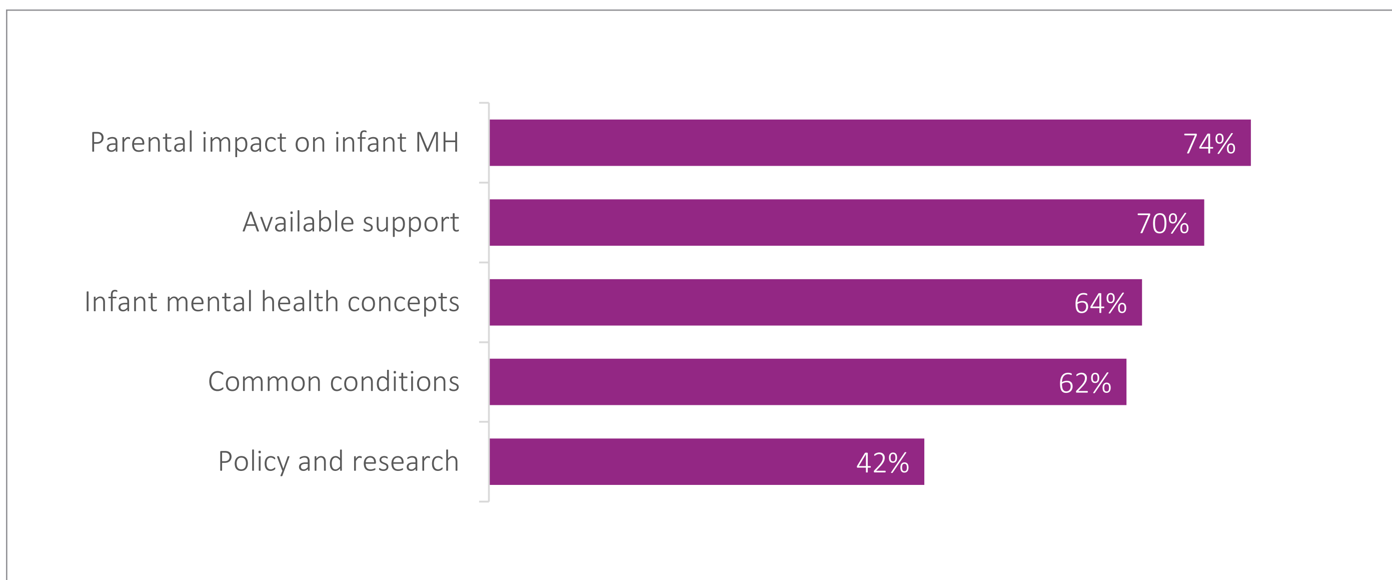
Figure 12: Knowledge Shifts Demonstrated in Post-training Evaluations



The majority of respondents reported that following training, practitioners had an increased ability to develop trusting therapeutic relationships and offered evidence-based advice and support to families that did not meet the threshold for referral, or were awaiting specialist intervention (61%). Over half reported that:

- more women were asked about their mental health at routine contacts (55%)
- mental health problems were identified earlier (53%)
- more women were asked about suicidal thoughts (52%)

Nearly half reported an increase in referrals to specialist services, such as talking therapies, perinatal mental health team, parent-infant teams (47%), and improved quality of referrals (42%). Over a quarter felt that the training resulted in increased access to and engagement with groups led by voluntary, community, or statutory services (29%), and almost a fifth reported positive impact on family wellbeing (18%).

Respondents were asked how they demonstrate the positive impact of practitioner training on family wellbeing. Around a third cited family feedback (38%), audits (36%), and referral data (32%). Over a quarter used standardised validated outcome measures such as the Patient Health Questionnaire-9 (PHQ-9) or Edinburgh Postnatal Depression Scale (EPDS) (29%). One respondent also referenced practitioner feedback as evidence of impact. It is worth noting that many respondents did not complete this question, and several selected 'not sure' or provided open-ended 'other' responses. This likely accounts for the relatively small percentages reported across individual methods.

Impact on Champions' Development and Services

The majority (74%) of respondents reported that being a Champion had positively impacted their practice and professional development. Respondents reported feeling "more educated in self", having a "greater insight into PIMH" and being more inclusive, for example, "working more closely with fathers". Many felt better equipped to deliver high-quality, inclusive PIMH care, providing evidence-based support to colleagues, and building trusting therapeutic relationships with families. Others noted being more proactive in supporting their own wellbeing and serving as role models for colleagues. Some also attributed career progression to their role as Champions, highlighting the Programme's potential to develop local leaders in PIMH.

Other reported benefits include:

- Development of stronger interdisciplinary relationships supporting integrated care (44%)
- Improved interdisciplinary working, such as invitations to Specialist Perinatal Mental Health Team referrals meetings (50%)
- Service-level and strategic improvements, such as new PIMH pathways (36%) and development of Standard Operating Procedures (20%)
- Introduction of mandatory PIMH Awareness training for staff (30%)
- Enhanced local support through new family wellbeing services, such as health visitor/midwife-led support groups (19%)
- Commissioning of new services and resources (24%) — e.g. Dad Matters, Parent-Infant Relationship Teams, Video Interactive Guidance.

Support for Champions

To help Champions stay current in the fast-evolving field of PIMH, they receive quarterly iHV PIMH Bulletins and are invited to attend quarterly virtual iHV PIMH Forums. Initially established with funding from The AIM Foundation, the Forums are supported by the Maternal Mental Health Alliance and their diverse pool of lived experience champions. Survey responses indicated 80% of Champions are using the Bulletins and 62% attending the Forums, with one stating in the survey:

"I always think no matter where you are in your career journey or role within PIMH, attending [the iHV PIMH Champions Forum] is very useful, I have continued to pop in to some meetings even post two years of completing this training."

This highlights the value of these resources in maintaining Champion confidence and competence. Additional support included iHV webinars (33%), iHV conferences (30%), iHV workshops (15%), research reports (58%), external PIMH events (42%), and regional networks. Regarding organisational support, 57% felt supported, 31% partially supported, and 12% unsupported.

