Putting the Baby First in Perinatal Mental Health

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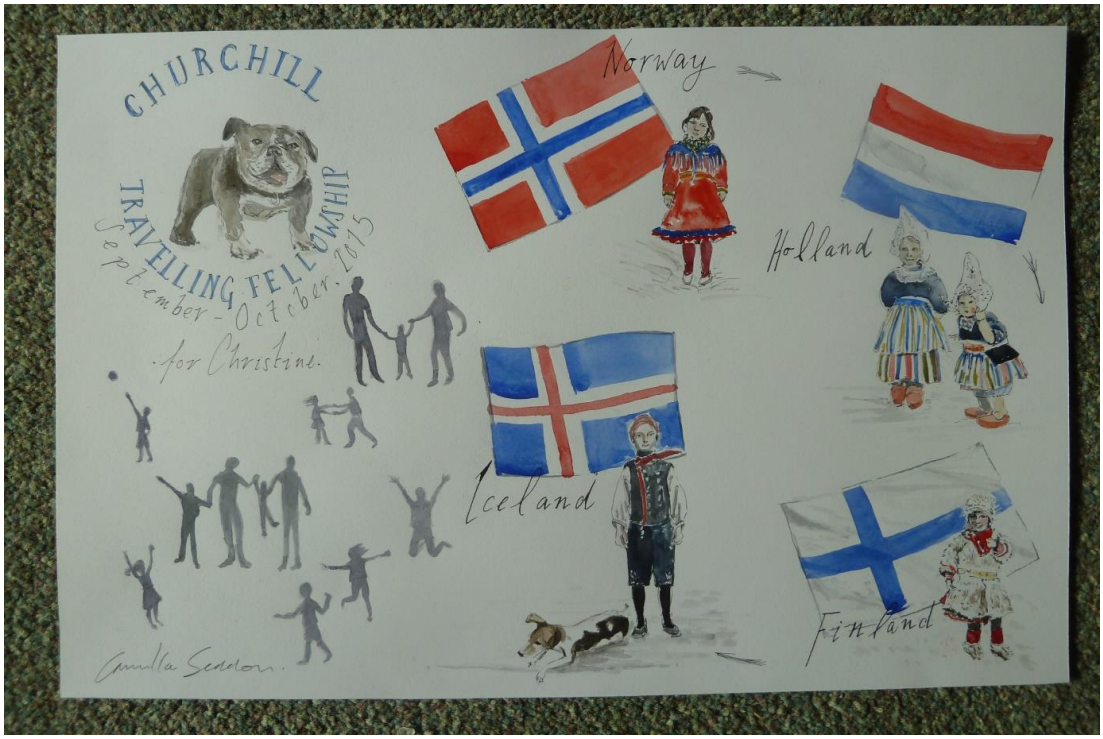
I am also very grateful to the Trustees of Mellow Parenting who gave me leave to travel and write, and to Crawford Logan, Jonathan Sher, Clare Simpson and Robin Balbernie who read earlier drafts of this report and made such valuable suggestions.

I am also grateful to my hosts in each country and the many busy people who took time and pains to talk to me and share their personal as well as professional experiences. I have listed them at the end of the report. There was at least one moment in each country where I would express surprise at some practice and would be met with amazement, 'But doesn't everyone do it that way?' Travelling, meeting people and talking revealed all sorts of information that is never written up, as we all take our own perspective for granted. My perspective has been broadened by this Fellowship and I have come to appreciate what we do well in the UK and what we can learn to do better.



My Fellowship Journey. Original Art work by Camilla Seddon, 2015

Executive Summary

An eight week Winston Churchill Travelling Fellowship in 2015, allowed travel to four countries where children have better health, education and wellbeing outcomes than in the UK, according to the UNICEF/Innocenti Report Card 12. The countries chosen were Norway, The Netherlands, Finland and Iceland.

My initial questions were:

- what are these countries doing to identify babies at risk as early as possible, in pregnancy or very early infancy, and
- what services are provided to enable the development of the best possible relationships between these babies and their mothers and fathers which give them such a good start in life?

In practice, it soon became clear that the identification of vulnerable families depended on well trained and well supported universal services and low thresholds of referral to specialist services as required. Where continuity of professionals and seamless access to infant mental health expertise was facilitated, good quality psychologically-informed practice was the norm.

Generous parental leave and financial support for both mothers and fathers, and excellence in child-care, was also evident, with well-qualified staff and access to outdoor play, free from excessive and petty restrictions because of risk averse safety fears. Male early years' practitioners were considered the norm, providing a healthy balance. Late entry to formal schooling, as late as seven in Finland, did not mean lack of consideration of children's learning and led to better educational outcomes than in the UK. The Netherlands does not have generous parental leave or allowances, but it is the norm for at least one parent, and even grandparents to reduce their working hours, and invest their time in the children.

Apart from paternal leave and the presence of men in childcare no specific interventions for fathers were observed.

The positive principles and practices will be shared with maternity, early years and infant mental health practitioners in the UK.

Putting the Baby First in Perinatal Mental Health

Background

Outcomes for children begin in the womb; indeed many inequalities can be traced back to powerful influences in the pre-conception period. Many risks, including maternal and paternal stress and social risks such as domestic violence and abuse can be evaluated before birth. The identification of babies at risk during pregnancy and the implementation of interventions in pregnancy and postnatally can support mothers and/or fathers to develop closely attuned interaction with their babies. This may be the basis of secure attachment, the foundation of later positive social emotional and mental health.

Aims

My aims were to examine perinatal practices in countries which have an excellent record of promoting children's wellbeing, and particularly:

- how vulnerable children are identified before birth
- what services are available to support mothers of these at-risk babies antenatally
- what services are available to support fathers of these at-risk babies antenatally
- what services are available to support attuned parent-infant interaction for mothers postnatally in these families at risk
- what services are available to support attuned parent-infant interaction for fathers postnatally in these at risk families

Methods

The Netherlands, Iceland, Finland and Norway are in the top seven of children's self-reported life satisfaction (Unicef, 2013[1]). I planned to visit these countries and find out what screening, programmes and interventions they had found to be of value in raising such happy children. It was very humbling that so many people spoke English!

[1] UNICEF/Innocenti Report Card 11: Child well-being in rich countries.
http://www.unicef.org.uk/Latest/Publications/Report-Card-11-Child-well-being-in-rich-countries/

I planned to examine systematically the funding and delivery of antenatal and postnatal services, and whether they identify and offer targeted help to babies at risk. I wanted to look at interventions to promote good attunement between parents and babies at risk of poor outcomes, including how children are kept safe when their parents cannot protect them, and how decisions are made about their longer term welfare. I hoped to do this by examining written papers, face-to-face interviews with managers and practitioners and visits and observations of antenatal and postnatal interventions if appropriate. I wanted to include fathers as they make an independent contribution to the outcome for the child

I quickly came to see that intensive and specialist services for infant mental health could only be built on the platform of universal services. As Herd et al (1995) described, without well-informed universal services to identify need, more intensive services would not be offered. Without the effective gate keepers, the wizards are inaccessible[2].

[2] Herd, B, Herd, A. and Mathers, N. (1995) The wizard and the gatekeeper: of castles and contracts BMJ 1995; 310:1042 doi: http://dx.doi.org/10.1136/bmj.310.6986.1042

Starting Life in Norway

My travels started with a huge advantage because I had previously met Marit Bergun-Hansen and been invited to R-BUP in Oslo who hosted my visit and set up visits to many centres, and meetings with knowledgeable people.

R-BUP East and South is a centre engaged in research, education and information activities on all key areas within the field of child and adolescent mental health and child welfare and is full of the best researchers and teachers in early years in Norway.

I was also very fortunate to be able to attend the Nordic Marcé Society, at R-BUP on 7th and 8th September 2015.

Country facts

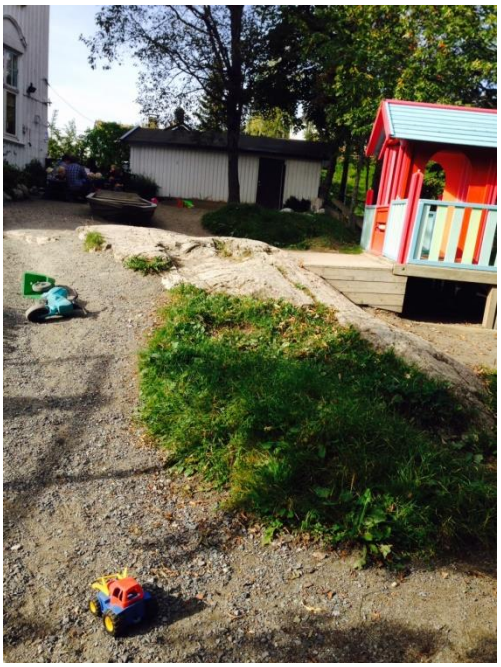
Norway has a population of around 17 million and a birth rate of 12.14 per thousand (12.17 in the UK). The infant mortality rate is low at 2.48 per thousand (4.38 in the UK).

Statutory parental leave is either 49 weeks at 100% salary or 59 weeks at 80% salary, divided between both parents, but with some constraints as to how much a mother must take or how much a father must take. The mother must finish work 3 weeks before the due date and then take the following 6 weeks to be home with the baby. This period will be paid at 100% or 80% depending on parents' choice. The National Welfare Office pays most of the costs, but many employers in Norway top up to the full salary.

Fathers are entitled to take 2 weeks' paid leave when the baby is born, and must take (by law) an additional 14 weeks of paid leave (either 100% or 80% salary depending on the applicant's choice) before the child turns 3 years old. The additional shared period of parental leave can be 26 weeks at 100% or 36 weeks at 80% of previous salary. Parents decide how to use the weeks e.g. the mother takes it all, the father takes it all or they both work part-time and share it – employers generally respect the choice of the parents in this matter, since Norway is such a family focused country. One of the effects of this is that babies get more time with their fathers but also that women are less likely to be discriminated against in the workplace.