Those who felt supported reported being valued and encouraged, with alignment between their job roles and Champion responsibilities. Supportive organisations demonstrated commitment through funding, mandated training, specialist posts, volunteer recruitment, and managers passionate about PIMH. Collaborative local networks among Champions also fostered positive working relationships. In contrast, the main reasons cited for lack of organisational support included organisational instability, isolation, and insufficient training delivery support. Barriers to training cascade included workload pressures, staff shortages, lack of protected time, and training overload.

Champions highlighted the importance of strong managerial support for training delivery, including adequate staff attendance, capacity, and protected time for both preparation and delivery. This also included support for training planning and advanced scheduling.

When asked about support from the iHV, the vast majority of respondents felt supported (81%) or partially supported (13%). Key themes are summarised in Table 5.

Table 5: Key themes relating to support from the iHV

1.	Proactive communications and accessibility of iHV	"Excellent communications." "They have always been approachable, available, helpful and empowering when I have contacted them." "Easily available to ask questions." "Regular opportunities to discuss, feel I can approach the team with any queries and get a response quickly."
2.	Opportunities provided for learning and networking	"Love the additional learning opportunities." "There are excellent webinars and Champions sessions." "I attend the Champion sessions and find it really useful to know what the iHV is doing to support me. I also enjoy connecting with other Champions."
3.	Quality and inclusivity of iHV PIMH Champions Training resources	"The resources available to me are excellent." "Good offer of training and Champions resources." "New slide set[s] are fantastic." "Inclusion in iHV programme."
4.	Reputation and expert knowledge of the iHV	"The iHV are instrumental in enabling this training. They have the skills to make the resources for training, and are a reputable organisation that gives kudos to the subject." "There is a wealth of information, updates, and support available from the iHV, helping me to feel confident with fulfilling the Champion's role."

Organisational commitment to PIMH was key to respondents feeling supported by the iHV. This included having a local leader to liaise with the iHV and encourage engagement with events, as well as funding to renew Champion memberships for continued access to resources.

Only 13% felt unsupported by the iHV, or were unable to access the iHV support on offer. These respondents cited similar reasons to organisational barriers: limited protected time, workload pressures, managerial changes, and professional isolation. Some also experienced delays accessing the iHV website, Champion resources, or felt the iHV lacked local influence. Respondents offered suggestions to enhance iHV support, summarised into four key themes (Table 6).

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Table 6: Recommendations for improvements to iHV support from survey responses

1.	Raising the Profile of PIMH in Services	"Would appreciate a more proactive role from iHV in supporting the benefits at strategic service level - maybe PIMH conference for managers and commissioners detailing why and how they could and should support." "Involving organisations and commissioning groups in the planning and presentation of the iHV Champions agenda." "I suppose for me, at the moment, the weakest link is midwifery services, so whether they could offer some kind of outreach there...?" "Contact management to request it be mandated and implemented by all teams." "By liaising with my trust to review caseload allocation for all PIMH champions."
2.	Facilitating Champion Connection	"PIMH Conference in person." "Maybe a page to link with another trainer! Most training is online, so don't need to be part of same area." "I would love to be able to deliver the training to colleagues. If there was another Champion to co-deliver with, but in another area that I could link up with."
3.	Improving Resources and CPD Opportunities	"The more practical elements of the course are the most useful." "I know every locality is different, but a bit more mapping of potential services who may benefit would be helpful." "Consider reviewing the slides for community and voluntary sector. They are very clinical." "The newer short courses [Spotlight Learn Workshops] are going to be very good." "Improve navigation of website." "More opportunities to learn about how best to support the mental health of parents from different cultures and those who are neurodivergent."
4.	Funding	"The cost of the training is a big barrier for getting other Champions trained up." "Those who already support the iHV with membership fees should not have to pay extra for access to the Champion resources." "Funded [Champion] roles especially for the voluntary sector as funding is really difficult currently."

Summary of Workstream 2 Findings

The survey findings demonstrate the wide-reaching impact of the Programme on practice, services, and professional development. Over three-quarters had already cascaded the training or planned to, with delivery reaching diverse professional groups across health, early years, and the voluntary sector. Champions reported increased staff confidence, earlier identification of perinatal mental health concerns, improved quality of referrals, and more meaningful support for families. The quality and adaptability of iHV resources were highly valued, and many Champions felt better equipped to lead inclusive, evidence-based care. The role also contributed to service-level changes, including new pathways, training mandates, and stronger interdisciplinary working. While most felt well supported by iHV and their organisations, some highlighted barriers such as time constraints and limited local influence. Champions recommended greater strategic engagement, peer connection, and tailored resources to strengthen the model further. Overall, the survey confirms the PIMH Champion model as a mechanism for improving workforce capability and family wellbeing through sustained, system-wide workforce development and influence.

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Workstream 3: Qualitative Interviews with PIMH Champions and Case Studies

Initially, fifteen PIMH Champions expressed interest in participating in a qualitative interview, and six were willing to contribute a case study for Workstream 3. However, this resulted in 13 interviews and 3 completed case studies, due to factors such as lack of time or non-responsiveness to the researchers' follow-up.

The interview participants included specialist health visitors (n=5), midwives (n=3), voluntary sector practitioners (n=3), Service Leads (n=2), all of whom had completed the iHV PIMH Champions training (Format 1). The interview findings have been themed into eight categories as follows:

1) Establishing a 'Perinatal Frame of Mind'

A recurring theme across the interviews was the significant shift in mindset experienced by practitioners following their engagement with the PIMH Champion training. One participant described this shift as establishing a "perinatal frame of mind". This moved practice beyond a task-based approach to one that is emotionally attuned, preventative, and relationship-centred, with a specific focus on early attachment, infant mental health, and whole-family wellbeing.

For several participants, this transformation was deeply personal. One midwife described how her awareness began with a shock after moving to the UK to practise midwifery:

"I became aware of the fact that maternal mental health is one of the leading causes of maternal mortality in the UK. I was shocked… so that became my passion to sort of see what I can do in terms of perinatal mental health."

(Midwife, England)

The participant's response was to immerse herself in perinatal mental health study and advocacy, driven by a desire to provide more emotionally responsive care. For others, it was the empathy of lived experience that shaped their understanding. One participant reflected:

"I retrospectively realised that I was quite unwell during my own pregnancy the first time and… nobody knew it, nobody helped me… there was no point at which anyone asked me a question that made me think they were interested in anything beyond my blood pressure and urine… I was always determined not to be that kind of midwife."

(Midwife, Scotland)

Across professions, the training helped staff see perinatal experiences through the lens of the parent and the baby. One participant described it as a "lightbulb moment," stating:

"Just the upskilling of the workforce and the parents themselves in terms of what matters, what they can expect, it's kind of changing attitudes really isn't it?"

(Midwife, Scotland)

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"The whole understanding of parent-infant relationships and communication and attachment... they weren't really in the midwifery remit. That wasn't something you learned in your training to be honest - didn't really learn anything about babies or children. So it's quite a huge shift for a midwife to think at all about babies or dads yeah."

(Midwife, Scotland)

The Champions training provided a common language and grounding in perinatal and infant mental health theory, supporting professionals to work in more connected, collaborative ways. One health visitor described how training across multiple disciplines improved the reach of their messaging:

"We shared it with managers from A&E, we shared it across the health board... we got such a good uptake from our professionals — allied medicine. So physios, OTs... that had a massive reach out, a much broader reach."

(Specialist Health Visitor PIMH, Wales)

2) Strengthened Knowledge, Confidence and Practice

Participants consistently reported an increased openness and confidence in those they had trained when discussing mental health with families and professionals. A key shift noted was from a narrow focus on postnatal depression toward a holistic understanding of perinatal and infant mental health, both individually and organisationally.

This change in mindset was underpinned by the structured, evidence-based training, which equipped practitioners with both the theoretical grounding and practical tools to apply in everyday settings. Participants described their trainees as feeling more equipped to use evidence-based tools, make appropriate referrals, and provide meaningful support. These findings align with the survey outcomes, which reflected similar increased awareness, knowledge, and confidence of staff after participating in the cascade training:

"It's not just about postnatal depression and anxiety anymore... People are seeing this much broader spectrum..."

(Service Lead in Family Mental Health, England).

"Without the PIMH Champions training... I wouldn't have had that boost that got me from hating mental health to loving it as a professional topic."

(Development Officer VCS, England)

Trainees became more comfortable using validated screening tools such as the Edinburgh Postnatal Depression Scale (EPDS), General Anxiety Disorder-7 (GAD-7) and Patient Health Questionnaire-9 (PHQ-9), and better understood what constituted appropriate referral routes. Champions noted that the training helped staff become more emotionally attuned and less fearful when supporting families with mental health concerns.

The training also contributed to more informed conversations with colleagues, helping staff advocate for families using current research and policy language:

"It's that confidence to say, 'Up-to-date research tells us this...'"

(Service Lead, England)

Several Champions described visible changes in referral behaviour and clinical decision-making after training. In one case, a newly qualified health visitor recognised and acted on a serious mental health concern during a visit, explicitly crediting her training for the ability to identify risk, initiate a safety plan and advocate for urgent care.

"She said if she hadn't done the training, she wouldn't have known how unwell this woman was."

(Specialist Health Visitor, Wales)

The effect of improved confidence extended beyond initial contact with families, influencing how staff collaborated across teams, escalated concerns, and reflected on their own practice. Champions repeatedly emphasised how empowering staff had long-term impacts for families:

"It's not just asking, it's knowing how to respond when someone tells you something hard."

(Midwife, England)

While not all professionals had the same access to protected time or support structures, the cascade model of training, reinforced by reflective supervision and peer learning, was reported to create sustained improvements in perinatal and infant mental health practice.

3) Impact and Sustainability of Training

The sustainability and long-term impact of the training emerged as a strong theme across participant interviews. While participants widely praised the quality of the training content, their ability to maintain momentum varied significantly depending on organisational support, peer collaboration, and system-level recognition.

A key factor in sustaining impact was confidence in applying knowledge and adapting delivery formats. Participants described how the act of facilitating training reinforced their own understanding:

"The running of the courses means that I constantly kind of re-update myself."

(Midwife, Scotland)

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In addition, participants highlighted long-lasting changes in practice, including the embedding of standardised approaches and care pathways. They emphasised the importance of flexible delivery (e.g., modular, bite-sized formats) and follow-up engagement as key to sustaining impact.

"The iHV training package has given us that standardised approach across Wales."

(Specialist Health Visitor, Wales)

Several participants reported modifying content or integrating guest speakers to tailor sessions to local needs, improving engagement:

"We made it feel like it mattered... we added some stuff, we took away... but also the material works on its own as well."

(Midwife, Scotland)

Support strategies included formal supervision models and informal approaches, such as being available for case discussions. The iHV Emotional Wellbeing Visits Programme was frequently cited as a valuable addition to the iHV PIMH training.

The continuity of delivery often hinged on the availability of co-facilitators. When participants were unable to maintain consistent partnerships, participants reported struggling to sustain the training programme:

"I delivered three courses with different people and none of them wanted to deliver it again... So the point I'm at now is having lost momentum, I intended to do one this year, it would be a year since the last one and I don't have anyone who wants to do it."

(Midwife, Scotland)

Conversely, where services lacked dedicated time or management support, participants experienced barriers to both delivering and embedding the training:

"We've not been able to sort of utilise the Champions training... we are still struggling with giving that time and acknowledging the fact that this is needed."

(Specialist Midwife Perinatal Mental Health, England)

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Some described the emotional and logistical burden of sustaining change in understaffed systems:

"The more time that goes, we'll be back to square one again."