Maternity and child health services

Pregnant women in Oslo usually have their pregnancy confirmed by a GP, and can then choose to have antenatal services provided by the GP, a midwife at the Helsestasjon (maternity and child health clinic) or a combination of both. Antenatal care is free. Most births are in hospital and all new babies are seen by the health nurse (health visitor) after delivery. The parents are offered a home visit, but some prefer to attend the clinic. All fathers take two weeks leave after the delivery, and since the health nurse usually sees new babies in that time, she is also likely to meet the father. There is a schedule of eight visits in the first year of the child's life, half to see a doctor and the others with the health nurse. Mothers or fathers can also drop in to the Helsestasjon at any time to have the baby weighed, feed the baby or change a nappy in a comfortable welcoming place where they can also get support and advice about parenting and child care.



After the first period of parental leave, at one year, all children get free childcare or an allowance of 6,000 NOK a month (about £500). The cost of private child care is capped and affordable (2,800 NOK, £260) a month. If mothers are not working, they are given a one-off payment of 30,000NOK (£2,500).

Child care setting Oslo, the 1-2 year old play space

Child care setting in Oslo, the 2-3 year old play space

For every 7-9 children under age three, there must be one trained pre-school teacher (3 years university study to Bachelor degree level) or pedagogical leaders with qualifications for working with children and pedagogical expertise. As well as free regular childcare, there are 'open preschools', with welcoming parent and child facilities available as well as health and social welfare professionals on hand to discuss child health and welfare.

Child care settings are physically challenging, with steps and rocky outcrops in the ground and lots of time spent outside, even for the youngest children. As well as the forest kindergartens, where all the children are outdoors all the time, in most kindergartens children play, eat and sleep outside. In Oslo, children from age 1 take their nap outdoors, down to temperatures of -10^{o}C. In the north of Norway naps are taken outside when the temperature is as low as -20^{o}C, though this is against medical advice. Children do not start formal schooling until age 6.

Child protection (Barnevernet)

There were about 53,000 (15 per 1,000 children) referrals to child protection in Norway in 2014, mainly of 9-11 year olds. Rates of referral for children under one year old are low. It is not clear whether other services are able to recognise and meet the needs of younger children without referrals, or whether early child protection needs are just not recognised. The standard protocol is that referrals should be followed up within a week. In 60% of cases there is no subsequent action. The remaining 40% of cases are further assessed, and in 50% of those cases there is no further action. Again the reasons for this are not clear. It may be that non-statutory action is sufficient or that needs are simply not responded to. This is in very marked contrast with the UK system where 400,000 children were referred to services in 2014 and 48,000 received help as children in need (33 per 1,000) with 26% being under five. In Norway, the majority of referrals are from the police. Social work services mainly offer support with material welfare needs, and are reported to lack expertise/training/supervision to recognise domestic violence, toxic stress and how to help more severe cases. There are 3 houses in Oslo where mothers, fathers and babies at risk can be accommodated. Recently, there has been some controversy that child protection services have unfairly judged the children of parents of non-Norwegian origin to be at risk, leading to allegations of prejudice and 'kidnapping' by the state.

From my visits and meetings

At R-BUP, Dr Marie Haga Silija has been developing a web-based pregnancy guide. Starting before birth, Dr Silija's programme is designed to deliver weekly on-line modules to raise the awareness of

parents of the emotional aspects of pregnancy and the importance of early interaction. The rationale is that better-informed parents will seek out services, and starting bottom-up as well as top-down is a good strategy for integrating emotional and social content for mothers and fathers-to-be. In her programme, Mamma Mia, women are approached in the antenatal clinic by psychology students who talk to mothers-to-be and invite them to sign up to the programme, with handy I-pads available to register them on the spot. It was noticed that recruitment almost quadrupled when there was a personal approach by students wearing scrubs rather than when there was no personal approach. Some 250 mothers agreed to be approached later for an interview about their experiences of the programme. Sixty six were eventually contacted, with the majority, by design, being those who had started the programme but dropped behind with their contacts. Interestingly, once approached, many chose to catch up with the weekly topics. The programme started mid-pregnancy with a very simple webpage that then 'channelled' users through information, followed by weekly sessions each lasting about ten minutes. A self-administered Edinburgh Postnatal Depression Scale (EPDS) was used to calibrate risk. Mothers scoring over 10 were regarded as higher risk. Each session included three 'rooms', one about the baby, one about the woman herself and one about the transition from a couple to a family. This latter proved challenging when the mother was a single parent or in a same-sex relationship. The content of the programme includes some normalisation of emotional reactions during pregnancy as well as some meta-cognitive interventions and advice on when to contact a GP or clinic if appropriate. The programme is currently undergoing a randomised controlled trial, but lessons have already been learned, including the importance of personal contact in recruitment and users being able to have some choices in using the programme, allowing flexibility for example for single parents. A dads' version is planned.

From pregnancy, all parents-to be can use the Helsestasjon. As an example, I visited the centre in the Bærum commune, where the Helsestasjon is near the town centre and used by almost everyone. The staff includes midwives and health nurses (health visitor) and psychologists, with visiting doctors on a sessional basis. Under new legislation in 2014, midwives make a post-birth visit to the new family and the health nurse meets the family before the birth, allowing a smooth transition from one service to another. New families are offered eight sessions in the first year of the baby's life which include a schedule of vaccinations, as well as time for chatting about parenting and the needs of babies. The health nurse offers parents a series of four group meetings and some of the mothers remain in touch with 'their' cohort of new parents long after this brief group intervention. A readily accessible system, with no formal referrals, means that parents and babies can be quickly connected with an on-site psychologist for additional help. The psychologists have undertaken specialist training in working with parents and babies and can offer some individual work, usually four

sessions, and also run Circle of Security DVD Parenting groups. The Helsestasjon is a welcoming building, with areas for drop in, baby weighing and breast feeding, and many young families do just 'drop in'. After school the Helsestasjon is transformed into an open clinic for 15-16 year olds, who can attend without an appointment or referral, for confidential health advice, to see a nurse, for contraception or any other concerns. Since the clinic is so open - 'everyone comes here' - there are no awkward questions or stigma about being there. Once young people choose to become parents, they already know the centre well and most pregnant women use the service, though they can choose to have antenatal care from a GP. The health nurse will follow them up with some diligence in either case. It was striking in talking to the staff that they all have a very keen awareness of the importance of psychological factors in pregnancy and parenting. Their language and approach was respectful and emotionally aware both in individual work and group interventions. I heard more than once that they felt their work was not formal therapy but was nonetheless therapeutic. Staff all mentioned R-BUP as being the source of their additional training and expertise in infant and parent mental health.

Where there is concern about the welfare of a child, either the health nurse or the psychologist will refer to Barnevernet, the state child protection service. It has been recommended that this lead to an early joint meeting with the family and all the agencies, but in practice this does not always happen.

I also visited the Helsestasjon at Søndre Norstrand, which in principle has the same function as in Bærum, but in a more disadvantaged neighbourhood, with fewer resources, the service is more strained. A high percentage of the population of the area are first and second generation non-Norwegian born families, with 147 ethnic groups in the population. The staff - midwife, health nurse, physiotherapist and dietician - offer a dedicated service to young parents and families. They also work with a nearby children's centre, where day care is available. The work can be challenging in an area where cultural expectations about parenting and relationships can be very different from Norwegian attitudes, where, for example, it is against the law to hit a child or even to verbally abuse them. The Helsestasjon works closely with the child protection service at Barnevernet which is located close by. The health nurses work smoothly with the child centre and the Helsestasjon in the same central location. The Helsestasjon has an 'open door' every Friday and at about four months after birth the parents are offered a group based on the Circle of Security DVD parenting intervention. The centre also uses the International Child Development Programme (discussed later). They have also offered groups with an Urdu and a Somali health care nurse to act as cultural interpreters. As well as different attitudes to corporal punishment, cultural clashes can arise when

children enter the Norwegian kindergarten and parents are bemused by ideas of free play. When feeling well-supported, parents will say that they accept that the law is that they must not hit their children, but they had no idea that it might be possible to 'talk to children like that'. The staff are very aware of different cultural attitudes to violence and are careful to undress children at vaccination sessions to be able to see their bodies are free of any bruises or marks, and will ask directly, 'what do you do when it is difficult at home?' and, 'what is the normal way to handle stress in your family?' to open up the topic in a sensitive way. In time, they are trusted by the families who will contact them not just about their little children but adolescents too. One afternoon a week, the Helsestasjon offers an open-door service for adolescents which covers sexually transmitted diseases, drugs, contraception and counselling. Services are offered without charge up to eighteen or twenty years of age. The Helsestasjon maintains close relations with the children's centre, the child welfare services and the local police and they join in periodic joint training seminars to enable sharing of ideas and smooth access when families need additional services.

I also met Greta Flakk and Else Skarsuane from the Norwegian Directorate for Children, Youth and Family Affairs, who organise and train practitioners to offer the International Child Development Programme (ICDP), a universal intervention used for parents, kindergarten teachers and after-school programmes. The programme was developed by an international group of concerned professionals and initially was principally used in Norway, and now internationally. It is based on the principle that human beings are social by nature, and are particularly vulnerable in social relationships, because that is the domain of suffering and happiness. These principles apply across the age range, but when applied to young children reflect the work of John Bowlby on attachment and the later understanding of caregiver-child communication as an important factor for children's mental and emotional development as developed by Colwyn Trevarthen and Daniel Stern among others. The programmes are generally eight sessions but adapted versions for ethnic minority families can run for as long as twelve sessions. The ICDP programme is widely offered in helsestasjons but also in prisons, schools, churches, mosques, child protection services and NGOs. The style of the programme is health promotion and empowerment, without fixed solutions, sensitising rather than instructing parents and carers. There are eight themes around which the sessions are planned:

- showing positive feelings
- following the child's lead
- talking to the child about their interests
- giving praise and recognition
- helping the child to focus; giving meaning by showing enthusiasm

- taking time to give explanations and details;
- setting limits in a positive way.