(Service Lead, England)

The indirect influence of training on everyday practice was notable in the participant accounts. They referenced shifts in how families were supported, such as engaging fathers and early recognition of mental health concerns:

"Including dads – everyone very quickly noticed how systematically excluded fathers are from everything."

(Midwife, Scotland)

"It's almost like a relief... and they're able to actually tell you more about their condition."

(Specialist Midwife Perinatal Mental Health, England)

Participants called for stronger national mandates and consistent structures, such as allocated time and structured follow-up, to ensure that the value of PIMH training translates into sustained change:

"If there is a strong recommendation nationally... it becomes almost like a policy."

(Specialist Midwife Perinatal Mental Health, England)

In summary, while the Champions training had clear individual and relational impacts, its sustainability depended heavily on local infrastructure, collaboration, and broader organisational support. In settings lacking organisational support, such as supervision pathways or clear roles, participants felt limited in their ability to effect change. Even the most committed individuals reported struggling to sustain impact under these conditions.

4) System-Level Collaboration and Integration

The iHV Champions training played a key role in promoting integrated care by enhancing multi-agency collaboration and improving the interface between maternity, health visiting and mental health services. Champions across diverse settings described increased influence over care pathways and the ability to shape service offers in response to emerging needs.

"We can directly refer into our community and primary mental health services, and we get really good feedback."

(Health Visitor, England)

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Champions also strengthened access routes for underrepresented groups, notably fathers, whose mental health needs were historically less visible:

"Now, the links with talking therapies for fathers are blossoming."

(Health Visitor, England)

In some areas, this influence extended to tangible service improvements, including the development of crisis response systems:

"We now have a designated sort of, I mean perinatal mental health nurse on site to sort of respond to our crises... we now have a single telephone contact for the crisis team."

(Specialist Midwife, England)

Multi-agency delivery of training, where implemented, was viewed as transformative. Champions who co-facilitated sessions with professionals from other disciplines spoke of shared learning and improved team cohesion:

"So I learned loads from working with her about child-centred care. But I think she learned lots from me about women-centred care and then together we both learned a lot about actually family-centred care and thinking about the whole family which was great."

(Midwife, Scotland)

"Having those conversations and getting to know each other more helped to see it from their perspective and I felt really supported that the whole multi-disciplinary team [was] working better."

(Midwife, Scotland)

Champions often acted as catalysts for integration, whether or not they were in formal leadership roles. Some facilitated knowledge exchange through education forums or informal peer networks:

"We do [education] forums monthly and bring in different services... it might be that we think about what do we do going forward for perinatal mental health."

(Health Visitor/Professional Lead Children, Young People and Families, England)

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Despite clear progress, several participants identified structural barriers that limited the scale and sustainability of integrated working. These included staff shortages, funding constraints and lack of protected time:

"We had people who wanted to be Champions… but there was no time to be given to them."

(Specialist Midwife, England)

"We've had to kind of not fight back, but say, actually, no, we haven't got capacity to do all the things the specialist health visitors were doing."

(Health Visitor/Professional Lead Children, Young People and Families, England)

Participants struggling to implement and embed PIMH training into their service felt that stronger national-level mandates and clearer governance structures would support their efforts:

"If there is a kind of recommendation, a strong recommendation from the national… then the Trust actually sort of buys into it and takes it on seriously."

(Specialist Midwife, England)

Participants emphasised that sustainable integration also depends on passionate, committed individuals, supported by systems that value and invest in ongoing development:

"The main thing is that whoever goes on the training wants to do it… that's the difference between kind of pushing someone and someone who's passionate."

(Health Visitor/Professional Lead Children, Young People and Families, England)

These experiences illustrate how Champions training enhances systemic integration when supported by multi-agency delivery, organisational backing, and strategic alignment, while also highlighting the challenges where structural support is lacking.

5) Champion's Role: Scope, Advocacy, and Influence

Across the interviews, participants consistently described how their roles evolved beyond delivering awareness training to becoming advocates, leaders, and strategic influencers within their services. While the original Theory of Change anticipated Champions cascading knowledge and supporting staff, many took this further, embedding mental health as a priority in their organisation, initiating new collaborations, and modelling changes in practice. Their motivation, passion, and growing confidence were key enablers of this expanded impact.

Several participants spoke of developing their leadership voice and becoming visible advocates across professional forums and at an organisational level:

"I go to quite a lot of regional and local multi-agency forums… I'll always bang on the drum…"

(Health Visitor, Scotland)

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For some, their Champion role prompted or coincided with career progression into leadership or strategic roles. One participant reflected on how their experience of delivering training and engaging in conversations around perinatal and infant mental health directly contributed to greater confidence and professional development:

"I was pushed outside my comfort zone... it's probably given me more confidence to deliver things... I was able to go to [the clinical director] and say, 'Oh, I think this needs to be changed."

(Health Visitor/Professional Lead Children, Young People and Families, England)

The participants discussed how they often took on the role of reassuring and guiding their colleagues through difficult or unfamiliar scenarios, especially in emotionally challenging situations involving acute mental health concerns. The participants described how these moments helped foster a culture shift when addressing mental health concerns and contributed to embedding mental health in everyday care:

"That presence... you can see how they were able to actually come out to help. As opposed to before it's almost like everybody tries to avoid that kind of situation."

(Midwife, England)

They also played a key part in creating safe spaces for colleagues to reflect, ask questions and grow in confidence:

"It's about making people feel confident to shine and really nurturing them to become Champions too."

(Health Visitor, Scotland)

Importantly, participants described a strong sense of long-term responsibility for maintaining momentum, ensuring consistency of care and using every contact to promote emotional wellbeing, and this was consistent even when they were no longer in clinical roles or not actively delivering training:

"It's always an ongoing conversation. It's never kind of... that's kind of how I see my input, if you know what I mean... It's not like you're trained and then that's it. It's always part of the conversation or it's always there."