It is routinely offered to all refugees and asylum seekers in Norway as an introduction to Norwegian society, and adapted versions have been offered to parents in prison, foster parents, in women's shelters and for the prevention of radicalisation and extremism. An evaluation by Lorraine Sherr[3] and colleagues from the University of Oslo and University College, London showed that compared with a control group, after ICDP involvement, parents reported themselves as more patient, and with better awareness of the needs of their children, felt their families were more harmonious and that their children were more collaborative and less likely to be in conflict. Parents in prison actually reported themselves as worse parents at the end of the course than the beginning, as they became more aware of their difficulties. A new independent RCT is now planned.

R-BUP is also planning a trial of the added value that the Family Nurse Partnership might bring to existing services. It is framed around the prevention of abuse and child poverty but needs modification both for the social structure of Norway and the adaptation of content.

In the children's hospital, I met Dr Betty van de Roy, child psychiatrist and Laila Breidvik, perinatal nurse. Referrals come to their team from the primary care perinatal teams, if the midwife is worried about the social needs of the family or the use of drugs or very young mothers. There are actually very few very young mothers (7 per 1,000 under 19 vs 25 per 1,000 in the UK) except in certain ethnic or religious groups where early child rearing is the norm and so socially sanctioned and supported. The Perinatal Mental Health team are also involved in the Special Care Baby Unit (SCBU). They are alerted if parents do not visit their baby often, or change nappies or offer close contact to their babies by kangaroo care[4], suggesting a lack of a close relationship.

They regard all families with a baby in SCBU as families at risk. The ward has space for 23 babies and has 5 parent rooms. The focus is on attachment and issues around traumatic births. The siting of the service in the neonatal facilities has been a great step forward, as making the journey to R-BUP was too great a demand for many families and it was difficult to get psychological/psychiatric staff to

[3] Sherr, L., Skar, A. M. S., Clucas, C., Tetzchner, S. V., & Hundeide, K. (2014). Evaluation of the International Child Development Programme (ICDP) as a community-wide parenting programme. European Journal of Developmental Psychology, 11(1), 1-17

[4] Kangaroo Care was devised in Colombia, where premature babies were put skin to skin with their mothers, under their clothing, and sent home from hospital as there were no special care facilities such as incubators to look after them in hospital. To the surprise of the medical services, many of the babies survived. http://www.who.int/maternal_child_adolescent/documents/9241590351/en/

travel to Arhus (University Hospital). The service aims to help parents see the child and how competent even these fragile babies are, and to help the parent to regulate the baby's state. The service is very alert to the issues of child protection in these vulnerable families and uses child welfare services to offer support. Children are rarely taken into care.

Reflections on Norway

Norway is a family-friendly country. Excellent universal maternity and child health services are run by well-trained professionals, with a deep understanding of psychological needs in pregnancy and beyond and backed up by high quality tertiary and University-level research and training. The integration of maternity and child health services, and the accessibility of specialist services, ensures that vulnerable families are identified and their needs addressed with the minimum of barriers.

Parental leave and allowances are generous. Child care is affordable and of a high standard.

The general impression is of a healthy lifestyle. The diet is good, and almost everyone gets out of the city at weekends, skiing in winter, hiking and cycling or other activities in summer. Even in Oslo, the forest plays a large part in family lives! On my return to Oslo on Sunday afternoon, after hiking in the forest like everyone else, I found all the shops in the city closed, except a few cafés and specialist craft shops. There is no incentive to drag miserable children round shopping malls or leave them in front of screens.

Starting Life in the Netherlands

I was fortunate to be welcomed by Prof. Femmie Juffer and her colleagues at the Centre for Child and Family Studies, University of Leiden. With her help, I was able to make contact with colleagues in the department and also other services.

Netherlands facts

The Netherlands has a population of around 17,000K and a birth rate of 3.62 per thousand (UK rate 12.17). Women get 16 weeks of pregnancy and maternity leave at 100% of their salary. At the time of my visit the statutory paternity leave was two days but about to be increased to five. Government employees, among others, may have more generous provision, at the gift of their employer. Many women choose to give birth at home, as discussed below, and the infant mortality is 3.62 per thousand births (UK rate 4.38).

Maternity and child health services

In the Netherlands, health insurance is mandatory, and this pays for most health care. Dutch residents are automatically insured by the government for long term care, but everyone has to have basic healthcare insurance for acute services (basisverzekering), or risk a fine. Often health care is supported by employers, but for those who are not employed or who are on a low income, government subsidies are available. This insurance allows parents to choose from whom they receive health care services. Most maternity care is offered by independent midwives with a strong emphasis on natural births and about 30% are home births. Antenatal visits are about every four weeks increasing to weekly as the delivery date approaches. There are usually two ultrasound scans; one at 16 weeks and another at 20 weeks or thereabouts. At any time during the pregnancy women can be referred on to secondary hospital care if risks become evident, but parental choice is strongly promoted. Infant mortality rates are low (3.62 per 1000 vs 4.38 per 1,000 in the UK), showing that the physical care around childbirth is effective.

Women can choose to have babies at home or in hospital in regular maternity care or a more 'home-like' birth centre. Most mothers and babies go home the same day if all is well, and all parents have a *Kraamzorg* or a maternity nurse, who will come to the home several hours a day for at least a week to help with the baby and household chores, most of the costs coming from health insurance. The *Kraamzorg* monitors the wellbeing of the mother and child, supports breastfeeding and writes encouraging and positive messages in the baby book e.g. 'I am pleased to see you went

back to bed to rest rather than do work in the house'[5]. If there are concerns about either the mother or baby the *Kraamzorg* will refer immediately to the midwife or to the health nurse.

There are ten planned contacts with the child health nurse or doctor at the Parent-Child centre in the first year. There is a home visit at two weeks, and then monthly contacts until the child is 11 months. Some visits are mandatory, and at 6 months it is decided whether families need additional help. Dutch early parenting values routines - the three Rs (Rust, Reinhied, Regelmaul = rest, cleanliness and predictability). This reminded me of Jimin Sung's paper in the European Journal of Developmental Psychology showing that Dutch babies are better on self-regulation and smiling while American babies are higher in activity and vocal reactivity, but also crying and fear[6]. However, one young mum-to-be said that while most families use the centre in the first year, after this people tend not to go unless they have a problem, and they are not widely used because it might incur a stigma.

There are Parent-Child Centres in every city which offer obstetrics, maternity care, child healthcare and education. As well as antenatal care, babies typically receive their regular check- ups, are weighed and measured and receive their vaccinations at the Parent-Child centre. Services usually include a health nurse, a visiting paediatrician and possibly a midwife. There may also be a psychologist or child development specialist, a toy library, singing groups and parenting classes ('Toddler says No'). More recently, services have been extended to include speech therapists, physiotherapists and dietitian. Some of the centres house a 'games library' where families can play or borrow games, access parenting courses and anti-bullying advice. Families can attend Parent-Child Centres without an appointment, but they are not generally used for 'drop in' unless parents need help. Parents are expected to call if they need help and then can be referred to a paediatrician, Home Start or VIPP-SD (Video interaction guidance-sensitive discipline). Nurses are sometimes avoided as parents can perceive them as 'strict'. Some fathers choose to reduce their working hours after a child is born, but most of the demands fall on mothers.

Maternity leave is short, four weeks before birth and 10-12 afterwards. Fathers get two days; this has recently risen to five. It is very common for mothers to switch to part-time work after having children, and fathers are now starting to follow suit, so that child care outside the home is minimised, 'The norm is that you should be at home some of the time'. Many grandparents also

[5] I am grateful to Eiskje Classon for generously sharing the contents of her Kraamzorg book.

[6] Sung, J., Beijers, R., Gartstein, M. A., de Weerth, C., & Putnam, S. P. (2015). Exploring temperamental differences in infants from the USA and the Netherlands. European Journal of Developmental Psychology, 12(1), 15-28.

take pleasure in being part of their grandchildren's lives, and work part time to accommodate this. Childcare centres are regulated to take babies from 3 months or there are registered child minders. Adult-to-child ratios must be no more than 1 to 4 for under-threes. Kindergarten staff must have two years' training after age eighteen. Employers may subsidise the cost of day care for children. Parents get about €720 per annum in child benefit payments and child care costs are about €7,300 per annum, with the government subsidising this for parents on a sliding scale according to their income, up to about 90% for parents earning less than €20K per annum. Childcare centres are tightly regulated (too tightly some think) with an emphasis on being risk free. One provider exclaimed that the environment I showed them in Oslo would be shut down immediately! Childcare in the very early years is seen as expensive, but at age 4, children can begin primary pre-school and this is free. A recent PhD by Dr Claudia Werner has offered VIPP-SD in childcare settings and this has been very well received and resulted in the child care workers showing increased sensitivity[7].

One mother I spoke to said she felt very badly served after birth. Kindergarten was very expensive so mothers leave work, as it is not feasible to work full-time until the child reaches age four and enters school. Schools are then very good, with many after-school activities (sport, music, dance) but on a paid basis. Another mother, who had developed health problems after the birth of her child, also felt that as she was 'middle-class' and expected to be able to cope, she had struggled to find help.

There was a recent major change in funding structures in 2015, so that the provision of services for families and services like foster care will now be funded at a local authority rather than government level. Local authorities will have to purchase services from licensed providers e.g. trauma therapy, foster care, residential care, disability services, and general health. At the time of my visit, there was great uncertainty how this would impinge on services.

There is some reluctance at a governmental level to 'interfere' in family life but the role of the early years in language development, prevention and treatment of foetal alcohol problems and obesity is now attracting attention.

Prof Marielle Bruning, Professor of Children and the Law, University of Leiden, described the system of care for children needing protection. The first notice of concern may come to the Advice and Reporting Centres on Domestic Violence and Child Abuse (AMHK) called Safe at Home, but the steps to reporting suspected abuse remain with the professional raising the concern. Child Protection Boards now have a check list of risk factors called 'Code to Report' in child protection cases, but no

[7] Werner, C.D. (2014) Carefree in Childcare. PhD dissertation. University of Leiden.

mandatory duty to report. Until recently, the court would grant only a supervision order, on the assumption that parents would be able to meet their responsibilities within a reasonable time. The children were then in long term foster care with annual reviews that threatened their security. It was with great reluctance that parental rights were terminated and a child placed for adoption. Recent changes have resulted in Child Protection Boards, consisting of medical doctors and social workers, referring cases to the court. Taking this responsibility from local authorities may lead to changes in practice and a greater willingness to make more permanent decisions for children's care. It is possible to make a supervision order for an unborn child (there are some 200-300 per annum) but many judges will not do so until after 24 weeks; this is in marked contrast to some other countries where referrals are more frequent at primary school age than in pregnancy, or even infancy. There have also been discussions of forced contraception in the most severe cases, where there are other children in compulsory care.

Dr Jiske Lems, Policy Advisor Program Change in Youth at the Ministry of Security and Justice, is a social worker who previously worked for six years in London and so is in a good position to compare Dutch and UK systems. She described the effects, good and less so, on family work where there are child protection concerns. In the past where there were statutory child protection measures, the services must always have been provided by a professional agency. Under the new legislation, there should be one designated key worker, who may be a social worker or youth worker, and services can be provided on a voluntary basis before the need for a court order. She felt that one big difference from the UK was that in the Netherlands there was a much smaller gap between the rich and the poor. 'Poor in the Netherlands are NOT poor', as families get subsidised homes, medical services, dentists and clothing. She also felt that in the UK, youth could easily become 'disconnected' but in the Netherlands the welfare system was over-involved, sometimes delaying necessary care for complex problems before effective intervention is offered.

At Stichting Opvoeden, Else Verklerk provides a really useful service. With a team of experts, Opvoeden vets web-based information and gives websites an accreditation of sound advice about child health, wellbeing and services, so that although parents can access any website, they have the assurance that the Opvoeden quality mark means that the information and advice is valid and reliable.

Reflections on Netherlands

At first, I struggled to see what made services for perinatal mental health special in the Netherlands, where parental leave is short, and child care expensive and highly regulated. Learning about the Kraamzorg service, offering informed, supportive care to mothers and new babies and the rest of the family, was a revelation. The Parent-Child clinics integrate obstetric and child health services, ensuring that families with additional needs are recognised and services offered smoothly. The frequent choice of safe home births, the Kraamzorg and the Three R's (Rust, Reinhied, Regelmaul = rest, cleanliness and predictability) may help families and new babies feel contained and lead ultimately to good outcomes. The emphasis I heard repeatedly was on balancing family life and work even when that meant limiting family income and more modest housing. Smaller houses are compensated for by more accessible local play spaces and perceived safety for children out in the community. One interviewee remarked that since the Netherlands is so heavily populated, everyone has to behave with respect and restraint lest they impinge unfairly on others.

Until recently, fathers were regarded as peripheral in children's lives and paternity leave and pay were minimal.

Stichting Opvoeden also deserves mention as a relatively low-cost service, easily accessible by most families via the internet, and able to help all parents find authoritative information and support.

Starting Life in Finland

I was very fortunate to make contact with colleagues Prof Kaija Puura and Prof Palvi Kaukonen, whom I had met through the World Association for Infant Mental Health and who proved invaluable in making contacts and visits to a wide range of services and agencies.

Finland Facts

Finland has a population of about 5.5 million and a birth rate of about 18 per thousand (12.17 in the UK), with a slightly falling trend. The age of mothers at the birth of their first child is rising slightly. Infant mortality is around 1.7 per thousand (4.34 in the UK). Parental leave is up to 27 months and is split between mothers and fathers.

Starting life in Finland

In Finland health care is free in pregnancy and for under-eighteens. Most families rely on the good state health service, but many larger employers provide additional private health insurance. Parents have to pay for inpatient care during childbirth, but the cost is low (€32 per day) and can be subsidised if parents cannot pay.

Maternity package

All mothers-to-be who live in Finland and have a residence permit are offered a maternity package of children's clothes and other necessary items, such as bedding, cloth nappies, gauze towels and child-care products by Kela (social welfare agency).

Alternatively they can receive a lump sum of 140 euros as a maternity grant. This is available to expectant mothers and adoptive parents. To qualify for a maternity grant, the pregnancy must also have lasted for at least 154 days and the mother must have undergone a medical examination at a doctor's surgery or antenatal clinic before the end of the fourth month of pregnancy.

Women have about 15 appointments during pregnancy, nine health examinations in the first year of the child's life, and annually thereafter. The family see the same nurse from pregnancy until their child is ready to start school, with no separation of midwifery and child health care nurses. This gives continuity of care and ample opportunities to build up relationships. Once during pregnancy, then at 4 months, 18 months and 4 years, more extended health examinations are offered, conducted by the child health nurse and doctor, either separately or jointly. Both parents are expected to attend. The topics covered include parents' health and wellbeing, major health problems, the couple relationship and home atmosphere. The interactions of parents and children and child-rearing practices are explored. The family's economic security, employment and support are discussed, as are the wellbeing and relationships of any siblings. These extensive health examinations can lead to interventions if necessary.

Mothers get nine months maternity leave and the parents can split another 18 months of parental leave between them. In the first year of life there are 3-4 child health visits and annually thereafter. Children can enter subsidised childcare as soon as maternity leave finishes, with parents able to choose state or private providers. Childcare is very good, with staff having degree level qualifications in early childhood education. Kindergarten starts at age six with a play-based curriculum for three to four hours a day and more formal academic demands do not step in until age seven.

I was also introduced to the 'Family Happiness Hotel' by Sanna Kaisa Kukko, Midwife and Master of Healthcare and Elina Rinne, Midwife and Public Health Nurse. The Norlandia Family Happiness Hotel is on the University Hospital site and offers postnatal care to all mothers after delivery if they and their baby are well.

Norlandia Family Happiness Patient Hotel

It looks and functions just like any other hotel, and indeed you can book rooms there on *Trivago*, but the fourth floor is equipped with all the medical care the mother and baby might need, with midwives and child health nurse on call at all times. The whole family, mum, dad, siblings and grandparents, can book in at a cost of €32 a night, the same cost as the hospital postnatal ward, obviously subsidised by the state. Most mothers choose to use this, and stay two nights or so. I am told that it costs the state less than keeping a mother and baby in hospital and is certainly a more attractive option, with all the family able to be involved while the mother and baby have access to any care they need.

When the midwife feels there is a need, she is in close contact with the child health nurse, and if appropriate, infant mental health services. I am not sure if Tampere is exceptional in Finland, but it has certainly led the way in infant mental health services. Tuula Tamminen, Palvi Kaukenen and Kaija Puura have in turn championed infant mental health services. The service values and uses a variety of theoretical models according to need; family therapy, Dynamic Dyadic Play, Theraplay, cognitive behavioural therapy and dialectical behavioural therapy. In the most severe cases, the whole family are admitted to an inpatient ward, to help with relationship problems or serious regulation difficulties. There is also a day unit where families attend 10-2 each weekday. Anna Hemmi, the ward manager for the child trauma psychiatric unit, manages a service from infancy to adolescence offering therapeutic services reflecting eclectic theoretical bases after an initial multi-disciplinary assessment. Whatever treatment is decided upon, the same team continues to manage the service for the family, giving continuity of care, whatever the theoretical model.

In Tampere, in a bid to reduce the demand for later remedial interventions, child health clinics are being integrated with child welfare services so that where needs are identified, more specialist services are easily accessed without the need for formal referral procedures and delays. Referrals can come from the child health nurses or anyone involved with the child and family, including the child care providers. The specialist multidisciplinary teams may consist of nurse, doctor, social-worker, family worker, childcare workers, psychologist and family counsellors. The family can choose to attend the meeting or to send a simple form stating what they feel they need help with and what help they have had so far. As the service is co-located with child health, there is no stigma in attending. At the meeting decisions are made as to what adult or child services might help.

I visited Vuores House, a new centre in a housing area being developed in Vuores, just on the outskirts of Tampere. The centre is not finished yet, but already houses health services with midwives and child health, a child welfare centre to offer more specialist help when needed, and education facilities from day care (starting at 10 months) through preschool, kindergarten and primary school to age 12, 6th grade. Eventually the school will also serve up to age 16.

Fold out beds in the child care centre, Vuores House

The building is light and spacious and built on energy conservation principles. It includes public space for events, and a good kitchen (I ate a delicious school lunch of local black sausage, potatoes and salad with the children and teachers). The centre is beautifully furnished and it was striking that in every room children were offered choice. In the pre-school classroom there were cushions to sit on the floor, but also three different types of chair so the children could choose what they preferred. Rikka Saarinen, Head of Preschool said 'Each child is different so we offer alternatives'. Rikka chose the furnishings and as she hated plastic so much, she chose dolls' houses and other toys made of wood and natural materials.