(Health Visitor/Professional Lead Children, Young People and Families, England)

These reflections suggest that participants often serve as internal change agents, working to amplify the visibility of perinatal and infant mental health, influencing pathways and supporting sustainable cultural shifts across their teams and organisations. Their impact, while sometimes informal, was widely felt and often extended beyond the initial scope of the training programme.

6) Training Delivery Challenges

The implementation of the training by Champions was not without challenge. Participants identified barriers to delivering training, particularly in under-resourced or structurally fragmented settings. The challenges identified by the participants reflect the survey responses. Common challenges included:

- Lack of protected time for training
- Difficulty engaging midwives and GPs
- Inconsistent management support
- Service restructures and staffing changes
- Lack of suitable co-facilitators
- Technical issues during online delivery

One participant summarised:

"Health visitors say they just cannot commit to that amount of time. And it's sad because it just does reflect their whole work life at the moment."

(Specialist Health Visitor PIMH, Wales)

The length of the training (two days) was also seen as a constraint, prompting many to adapt it to shorter formats. These challenges illustrate that without ongoing support and investment, even highly motivated Champions may struggle to sustain the outcomes envisioned in the Theory of Change.

7) Ongoing Professional Development

Continuous professional development was a consistent theme throughout the interviews, with participants highlighting how essential it was to stay informed, connected, and confident in their role. Many explicitly valued the iHV's bulletins, webinars, forums and other structured opportunities for learning. These resources helped them maintain current knowledge and feel part of a wider network of knowledgeable professionals.

"I sign up for everything—webinars, newsletters. I'm always keeping up to date!"

(Health Visitor/Professional Lead Children, Young People and Families, England)

Participants frequently described the iHV website and bulletins as core to their routine, with some accessing them daily to ensure they remained up to date with the latest available evidence and information:

"I do refer to iHV every day, really. I like to go on the iHV page every day."

(Specialist Health Visitor, Wales)

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The forums and networks were also particularly valued for their peer-to-peer learning opportunities and the sense of being part of a broader, shared mission to embed PIMH into practice:

"Networking, definitely. Networking helps. And how other specialist health visitors work in other areas, it's really interesting."

(Specialist Health Visitor, Wales)

"We've also got the email thread... So if somebody's got a question, it's nice you can just reach out and say, have you tried this in your area?"

(Specialist Health Visitor, Wales)

Despite practical challenges such as workload and staffing pressures, participants made efforts to engage in ongoing learning:

"I try as much as possible to read, to sort of catch up with the updates on the [iHV] site."

(Midwife, England)

"I read the newsletter... sometimes the events, what has happened, is quite interesting."

(Midwife, England)

Participation in iHV's community of practice fostered a sense of shared purpose and motivation. For many, the support and learning opportunities it provided were not only beneficial but also seen to be essential to sustaining impact over time.

8) Equity and Standardisation in Care

Participants expressed a strong commitment to equitable and consistent service delivery across regions. In Wales, where national policy alignment and structured investment were evident, Champions felt supported in delivering standardised, high-quality care to all families.

"We want all families in Wales to have the same assessment... regardless of where they live."

(Specialist Health Visitor, Wales)

This national approach facilitated clear expectations and consistent practices. As one Champion explained:

"Because we're all funded by Welsh Government, we all follow the same training pathway... There's a commitment there to keep things equitable."

(Specialist Health Visitor, Wales)

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In contrast, Champions working in areas without such structured national backing described more fragmented systems, making it harder to embed and sustain consistent standards. For example, changes to funding and organisational structures created service gaps that were difficult to fill:

"They have said that to us—'oh, you can do the listening visits, you can do this, you can do that.' But we've had to... say actually, 'no, we haven't got capacity."

(Health Visitor/Professional Lead Children, Young People and Families, England)

Where participants were trying to encourage a shift to the 'perinatal frame of mind' where there were no formal or organisational structures in place, they reported that their progress was hindered by shifting priorities or resource constraints:

"It's been very difficult because there was no blueprint... no sort of kind of framework to work on."

(Midwife, England)

Despite these challenges, the desire to ensure equitable access to high-quality care remained strong, consistently mentioned by the participants who continued advocating for better systems, greater investment and strategic alignment:

"We need to see the same offer for all women, not a postcode lottery."

(Midwife, England)

This continued commitment highlights the need for policy-level support and strategic infrastructure to ensure long-term equity in perinatal and infant mental health provision across the UK.

Three case studies were received, which were anonymised by the research team and presented in the appendices, which further illustrate the impact of the PIMH Champion training.

Case study A (Appendix – 1) showcases how Champions creatively address gaps in local perinatal mental health services.

This case study discusses an initiative by PIMH Champions, piloting Emotional Wellbeing Groups in Family Hubs to address limited perinatal mental health service capacity. Aimed at mothers and birthing people needing early support, the groups use the iHV Emotional Wellbeing resource to promote self-care, coping strategies, and connection. The initiative has received high referral rates, especially as step-down or early intervention and parents report improved mental health and reduced isolation.

This model demonstrates how Champions are creating accessible, preventative support where one-to-one care is limited and reflects findings from the qualitative interviews, which emphasise innovation and adaptability in addressing service capacity challenges. During the interviews, participants described working closely with other professionals to address unmet needs. Participants consistently recognised the value of inclusive, early intervention formats and advocated for accessible, community-based support where thresholds for specialist care were not met. This case study reinforces the understanding gained from the participant interviews, which suggests that the Champions model fosters proactive, needs-led care that aligns with the group-based intervention piloted in this case study.

Case study B (Appendix – 2) demonstrates how a Champion's learning led to meaningful actions after a 'near miss' involving postpartum psychosis.

This case study, shared by a Specialist Midwife, illustrates the critical role that Champions play in service improvement and mental health crisis response. Following a near-miss incident involving postpartum psychosis, the midwife led significant changes, including revising referral pathways, expanding the Champion roles within the unit, enhancing training and strengthening multi-agency collaboration. The case highlights how Champions act as catalysts for systemic change, aligning with the themes discussed above, such as leadership, improved integration with specialist teams, and a strong commitment to equity and safety in perinatal mental health care.