Learning though play. Sequencing in the kindergarten at Vuores House

I sat in on 'Circle Time' with the four to five year olds and the teacher immediately summoned up material from a PC and showed it on the white board, so the children saw where Scotland was and what the countryside and castles looked like. Very impressive! The teacher and nurse were both male, and there were several other male staff in sight, not just the head teacher.

There was extensive outdoor space and children were well wrapped up to play outside on the wet day. The youngest children had their own play space, but the older children ranged off into the forest behind the school. No sanitised environment this!

Play time at Vuores House

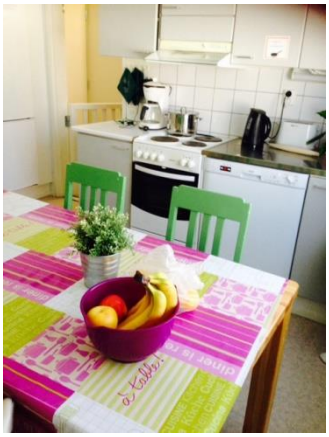
It was very noticeable that the atmosphere was largely calm and pleasant, with busy and contented children giving only a passing glance to visitors, as they had more interesting things to do. Hans Leyden, assistant head, called it 'Life Journey', but this journey starts in utero and children and families can move seamlessly within the same building to find what they need!

Later, I visited Paiaperho, a residential day and drop-in unit for parents with substance abuse problems. The unit has a very low referral threshold, just a phone call, and referrals can be made by midwives, child health nurses or by parents or parents-to-be themselves. The service accepts parents-to-be from as early in pregnancy as possible, understanding that most parents want the best

for their child even if they don't know what the best is. At Pairaperho, Anna Trygg, the nurse, offers antenatal care and child health services. Other staff can offer counselling, individually and in groups. Babies with neonatal abstinence syndrome are admitted from the University hospital to help parents understand and respond to their needs. There is a daily drop-in where parents can have a free lunch as well as receiving services. In addition, there is a crisis admission unit where parents can stay for about two weeks until their needs, whether for housing, financial support or addiction services, are addressed. There are also six units where parents, babies and siblings can stay for rehabilitation. The units are self-contained and parents shop and cook for themselves, but there is also communal space. The daily programme includes psycho-educational groups, a psychodynamic parent and child group and peer support groups as well as individual video-based feedback based on PICCOLO (Parenting Interactions with Children: Checklist of Observations Linked to Outcomes[8]). ADBB (Alarm Distress Baby Scale) is used for assessment of the babies and sometimes used in evidence when children need to be removed from family care[9]. Prof. Kaija Puura provides expert supervision.

Ensi-coti and the Women's prison, Vanaja

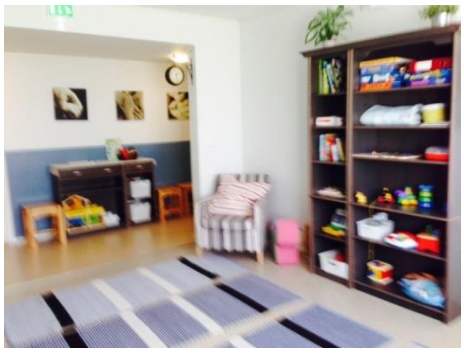
I was introduced to the Women's Prison at Vanaja by Mari Manninen, formerly of Ensi-Coti. The setting of the prison is not an obviously custodial unit. Approaching it is more like visiting a country estate, travelling up an avenue of trees. The unit is open, with no fence but with short, unobtrusive white posts to mark the boundary which women should not cross unless accompanied. There is a ten-bedded mother and baby unit run within the prison at Hameenlinna but staffed by workers from Ensi-coti, an umbrella organisation for families is difficult circumstances.



[8] Roggman, L. A., Cook, G. A., Innocenti, M. S., Jump Norman, V., & Christiansen, K. (2013). Parenting interactions with children: Checklist of observations linked to outcomes (PICCOLO) in diverse ethnic groups. *Infant Mental Health Journal*, *34*(4), 290-306.

[9] Guedeney, A., & Fermanian, J. (2001). A validity and reliability study of assessment and screening for sustained withdrawal reaction in infancy: the alarm distress baby scale. *Infant Mental Health Journal*, *22*(5), 559-575.

The women have single ensuite rooms for themselves and children up to three, and share a kitchen, where they can prepare their own food, and a sitting room. Daily programmes are based on group interventions with opportunities for work and study while the children are cared for. The children are free to visit relatives or friends outside the prison to ensure they do not miss out on normal experiences. There is one separate cottage which acts as a half-way house before release, with many women being eventually released, but tagged for a period. The programme aims to build up relationships between mothers and babies using a variety of methods, including supported play sessions, and have pioneered a trial of materials and methods from Mellow Babies which fits well into their agenda.



The organisation Ensi-Coti (First Home) was originally founded in Helsinki by a group of politically active women. When they failed to convince the parliament that a home for single mothers, who were regarded as 'fallen women', was needed, they set about fundraising and opening a shelter themselves. Ensi-coti Federation now has bases across Finland, and offers day and residential support to parents-to-be and mothers and fathers with psychological problems, drug and alcohol problems and domestic violence. They also offer volunteer doulas for a small charge to support mothers before, during and after birth and a phone help-line which is in huge demand. I asked why a phone advice line was needed when child health clinics had such a rich schedule of visits. The view was that sometimes parents still needed to talk, and that child health clinics could tend to dismiss parents' fears and stress as 'normal' without taking time to listen. The Ensi-Coti services are partly funded from the 'Slot Machines Fund'[10] with the municipality paying for services under a service level agreement. With increased austerity, the municipality funding has decreased, while the severity of the families' needs have increased as thresholds are raised. Ensi-Coti has taken a lead in offering training in 'father awareness' to professionals who have more often been accustomed to working with mothers and may see fathers as part of the problem rather than a potential asset in children's lives.

Finland also continues to use The European Early Promotion Project (EEPP), implemented and evaluated in five countries, which examined whether the input of specialist trained child health

[10] The government raises revenue through the "Slot Machines" fund, a tax on gaming.

nurses could improve outcomes for very young children[11]. In Finland, where services were already very good, there was still positive progress on the HOME Inventory (Home Observation for the Measurement of the Environment) as a result of the intervention, suggesting that it had a positive effect on the mothers' ability to maintain positive interaction with their children. The EEPP project is still the foundation of services, and training and implementation is managed by Prof. Kaija Puura.

Major legal reform is underway in Finland with health, and social care all becoming part of one ministry with five joint social welfare and health administration areas. The likely effects of this are as yet unmeasured.

Reflections on Finland

Finland has a unique level of expertise and investment in infant mental health, with specialists based in each of the five University Hospital departments. A combination of NGOs and statutory services provides a wide range of support, from phone lines to in-patient admissions for families. The international expertise of the specialists is easily accessible.

The unique offer to all the family of the patient hotel accommodation soon after delivery gives maximum assurance of safe perinatal care and a chance for families and babies to get to know each other before they go home.

It was striking that a very wide range of theoretical models was used with well-trained staff able to offer a variety of interventions from psychodynamic to trauma-based cognitive behavioural therapy, in a variety of settings including individual, day patient, group, video feedback and family interventions.

Well-informed political and ministerial policies make the best opportunity for services to be well-trained, resourced and supported.

[11] Puura, K., Davis, H., Cox, A., Tsiantis, J., Tamminen, T., Ispanovic-Radojkovic, V., ... & Layiou-Lignos, E. (2005). The European Early Promotion Project: description of the service and evaluation study.International *Journal of Mental Health Promotion*, *7*(1), 17-31.

Starting life in Iceland

My discussions and visits in Iceland were vastly enhanced by Dr Anna Maria Jonsdottir and her team, who certainly put the baby first in perinatal mental health, often having to fight against the tide of political, financial and theoretical neglect.

Iceland facts

Iceland has a population of 320K and a birth rate of 20.4 per thousand (12.17 in the UK). Iceland is justifiably proud of its excellent infant mortality rate (3.17 per thousand live births, compared with 4.38 in the UK).

The Financial Crash, its effects and responses

No discussion of life in Iceland can begin without acknowledging the dramatic effects of the 2008 financial crash in which 90% of the Icelandic banking system collapsed in the space of two weeks. Supported by the IMF, Iceland was quick to institute remedial measures and there has been a slow recovery, but many families lost their homes, jobs were lost, incomes fell and, as ever, the strongest effects of the downturn fell on the poorest families and particularly the children, with a three-fold increase in child poverty, albeit from a very low base (0.9% to 3%,UNICEF/Innocenti report card 12). Welfare Watch, a consortium of NGOs and statutory agencies, advised the government, which took measures to moderate the effects of the crash on children. This led to better data collection and more indicators for children's wellbeing, though primarily for school age children. A paper by Geir Gunlaugsson, former Chief Medical Officer and now at the School of Social Sciences at the University of Iceland, has shown that six years later there has been little impact on key child health indicators, such as croup, otitis media, skin infections, gastroenteritis, survival from cancer or asthma but an increase in 'small for dates' babies from 2% to 3.4%, bringing a larger number of very young children into risk categories[12]. It is interesting to speculate whether if I had planned my Fellowship on statistics collected after 2008, Iceland would have figured!

Among the measures to protect the welfare of children, the government continued to provide free maternity and child health care (though not dental services), improved national guidelines and tools for child health. Mental health services for children have been extended, though this tended to be

[12] Gunlaugsson, G. (2014) Child health in Iceland before and after the economic collapse in 2008. *Archives of Disease in Childhood*, doi:10.1136/archdischild-2014-307198

for older children, offering parental training programmes and multisystem therapy for children and adolescents with behavioural and drug abuse problems. Younger children were little represented.

One measure that backfired was the cut in maternity/paternity leave funding, with compensation cut to 42% of its previous level. As a result, though many parents were more available to their children due to unemployment, other parents of new babies, and particularly fathers, did not take their parental leave entitlement as the financial loss was too great.

An NGO, Children's Health, continues to raise a great deal of money for the Children's Hospital, specialist equipment and related services.

Universal services

All pregnant women get free antenatal care at a primary care clinic, usually seven visits in pregnancy with an option of up to ten for first babies. The midwives stay in touch with the mother and baby until the tenth day, with daily home visits, and then the family are handed over to the health nurse. The family are offered eight visits in the first eighteen months of the child's life. Physically at-risk women attend the antenatal team at in the Women's Hospital (Landspitali University Hospital in Reykjavik) which offers a service for women with physical problems e.g. diabetes or pre-eclampsia. An embedded social 'at-risk' team, including specialist midwives, a social worker and a psychologist, offer services to women with psycho-social problems.

Child health surveillance services offer organised visits to the health centres at the ages of six weeks and 3,5,6,8,10, 12, and 18-months and at two and a half and four years of age, to meet the child health nurse or doctor. Extra visits can be offered as needed. Health professionals discuss with parents the growth and development and well-being of the child, and information is given about nutrition, sleep, crying, comforting, teething, hearing, family bonding, stimulation and accident prevention.

Meetings and visits

My first visit was to the Icelandic office of UNICEF, where Bergstein Jonsson and Lovisa Arnadottir described the Icelandic child protection services. Violence against pregnant women is recorded but figures are not collected for violence against children under three. In pregnancy, women are asked about physical abuse, close observation being the main tool. There was a question as to how well midwives and antenatal staff are trained to ask about partner violence. Postnatally, the same issue

of lack of training was mentioned about kindergarten teachers and 'day mothers', what we would call child minders, who are seen as being too close to the families to see or report problems. There has been an increase in child protection referrals since the crash, but it is unclear whether this is due to more sensitivity to family needs or is an increase in incidence. The UNICEF staff felt that since recognising child protection concerns and interpreting children's messages needed specialist knowledge, it was easy to cut services to the youngest children because their messages could be disregarded.

Municipalities control education, schools, disability services, social services and child protection. Governmental reform is underway to reduce the number of municipalities from 74, seven of which have fewer than 100 residents, to simplify service delivery and ensure more equality of access. The municipal officials are elected every four years but in such small constituencies there are 'many vested interests' and lack of independence, leading to uneven services and the possibility of child protection concerns being overlooked or ignored. Parents of a child with a disability, e.g. autism, may opt to move area to get services for their child.

Parliamentary spokespersons for children

I met Karl Gardesson, Pall Valur Bjornsson and Bjarkey Olsen Gunnarsdóttir, Members of Parliament, at the Icelandic parliament. Recent changes have led to early screening for mental health in 9th grade at age 14. The MPs were astonished to find that other countries do it earlier.

Recent legislation for children's mental health has failed to recognise the needs of mothers, younger children or infant mental health, and there is a two year waiting list for Child and Adolescent Mental Health services, resulting in an increase in acute and emergency referrals.

I also met with Sigridur Ingiberg Ingdottir, leader of the working group for children's mental health legislation. She felt that while parental leave, maternity care and child health services are free services available to all, when children have special needs 'it depends on luck' whether parents find help. In her view, health centres, kindergartens and schools do not have the experience to recognise or meet children's needs. Child and adolescent mental health services have a long waiting list and tend only to see extreme cases. If children need specialist help, parents may need to pay for psychological assessments and therapy. Approaches to children's behaviour such as dyslexia or ADHD are very medical. There is no guaranteed government funding for infant mental health.

Primary care services

Following NICE guidelines, which are known in Iceland, pregnant women attend about seven antenatal screening appointments, and up to 10 if they are having a first baby. The midwives can offer more visits where these are needed. The midwives I met were all trained in at least two antenatal interventions which have some evidence of effectiveness (Mellow Bumps[13] and Calgary Family Nursing Model[14]). While they have used both of these interventions, they no longer do so, preferring to offer repeated non-directive visits throughout pregnancy. After delivery the care of the mother and baby is handed over to the health nurse, and the family offered child health appointments. Mothers are screened using the Edinburgh Post-natal Depression Scale (EPDS) at 9 weeks post-partum, and the family offered more appointments, longer visits or referral to a psychologist though waiting times are long.

The perinatal 'At-risk' team (Landspitali)

The perinatal psychosocial At-Risk team will see women antenatally and for up to five days postnatally. They see women whose baby is in the neonatal intensive care unit and offer services to mothers, and occasionally fathers, who are anxious, depressed or grieving. They also see women who have still births later than 22 weeks or where there is a termination for congenital abnormalities or late miscarriage. They do not directly treat women with addiction problems, whether alcohol or drugs, but may refer them to the Parent, Pregnancy, Baby (PPB) team and addiction services.

Their experience is that perinatal problems are being recognised earlier. All midwives are expected to follow the antenatal protocol, using NICE guidelines [15,16] and use the Whooley[17] questions, but may be unsure what to do if problems are identified. Where the perinatal team are very concerned about the mental health of the mother or attachment problems with the baby, the woman is referred to PPB. The two teams meet twice a month for joint case discussions, which makes for easy transitions and they are not left with anxieties. The perinatal at-risk team have run courses for midwives on how to recognise perinatal health problems and how to ask questions and talk about the baby.

[13] White, J., Thompson, L., Puckering, C., Waugh, H., Henderson, M., MacBeth, A., & Wilson, P. (2015). Antenatal parenting support for vulnerable women: an exploratory randomised controlled trial of Mellow Bumps versus Chill-out in Pregnancy or care as usual. *British Journal of Midwifery*.

[14] Thome, M., & Arnardottir, S. B. (2013). Evaluation of a family nursing intervention for distressed pregnant women and their partners: a single group before and after study. Journal of advanced nursing, 69(4), 805-816.

[15] https://www.nice.org.uk/guidance/cg192

[16] https://www.nice.org.uk/guidance/cg187

[17] Whooley, M. A., Avins, A. L., Miranda, J., & Browner, W. S. (1997). Case-finding instruments for depression. *Journal of general internal medicine*,*12*(7), 439-445.

Where mothers have substance abuse problems, they can be referred to the addiction ward for admission that day or the next day for immediate treatment. There is ready access for terminations on social grounds up to 16 weeks, with the majority being under 9 weeks. Above 16 weeks gestation, terminations can be performed only on medical grounds. Where mothers are active drug users, there are immediate discussions with child protection. Continuity is ensured by mothers seeing the same worker every week, establishing a relationship before and after birth, with social work and child protection remaining in contact throughout. Where a mother-to-be is abusing alcohol or drugs it is possible to admit her under compulsory measures of care, but this is rarely done (about once a year on average).

The team has no formal structure and operates entirely through the interest of individual workers and their perceptions of the needs of the women. They describe themselves as 'pushy Icelandic women' and since regulation is not strong, they find ways to do the work as they feel it is needed.

FMB team (Foreldrar meðganga barn teymi): Perinatal Psychiatry Team – 'Parent, Pregnancy, Baby (PPB)' (hospital based-tertiary psychiatric service)

The team of very skilled and dedicated workers are all on secondment from other agencies and services, primarily general adult psychiatry. They currently have services from psychiatry, social work, and family therapy, nurse and addiction work. They have no psychologist, as mainstream psychologists in Iceland are strongly aligned to cognitive behavioural theory and are seen as 'quite negative' about attachment-based interventions which they regard as having no evidence base. The service has no guaranteed funding but bids for funds in competition with other services. Mothers with severe perinatal mental health problems can be admitted to the inpatient psychiatric unit, where there are rooms with cots and a comfy chair, and an understanding that the 'baby is not a toy', but no specialist skills to support the relationship. Mothers are admitted 'for a rest' and treatment of psychiatric problems.

PPB work in close collaboration with the high risk antenatal team at Landspitali, and have close relationships with the children's team. PPB receives about 218 referrals a year from primary care midwives, the at-risk antenatal service, social services, child protection and substance abuse services. Referrals are increasing. They see mothers and fathers before the birth and offer parent-infant psychotherapy after birth, as well as massage; specialist addiction services; Mellow Bumps; and referral to foster care for the baby or baby and parents, though this is in short supply. The team can also offer CBT, hypnosis, biological and psychodynamic psychotherapies. The team try to avoid any waiting list, with services being offered within a few week**s**. They can also refer a family to a flat

which can be used by women in pregnancy, single mothers or a couple with a baby. The team can also offer CBT, hypnosis, biological and psychodynamic psychotherapies. Some mothers are found to be ambivalent about referral and may miss appointments and call several times before choosing to engage, reflecting their ambivalence about seeking help.

MFB (Midstod foreldra og barna/Centre for Parents and Children: Parent Infant Psychotherapy Service)

MFB is a self-funded initiative, with staff from psychiatry, social work, nursing and family therapy, offering highly specialist psychological services for pregnant women and new parents. They have been able to access some government money but have no guaranteed funding, making service planning and continuity difficult. Though they are a unique service in Iceland and available to all, in reality, because of geography and transport requirements, mainly parents from the Reykjavik area access the service. Most referrals come from midwives and family centres. The trend is for referrals to increase each year (95 in 2012, 124 in 2013), but dropped to only 105 in 2014, when funding was halved and services could not be guaranteed. Services are offered to individuals, families or groups using eclectic models to meet different needs, but with a strong emphasis on attachment. They are based in a comfortable, central, well-known building providing a service that is very much respected, but with funding under threat, referrals drop as there is no guarantee of the service surviving.