Case study C (Appendix – 3) highlights the positive career development experienced by a Champion following completion of the training.

This case study, submitted by a health visitor who progressed into a Service Lead for Family Mental Health role following iHV PIMH Champion training, demonstrates how the programme builds leadership capacity and helps drive strategic change. Aligned with themes which emerged from the interviews such as ongoing professional development, strengthened knowledge, confidence and practices, and a drive to promote equity in service delivery. The health visitor used the confidence and skills gained through cascade training to revise care pathways, implement Emotional Wellbeing Visits and advocate for inclusive support, particularly for fathers and non-birthing partners. This case study reinforces findings that Champions become catalysts for wider organisational development, integrating mental health into their organisation and improving continuity and communication across multidisciplinary teams. The health visitors account reflects findings discussed earlier, in that they actively support colleagues, attend forums and seek to expand PIMH capacity despite constraints.

Summary of Workstream 3 Findings

The insights gained from the qualitative interviews were strongly supported by the survey findings. While the interviews offered rich, in-depth perspectives on the impact of the PIMH Champions Programme, such as increased practitioner confidence, improved multi-agency working, and systemic change, these themes echoed consistently across the survey responses. For example, interviewees' reflections on a shift towards more holistic, inclusive PIMH practice aligned with the survey findings showing increased confidence and knowledge among those trained. Similarly, the challenges identified in interviews, such as limited protected time, training fatigue, and the need for co-facilitators, are mirrored in the survey data. This convergence across methods strengthens the overall evaluation and provides a robust evidence base for the Programme's ongoing development.

The findings demonstrate the significant impact of the training reported by practitioners on their knowledge, confidence, and practice across the UK. The training has enhanced multi-agency collaboration, empowered Champions as leaders in PIMH, and driven systemic improvements in care delivery. The three case studies further support the PIMH training's role in fostering innovation, improving safety and practice, and supporting professional growth among PIMH Champions. Recommendations are provided to inform future developments and ensure equitable, high-quality perinatal and infant mental health support.

Conclusion

This three-part evaluation, which incorporates the views of 2,151 participants, shows that the iHV PIMH Champions Programme is an effective, scalable model for improving workforce knowledge, confidence, and practice in perinatal and infant mental health. It has enhanced practitioners' understanding and capacity to support families, while fostering leadership, advocacy, and system-wide change throughout the UK. Key enablers include organisational support, flexible delivery models, co-facilitation, and a strong professional network. Conversely, resource constraints, lack of managerial support, and system fragmentation are significant barriers.

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The Theory of Change (ToC) developed for the iHV PIMH Champions Programme (Figure 2) provided a clear framework for evaluating its effectiveness and clarified the assumptions underpinning its design. Evaluation findings supported many of these assumptions — particularly the need for enablers such as dedicated funding, organisational backing, protected time, and access to iHV training, peer forums, bulletins, and digital resources[14]. A key short-term outcome identified in the ToC was the development of place-based Champion leaders equipped with strong skills and up-to-date knowledge of PIMH. Evidence from this evaluation suggests this outcome was achieved, with Champions demonstrating increased capability and influence within local systems. The training reached a wide multi-professional audience, including health visitors, midwives, students, VCSE staff, AHPs, GPs, and social workers. Their growing involvement in multi-agency collaboration supports the ToC's vision of Champions as catalysts for systemic change.

Importantly, the evaluation shows that the Champion's role has evolved beyond its original scope. Many Champions now operate at strategic and leadership levels, contributing to workforce development and staff wellbeing. This shift signals the need to revise the ToC to better reflect their expanded influence and organisational impact. However, challenges such as limited protected time, inconsistent funding, and variable local support may threaten long-term sustainability. While the ToC recognises the need for ongoing support, findings point to a greater need for systemic investment and organisational commitment.

Overall, the iHV PIMH Champions Programme is a credible, scalable model for workforce and system-wide transformation in perinatal and infant mental health. With sustained investment and strategic support, it is well-placed to shape a more equitable UK PIMH system and offers a replicable model for international contexts.

Strengths and Limitations

A strength of this evaluation is the consistency of themes across all data collection methods. Findings from the pre- and post-training data, survey data and qualitative interviews were strongly aligned, reinforcing the credibility and reliability of the insights gathered. Data sufficiency was achieved during the interview stage, with recurring patterns and no new themes emerging in later interviews. This suggests that the qualitative sample was sufficient to capture a broad and representative range of Champion experiences.

The pre- and post-training and survey data reflected Champions' views from across all four nations of the UK. Interviews were conducted with Champions based in England, Wales and Scotland which encompasses a broad geographical perspective and captures views across a diverse range of service models. These reflect variations in commissioning structures and workforce composition.

A limitation of this research is the potential for self-selection bias. It is possible that individuals, who chose to respond to the survey or participate in interviews, were those who felt most positively about their role as PIMH Champions or were more actively engaged in the Programme. As such, the findings may overrepresent motivated or confident practitioners and underrepresent the experiences of those who faced greater challenges, were less engaged, or who have not been able to cascade the training. This may limit the generalisability of the findings across the full cohort of Champions.

The evaluation was conducted by the iHV, and as a result, participants may have been less inclined to share critical feedback if they perceived the evaluators as closely connected to the Programme's delivery.

Survey participants were asked if they would be willing to take part in an interview or share a case study. Although many initially agreed to provide case studies, fewer than expected were received (n=3). Participants frequently reported a lack of time or capacity, reflecting the barriers identified in the findings.