Icelandic Centre for Social Research and Analysis - Inga Dora Sigfusdottir

Inga Dora Sigfusdottir heads up projects following Icelandic children from pre-birth onwards, linking data from the 2004 birth cohort. There is a very comprehensive registry for mother and child from birth, health centre records up to six, then school records and health checks at six and nine years, and school grades at 12. All health, social work and education data can be merged.

The centre has developed a model from cross-sectional studies for substance abuse, showing that it is possible to reach out to children in more difficult circumstances. Where children live in families with high conflict and violence, this can be counteracted by involvement in positive activities, including sport. Conversely in high conflict areas, they are more likely to show problems and suicidal behaviour regardless of their family situation. Strengthening community networks therefore protects all children in all families.

New studies are collecting data on bio-markers in hair and saliva at three time points to evaluate whether engagement in sports and controlling bio-rhythms with ambient classroom lighting can alter negative effects.

Inga Dora felt that the lessons of the financial crash had been salutary, and the traditional, egalitarian Icelandic society had been in danger of being lost. Children were in some ways 'better off after the crash', with more time spent in the family with parents. She was concerned that the demands for better educated teachers and child care workers were not being matched by a rise in their remuneration. In a small society, 'raising the tide' with better universal services still left a gap between rich and poor.

Barnaverndarstofa, Government Agency for Child Protection - Steinunn Bergman, Social worker

There are 27 child protection committees for the 74 municipalities (services for the smaller municipalities are combined). The child protection committees consist of social services, a social worker and a psychologist. In the smaller municipalities, independence is compromised when there is a good chance that everyone has a friend or relative on the committee.

The central government agency gives support to remote areas where there may be limited experience in some specific fields. There is mandatory reporting for all citizens to make a child protection report if they fear for the wellbeing of a child. The public can make an anonymous report but professionals must identify themselves.

There is screening for risk to the foetus in pregnancy. Where drug or alcohol abuse is suspected, the mother is obliged to follow a child protection plan, including weekly drug screening, with compulsory measures if the plan is not observed. Specially trained midwives work with the mother during pregnancy and child protection services are notified. Parents, who are wary of child protection services because they fear their children will be removed, will often accept help from a midwife.

For older children, there is a Children's House in Reykjavik for the joint investigation of sexual abuse. There is also a mother's home for pregnant and postnatal mothers but due to cut backs and changes of policy, these services are little used. They were not well-liked by families as they did not like sharing bathrooms and facilities. There are facilities one hour from Reykjavik for drug treatment, but again, families do not want to use them. In Reykjavik there is a mother and baby home and an

institution run by privatised social services. Remoter regions purchase services as they do not have their own facilities.

Before a child is taken into foster care, the social worker must be able to demonstrate that they have done all they could to keep the child in the family.

Most services are aimed at school age children and above. There is little investment or recognition of the needs of very young children, though Steinunn did have a copy of 1001 Critical Days[18]!

Public Health Research Unit, University of Iceland – Helga Zoega

Dr Zoega and colleagues conduct epidemiological studies of the health of children in Iceland, especially drug use. She shared Dr Inga Dora's interest in the national survey information.

There is a high rate of psychotropic medication for adults and children alike, four to five- times higher than in Sweden for example[19,20]. Two reasons are quoted. Firstly, most psychiatrists in Iceland have trained in the US model where psychopharmacology is strongly endorsed: secondly, access to other treatments is limited. Reimbursement for specialist psychological services for children is low and there are long waiting lists, while GPs can readily prescribe medication. Parents can expect to pay $4K dollars for an assessment of their child for ADHD. Talking therapies such as CBT take time and are on a fee paying basis, while visits to a physician are free.

Child and Adolescent Mental Health Services

The CAMHS team in Reyjkavik rarely see children under six but have inpatient and outpatient clinics for all psychiatric cases. They received some 780 referrals in the previous year and they have seen a change in referrals with more acute cases, self-injurious behaviour and suicidal behaviours, as primary care services struggle to cope. They offer individual, group and family treatment including DBT, CBT, eye movement desensitisation and reprocessing, family therapy and occupational therapy. The team would like to see younger children and intervene earlier, but as resources are limited, they

[18] www.1001criticaldays.co.uk/the_manifesto.php

[19] Zoega, H., Baldersson, G., Hrafnkelsson, B., Almarsdottir, A.B., Valdimirssdottir, U. and Halldorsson, M. (2009) Psycotropic Drug Use among Icelandic Children: A Nationwide Population Based Study. Journal of Child and Adolescent Psychopharmacology, 19(6), 757-764

[20] Zoega, H, Rothman, K,J, Huybrechts, K.F, Olafsson, O., Baldersson, G., Jonsdottir, S., Halldorsson, M Hernandez-Diaz, S and Valdiirsdottir, U.A. (2012). A population Based Study of Stimulant Drug Treatment of ADHD and Academic Progress in children. *Pediatrics*, 130, e53
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have gone some way towards this by training primary care services to offer help for younger children. They also provide monthly support to a more remote team in Westfjord.

Reflections on Iceland

The topic of the financial crash came up in every conversation I had, with lingering anger at the banks, and the politicians who allowed the banks to behave in such a dangerously cavalier way, and fears that now that the recovery is underway, similar over-optimism and hubris could lead to a repetition of the cycle. One professor of sociology called the crash a benefit as it 'brought us to our senses'. The UNICEF report card 12[21] unfortunately suggests that the costs were high, particularly for children and poorer families, although government measures mitigated the effects on children, and even led to some additional investment in children' services.

There seems a contradiction in Icelandic society. There is a proud self-reliance and independence, the Viking legacy of strong people and hard work. However, there is also a sense of entitlement, originally stemming from the Marshall Plan which financed Iceland's rise from poverty after the war, the IMF who backed the economy and a high tax, egalitarian society where education and health care are taken as read. A second layer of contradiction is evident when Icelanders are described as the happiest of people but have the highest rate of antidepressant use both in parents and children. Some of this can be accounted for by the training of many Icelandic psychiatrists and doctors in America. Psychological 'talking therapies' are hard to access in rural areas, while patients have to pay for psychological consultations, so taking medication is an easy response to the wish for a quick solution.

Iceland was hit by a major financial crisis, amounting even to fraud. Services for children were deliberately protected by the government but services for perinatal mental health are precarious. Figures and services represent children from school age, while younger infants are omitted. The services around psychological aspects of perinatal health, mental health, the At-Risk maternity service, the *FMB* perinatal hospital psychiatry team and MFB parent infant psychotherapy service are all run by individuals who prioritise infants and vulnerable mothers by carving out time and budgets against the odds. What they offer is of the highest standard, but its very existence is fragile. It seems unlikely that services such as these could have a powerful protective effect except in a small country, where a lot is achieved in innovative ways by a few dedicated people.

[21] UNICEF. (2014). Children of the recession: The impact of the economic crisis on child well-being in rich countries (Innocenti report card 12).*Florence: UNICEF Office of Research*.

Discussion

All the countries visited had active antenatal care. In some, this was psychologically well-informed and where that was the case, easy access to secondary or tertiary care followed smoothly. Psychological understanding of pregnancy, the role of antenatal stress and the importance of infant mental health for later development should play a formative role in the training of the universal health care services including GPs and midwives, so that they can give sound advice to parents-to-be but also recognise and refer on parents-to-be with additional needs.

To some extent this is already happening in the UK, where the antenatal education curriculum for parents in Scotland stipulates that infant mental health should be part of antenatal classes, but without specification of how that is best delivered[22]. No parallel stipulation is active in England, though through 'Birth and Beyond' materials are made available for antenatal classes[23]. Midwives, who usually deliver the classes, need to be well-informed themselves to give this the authoritative weight it deserves.

Special needs midwives in the UK, who may now be more involved in assessing child welfare of the unborn child in a manner analogous to a child protection investigation and precipitating or contributing to a pre-birth case conference, should be free to move from an investigatory to a therapeutic position.

All midwives and health visitors, who have a unique door-keeping role in seeing almost all families, must be psychologically aware and enabled to make fast referrals to specialist infant mental health services. This was what I saw in the Bærums Helsestasjon in Finland, which provides a model of good practice where midwives, health nurses and psychologists work in smooth cooperation.

All the countries visited had a schedule of frequent child health and family surveillance. As with antenatal screening, when child health nurses are psychologically informed, they will recognise and offer appropriate intervention themselves or by referral to a specialist. Health visitors in the UK are trained to screen for maternal mental health problems either using a questionnaire or asking well-formed questions. In many areas, health visitors can offer a brief series of 'listening visits', i.e. non-

[22] http://www.healthcareimprovementscotland.org/our_work/reproductive,_maternal_child/parent_education.aspx

[23] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215386/dh_134728.pdf

directive counselling. Women with mild to moderate postnatal depression report finding these helpful, but not always sufficient in themselves to treat depression[24].

The aim of listening visits is to reduce postnatal depression, but there is no emphasis on infant mental health, and treating postnatal depression in itself does not guarantee better outcomes for children[25]. Health visitors should be trained to offer a wider range of effective interventions and have better access to infant mental health services with low thresholds and available trained practitioners. All health visitors should have access to planned reflective consultation supporting their own practice, with an infant mental health specialist.

There is marked dissatisfaction in the UK with the adequacy of offering IAPT (Increasing Access to Psychological Therapies) for women and babies with perinatal mental health problems. The training of IAPT therapists and the length and intensity of the treatment they can offer is not sufficient to meet women's needs in the sensitive area of infant mental health or to support their babies and families.

The Institute of Health Visiting (iHV) have appointed infant mental health champions, and this is to be applauded and should be expanded and reinforced, so that all health visitors are fluent in infant mental health, skilled to identify difficulties and empowered to offer or seek additional help for families. This needs to be done smoothly and sensitively as many new parents find psychiatric services threatening and stigmatising.

Some of the best practices I saw were where the antenatal and postnatal services were either co-located or worked very closely together, with little in the way of referral barriers or time delay. Where services were located alongside early education, this was particularly beneficial, as all services were easily accessible to patients and each other for consultation, and in environments that are familiar and non-threatening for families. Families benefit from the co-location of midwifery and child health services with early education services, including children's centres, nurseries and pre-

[24] Shakespeare, J., Blake, F., & Garcia, J. (2003). A qualitative study of the acceptability of routine screening of postnatal women using the Edinburgh Postnatal Depression Scale. *British Journal of General Practice*, *53*(493), 614-619.

[25] Murray, L., Cooper, P. J., Wilson, A., & Romaniuk, H. (2003). Controlled trial of the short-and long-term effect of psychological treatment of post-partum depression 2. Impact on the mother—child relationship and child outcome. *The British Journal of Psychiatry*, *182*(5), 420-427.

school centres. The Children's Centres in the UK, currently under threat and often run by third sector organisations, are the ideal setting and should be maintained, developed and their services increased by the offer of community midwifery and health visiting. The availability of well-informed health practitioners, with an understanding of infant mental health, will not only increase access for families, but by osmosis increase the psychological awareness of child care and early education providers. The integration of early education and child care is probably cost-neutral but the effects are potentially strong.

In the ideal case, as seen in Finland, continuity of care was provided by a single professional offering antenatal care and child health services. Since this is not a likely development in the UK, the integration must happen at a service delivery level and co-location.

For most families in The Netherlands, a week of daily visits of several hours after the birth of a baby by a Kraamzorg, or midwife or health visitor assistant provides the security and stability now often lacking since the loss of close extended families. While sounding as if this would require a high level of investment, it may pay off in reducing perinatal mental ill health. Such a measure would be of immense value to all members of the family.

The ready availability of tertiary infant mental health services gives confidence to universal care providers to ask key questions about parents-to-be and parents' mental health and wellbeing and their relationship with their baby, issues they may skirt around if they do not feel there is help on offer if needed.

Infant mental health should be a core part of undergraduate and post-graduate training for psychiatrists, GPs and clinical psychologists. As in Finland, each academic department of psychiatry, psychology and child mental health should have at least one practitioner with well-developed training and skills in infant mental health. Infant mental health should not be the poor relation or an overlooked part of mental health. Currently there is no specific training or career pathway for psychiatrists with an interest in infant mental health, and services for perinatal mental health are often headed by adult psychiatrists. To be effective for the whole family, adult psychiatrists must routinely ask about the family, and specifically the very young children of patients, and be prepared to make referrals and work in conjunction with infant mental health professionals. To achieve this level of penetration of the important messages about the impact of the early years and parenting, academic departments of clinical psychology and psychiatry would need at least one member of

staff at a senior grade to offer weight to the topics in teaching and clinical supervision. All specialist perinatal mother and baby mental health units should have at least one practitioner skilled in infant mental health.

Current SIGN and NICE guidelines for perinatal psychological problems identify the long term effects on the child as a reason for the guideline, but then focus almost exclusively on maternal problems and treatment. Guidelines need revision with the strong inclusion of infant mental health specialists in the development teams and core recommendations. The trend to name services and NGOs for the perinatal period as 'maternal mental health services', thereby marginalising the child and the rest of the family, should be resisted.

The best services I saw, in Finland and in Norway, offered diversity in their therapeutic skills and in the opportunities to access information and services. Mamma Mia, a web-based app for pregnancy under development at R-BUP, aims to raise the psychological awareness of all parents-to-be. By 'raising the tide', a population of well-informed parents are more likely to understand their own and children's needs and seek help when needed.

Stitching Opvoeden (Netherlands) has a well-developed quality-marking system to help parents seeking information from websites to be assured which information is sound, in an otherwise unregulated market.

At R-BUP (Norway), and in the Tampere region (Finland) specialist services are well developed both academically and in practice. The interface between practitioners and academics is smooth, with generous opportunities for learning, training and consultation. No single model is assumed to be the answer for all families, with psychodynamic and attachment-based models being accessible alongside more cognitive, behavioural and didactic interventions. Neither the level of need, nor the most effective intervention is assumed *a priori.* In Iceland, despite a strong behavioural and cognitive behavioural trend in psychology and a medical model of psychiatry, FMB and PPB continue to offer very high quality services, again with a diversity of options.

No single theory or model of interaction is necessary or sufficient for all. Web-based and app services could be developed and without great cost. One organisation in the UK, 'Best Beginnings'[26] has already developed 'Baby Buddy' to serve this function.

A vetting scheme, such as Stichting Opvoeden (Netherlands) should be devised to examine websites for parents-to-be and new parents and offer a quality mark to give parents confidence in the validity

[26] www.**bestbeginnings**.org.uk/

of advice offered. This requires an organising agency, teams of experts to review content and regular upgrading to reflect new websites. The teams of experts should include a wide range of professional expertise and theoretical alliances and avoid the unwarranted restriction of randomised controlled trials as the sole criterion.

Infant mental health services should reflect a variety of theories and models so that the needs and approaches of each family can be most effectively met. Undue adherence to one model may limit the usefulness for some families.

Childcare in Finland and Norway in particular is exceptional. There are well-trained staff (bachelor degree level) and facilities which gently challenge children from the earliest years. Good diet, an emphasis on outdoor activities, even in less than clement weather, produce a salutogenic environment for play, relationships and learning. It makes many British day nurseries and day care services look shabby and anaemic!

In the UK, the low academic level of staff is compounded by poor pay and conditions, leading to low staff commitment and high staff turnover, the very conditions least likely to foster children's wellbeing. The UK government have recently given guidance that child care workers should have GCSEs in English and maths at grade C, but this has been met with incredulity in some circles. The suggestion that child care does not need qualifications, over-and-above kindness, devalues the significant role early years workers can play in children's wellbeing as well as their development. Good training and more favourable pay would give recognition of the importance of the work done with very young children and start to increase staffing stability. The academic requirement for all day care and nursery settings should be at least one member of staff with a degree in psychology, pedagogy or education.

My attempt to find out what is done to support fathers was disappointing. I found few specific services for men as fathers. The significant paternity leave given to fathers in Finland and Norway is playing a big part in changing the roles and expectations of fathers and society. I have never seen so many men pushing buggies! One significant factor however is the financial impact on the family. This rebounded in Iceland when the paternity allowance was reduced, making it financially unattractive to men to take paternity leave. A paucity of male staff in early years in the UK, partly no doubt a result of the poor pay and tendency to question the motives and validity of men's role in childcare, further reduces variety and stimulation for children. Positive male role models for men in childcare

should be sought. The cooperation of the charity Men in Childcare[27] should be recruited to develop all new and existing childcare outlets

Dr Marie Haga Silija's web-based Mamma Mia app (from R-BUP, Norway) is to be extended to fathers. Ensi-coti in Finland has led the way in developing and offering services training for practitioners to work with men, and for dads.

To enable men to take a full role as fathers, they need parity of parental pay for mothers and fathers so that each family can decide the best balance for themselves. Governmental strategy and policy must recognise the particular role of fathers and the unique opportunity to make relationships with very young babies at the time they are most receptive to environmental influences.

Both the mothers' and fathers' versions of Mamma Mia(Norway) should be translated into English and made available. Once produced, the cost for distribution will be low.

<u>Recommendations</u>

- Infant mental health must be prioritised in the training and development of all universal services which routinely come in contact with new families, GPs, midwives, health visitors and early years' workers.
- Infant mental health training should be mandatory for adult and child psychiatrists in training and to all clinical psychologists. To achieve this, academic staff should include an infant mental health specialist.
- Models of intervention on perinatal mental health should be diverse. Undue adherence to any one model inhibits choice and limits sensitive responsiveness to diverse needs.
- All staff should have access to reflective supervision by infant mental health professionals, to endorse and support good practice.
- Referral thresholds to specialist intervention should be as low as possible, so that easy access to consultation and, if necessary referral is as smooth as possible.
- Mother and baby mental health units should always have an infant mental health professional as part of the team, so that the balance of the needs of the mother and baby is maintained.

[27] http://www.meninchildcare.co.uk/

- Men as fathers, childcare workers and early educators should be given a more positive recognition. This requires both government action in paternity rights, and support and better training and remuneration for early years staff.
- Mothers and babies in prison should have their needs and the services offered reviewed.

Future plans and next steps

- A presentation called 'Putting the baby first in Perinatal Mental Health' has been accepted for presentation at the World Association for Infant Mental Health congress, Prague 2016. A second presentation called 'Putting the baby first in Perinatal Mental Health' will be given at the Mellow Parenting practitioners' conference day in September 2016.
- I will propose a presentation at the All Party Parliamentary Group on 1001 Critical Days.
- I will approach Cheryll Adams, CEO of the Institute of Health Visiting to discuss the recommendations of the report.
- I have joined the 'Joining the Dots' consortium, a multi professional, multi-agency group considering services for Perinatal Mental Health in Scotland.
- I will submit a paper on babies in prison to the Journal of Birth and Parenting Education –this fits well with the government agenda.
- I will lobby the Scottish Prisons Service to consider further the use and running of Mother and Baby units in Scottish prisons.
- Along with other early years and prevention Fellows we will arrange a seminar on our findings to include commissioners and public health and early years' managers and heads of strategy.
- I will contact Tom Freeman of the Holyrood magazine widely read by Scottish MPs. Holyrood is publishing a case study of a fictional child (Kirsty) starting life in Scotland and I will contribute comments based on my findings.

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