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Recommendations

Based on the findings of this evaluation, the following recommendations are proposed to inform future research, strengthen programme delivery, and enhance systemic impact:

Future Research

- **Evaluate long-term outcomes:** Conduct longitudinal studies to assess the sustained impact of the Champions training on family wellbeing, perinatal and infant mental health, child development, and service quality, delivery, and uptake

- **Broaden engagement and representation:** Expand efforts to include a wider range of professional voices in evaluation, specifically targeting Champions who have faced challenges in implementation of the Programme or cascading training. Assess the reach and impact of training across underrepresented sectors such as midwifery, general practice, and the VCSE sector, and consider how to ensure content is accessible to practitioners working in areas outside health, to mitigate potential self-selection bias and strengthen inclusivity.

- **Incorporate the perspectives of families and children in future research:** To build a fuller understanding of the impact of the Programme, future research should include the views and experiences of parents/carers, infants and families who receive care from trained practitioners.

iHV Programme Development and Improvement

- **Revise the Theory of Change:** Update the Programme's Theory of Change to reflect Champions' evolving roles as strategic leaders, advocates and system influencers and include the conditions necessary for sustained impact.
- **Facilitate co-delivery:** Develop a mechanism to help Champions identify potential co-facilitators, particularly in areas with limited local peer support.
- **Improve access to resources:** Continue to enhance navigation and usability of the iHV website and Champions resource hub, ensuring clarity around updates and access to current materials. Consider the suitability of materials for non-health professionals.
- **Review post-training support:** Consider structured follow-up mechanisms such as supervision models, peer support groups, or refresher training.
- **Standardise data collection tools:** Ensure consistency in survey tools and questions across training formats to enable more robust comparison and outcome tracking.
- **Monitor Programme fidelity:** Develop simple tools to monitor whether cascade training remains aligned with the Programme's core principles and content.

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For Champions

- **Lead with purpose:** Champion the PIMH Programme by embedding a 'perinatal frame of mind' across the organisation. Encourage its integration into assessments, conversations, and care planning to promote relational approaches that centre the parent–infant relationship. Support colleagues through reflective supervision, share expertise, and maintain fidelity to core materials to ensure consistency and quality.
- **Cascade with fidelity:** Enable easy access to the most up-to-date materials and maintain the core structure of the Programme to ensure quality and consistency.
- **Prioritise reflection and supervision:** Build in time for reflective practice and seek opportunities for peer discussion to maintain confidence, emotional wellbeing and professional growth.
- **Engage in continuous learning:** Stay connected through iHV webinars, bulletins, and forums, and seek out relevant CPD opportunities to keep knowledge current and practice evidence-informed.
- **Utilise collected training data:** Utilise data to evaluate and influence service development and organisational commitment to PIMH training and sustained funding for training.

For Organisations and Service Leaders

- **Protect time for Champion roles:** Allocate protected time for Champions to deliver training, update resources, and engage with wider strategic PIMH activities.
- **Align job roles and training responsibilities:** Consider integration of the Champion role into job descriptions and service plans, with clear expectations and support for training delivery.
- **Promote multi-agency delivery:** Encourage joint facilitation of training across sectors to reflect the Programme's multi-agency approach and support collaborative working.
- **Foster a culture of psychological safety:** Create environments where Champions and staff feel safe to raise concerns, reflect on practice and explore emotionally challenging issues within supervision or team settings.
- **Invest in ongoing development:** Support Champions to access CPD, supervision and peer networking.
- **Embed PIMH training into strategic plans:** Mandate PIMH awareness training across teams and support Champions to help embed it into workforce development strategies.
- **Monitor and evaluate impact:** Collect feedback from cascade training and link learning outcomes to service metrics (e.g. referral quality, family feedback, staff confidence) to demonstrate effectiveness.
- **Develop a sustainable funding model:** Ensure long-term sustainability of the Champion role and training delivery by embedding dedicated funding into service budgets and commissioning plans.

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Appendix - 1

Case Study A: showcases how Champions creatively address gaps in local perinatal mental health services

This case study illustrates the innovative work of Champions in addressing lack of service capacity to meet the perinatal mental health needs of families in their local area.

Lead health visitors for PIMH in an area in the South of England are piloting Emotional Wellbeing Groups at Family Hubs in each of their geographical areas, offering 6 sessions of 90 minutes to groups of 10-12 parents.

The aim is to increase access to emotional wellbeing support where HV team capacity for one-to-one support is reduced and is specifically aimed at mothers and birthing people who were hoping to extend their social networks in a group setting.

The groups foster and maintain positive emotional wellbeing with the prevention, early detection, and prompt and appropriate treatment of mental ill-health. Utilising the iHV Emotional Wellbeing resources, the groups focus on facilitating maternal self-care, coping skills and strengthening the parent-infant relationship, and include a combination of low-intensity cognitive behaviour approaches, lifestyle interventions and happiness tasks.

The Emotional Wellbeing Groups have been well received by HV teams with some areas generating 19 referrals for each group. A simple referral process was designed with a generic email which the 4 PIMH Leads can access. Perinatal MH services have been able to refer clients when they have not met the threshold for specialist intervention following assessment, or as a step-down support from their service.

Some of the mothers referred reported never having accessed a group or feeling confident in leaving the house post birth and have gone on to attend universal family hub groups, as well as other targeted groups offered.

In addition to improved scores on the PHQ9 and GAD7 questionnaires, written feedback from parents illustrates how highly valued and impactful the groups have been to date:

'[HV] has really helped me in such a complicated time. A very informative group and we were allowed to talk about experiences.' (PHQ9 score from 15 to 3 and GAD7 score from 9 to 3)

'Very useful to have a safe space to outlet and feel 'normal'. Enjoyed the happiness tasks and found useful tips on parenting older children.' (PHQ9 score from 12 to 5 and GAD7 score from 16 to 14)

'Loved coming and joining in with the conversation. [HV] is so welcoming and made us feel heard. It was a good balance of structure and free conversation. We were never rushed and really enjoyed coming. Thank you so much.' (PHQ9 score from 10 to 3 and GAD7 score from 10 to 4)

'It's been lovely to spend time in an understanding and acceptive environment despite the difference in my circumstances.' (PHQ9 score from 19 to 16 and GAD7 score from 16 to 13)

'It was lovely to not feel alone and learning coping strategies. I had some anxiety and trouble speaking up in the group setting. [HV] was lovely and great with information and made me feel comfortable.' (PHQ9 score from 19 to 9 and GAD7 score from 21 to 17)

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Appendix - 2

Case study B: demonstrates how a Champion's learning led to meaningful actions after a 'near miss' involving postpartum psychosis

The following case study was provided by a specialist midwife (Sp MW) for maternal mental health who has been in post since 2018 and has built good working relationships with the specialist perinatal mental health team in the mother and baby unit (MBU). The MBU is co-located on the maternity hospital site in the South-East of England.

The case study highlights the learning and subsequent actions following a 'near miss' incident of a 31-year-old first-time mother with no previous mental health concerns who developed postpartum psychosis at 10 days postnatal. She had been referred urgently by the Sp MW to the Crisis Team at 16 days postnatal when her worsening 'red flag' symptoms of rapidly deteriorating mental health, sleeplessness and sense of incompetency as a mother, were recognised by midwives. The Crisis Team offered a telephone consultation four and a half hours after the initial referral. In the early hours of the following morning, the mother went missing and was found by police on the edge of the motorway, wearing only a nightshirt with no shoes in subzero temperatures. The Sp MW arranged admission to the emergency unit and subsequent transfer to the MBU where the mother and baby remained for 8 weeks before being discharged home under the care of the psychosis recovery team.

Following this incident the Sp MW outlined these actions and outcomes:

- *My trust had an MDT meeting review and proposed to increase the number of perinatal mental health Champions.*
- *The perinatal mental health pathways were amended, with improved access to the Crisis Team.*
- *The Crisis Team now has prompt response to maternity referral, bring women /birthing people or go to them to perform face-to-face assessment.*
- *We now have a weekly review with the perinatal mental health team.*
- *Update course on perinatal mental health was delivered to GPs.*
- *Increased hours for training on maternal mental health alongside other obstetric emergencies such as postpartum haemorrhage. Postpartum psychosis is a psychotic emergency requiring immediate psychiatric evaluation and inpatient hospitalisation to be delivered by the Champions.*
- *After discussion with my line manager, we now have information postal boards in the maternity unit reassuring and explaining perinatal mental health illness, including postpartum psychosis and how to get help.*
- *As a Champion, I conduct a ward round on the postnatal ward and Special Care Baby Unit.*
- *I was sent on the postgraduate perinatal health course.*
- *I am more confident to assess and support colleagues around perinatal mental health challenges.*

The Sp MW also reflected on her own learning from the incident, stating: "Some of the challenges I had dealing with the case was in cutting the red tape to get the patient assessed and admitted into MBU. Having a good rapport with the multi-disciplinary team really helped. I have learnt to become more confident with discussing puerperal psychosis with women/birthing people and their families, and professional colleagues. I particularly learnt from the importance of involving the family in the care."

The Champions have reflected on the need to refine preparation and recruitment processes and how to gather relevant equality data for commissioners. They are keen to share the findings of the pilots with other PIMH Champions and Specialists through the iHV Forums.

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Appendix - 3

Case study C: highlights the positive career development experienced by a Champion following completion of the training

This case study was submitted by a Health visitor who, having completed the iHV PIMH Champions training, successfully applied for a new role as Service Lead for Family Mental Health. She described the impact of the Champion's role as follows:

The cascade training significantly improved my skills in delivering training sessions. This experience has been invaluable, as I discovered that I both enjoy training and am quite good at it.

Additionally, I became much more confident in providing one-on-one support to clients. Over time, I realised that mental health support could be both practical and joyful, with small actions making a big difference.

After becoming the Service Lead for Family Mental Health, I took the opportunity to review and update our standard operating procedures. I have initiated the implementation of the Emotional Wellbeing Visits Training and am in the process of designing a service to support Infant Mental Health. Both of these initiatives are grounded in the principles of nurture, joy, and prevention. Throughout these developments I have been well supported by other PIMH Champions. I regularly attend the forums and also ask for support from the group via email.

I have also been able to champion the needs of all parents, not just birthing parents. As a result, all new fathers and non-birthing partners should have their mental health screened before their baby is 8-weeks-old.

Currently, our service does not have sufficient funding to train more champions. However, when we secure additional funding, I aim to enable more staff to attend the iHV Champions training. This training promotes productivity and drives positive change. The more change agents we have within our service, the better we can support our community.

Further benefits to the organisation, families, teams and the wider PIMH pathway have been gained as follows:

Our team: *Practitioners are now less afraid to assist people with their mental health. They are also better equipped to help themselves, as they are aware of the services available. I have mapped out local services, enabling practitioners to either signpost parents to other agencies or provide direct assistance. This not only offers bespoke care packages to parents but also helps practitioners manage their workload more effectively.*

Our organisation: *Without the PIMH champion training initiative, I am not sure we would have created the post I am now in. Even if we had, I would not have been as prepared for the role. For example, there is a similar position in the local midwifery service, and the practitioner in that role reports struggling to deliver training. In contrast, I have a training package ready and am confident in delivering it. This not only benefits my service but also allows me to provide multidisciplinary training, which is critical for improving continuity of service delivery.*

The families we work with: *receive an evidence-based service grounded in nurture and joy. This approach ensures that the mental health support we provide is both effective and compassionate.*

The wider PIMH pathway/system: *We are starting to see the potential for our clear approach to help us integrate our services with other services more effectively. For example, we can now communicate what we offer to clients with services like Talking Therapies. In the future, we aim to establish a two-way referral pathway, where we can refer clients to Talking Therapies, and they can refer clients to us for Emotional Wellbeing Visits.*

We have also begun to champion the needs of fathers and non-birthing partners. The more fathers we ask about their mental health and refer to Talking Therapies, the more they recognise the need for support. They are open to creating a specialist group-based mental health support service for fathers and/or non-birthing parents, if we refer enough people to their service.

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