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Infants and War Statement

By Campbell Paul, President, Australia

Astrid Berg, President-Elect, South Africa

Kaija Puura, Executive Director, Finland

The current war in the Ukraine has brought into sharp focus once again that our world is beset by violence and destruction – from Afghanistan and Palestine to Myanmar, from Yemen to Sudan, Ethiopia and beyond. There are more infants and family refugees than there have ever been. Of the 26 million refugees worldwide, over half are children under the age of 18 years. The devastating effect this has on people is seen on our screens with stories of loss and pain. Infants, toddlers and young children are however not able to tell their stories, but their trauma is profound.

Three years ago the World Association for Infant Mental Health (WAIMH) published a position paper on Infants' rights in wartime. It points out how despite numerous areas of violent conflicts globally, little attention is paid to the enormous price that infants, toddlers, and young children pay. It states that "The needs and rights of all children are the same everywhere: nutritious food, adequate healthcare, a decent education, shelter and a secure and loving family. These are disregarded at times of war."

The above basic needs are supplied by the adults in the society into which the child is born. A parent or caregiver who is suffering from the psychological effects of trauma may be less able to provide infants, toddlers, and young children with what they need. The effects of war thus reverberate through all the layers of care on which the physical and emotional survival and growth of the young child depends.

We express our solidarity with parents and caregivers of infants, toddlers and young children in all parts of the world affected by violent conflicts.

What we can do: we recommend supporting/donations to UNICEF which could reach young children and families affected by the wars. Donation website: <https://www.unicef.org/take-action>



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From the Desk of the President of WAIMH

By Campbell Paul, Melbourne, Australia

President of WAIMH, Associate Professor, Royal Children's Hospital Melbourne, University of Melbourne, Murdoch Children's Research Centre

I give my warm greetings to all WAIMH members and readers of Perspectives.

I would like to acknowledge the traditional owners of the land from which I'm working today in Australia. I am on the lands of the Wurundjeri people of the Kulin nation, the First Nations People who have cared for this land, nurturing a continuous culture for many, many thousands of years. I would like to honour and pay my respects to their elders, past, present, and emerging. We have so much to learn from our first Nations People about respect for each other, and respect for the environment.

World Infant, Child, and Adolescent Mental Health Day 2022

*I am very pleased that, on 23 April 2022, the **World Infant, Child, and Adolescent Mental Health Day** will be launched.*

The following is a brief talk I delivered with my colleagues on World Infant Child and Adolescent Mental Health Day in an online symposium which is available to anyone around the world.

We are at a time in our world when we are most acutely aware of the vulnerability of the human condition, the vulnerability of infants, children, and families. Our awareness about what is happening around us in the world is more acute than at any time in history. We have this troubling information at our fingertips. It is a time now when we must all work towards understanding and ensuring the optimal mental health of our children who will inevitably inherit the consequences of these worldwide crises.

In the context of the immense pressures on psychological health of infants, children and adolescents around the world at the moment, Dr Daniel Fung, Singapore, President of the *International Association for Child and Adolescent Psychiatry and Allied Professions* (IACAPAP), stepped forward and invited three other key organisations of professionals caring for the mental health of young people (The *World Association for Infant Mental Health*, the *World Psychiatric Association Child and Adolescent Psychiatry*

Section and the *International Society for Adolescent Psychiatry and Psychology*), to come together to sponsor this important day to acknowledge the mental health needs infants, children, and adolescents.

My own work is at the Royal Children's Hospital, and the Royal Women's Hospital in Melbourne, Australia. I have a special interest in the emotional life, and difficulties, experienced by infants and very young children and how to support their parents in ensuring the best outcome for their children. Our clinical teams see very young children, and their parents, within the hospital context. Many of these infants with their families, have experienced major trauma with acute or chronic illness and trauma due to for example, being born premature or sick, or being unwell after surgery. In addition, infants and young children may be exposed to violence, including family violence, and can present to the hospital, or directly to one of many child and family agencies. I believe it is crucial for us to try and best understand the experience of very young children themselves in the context of stress and trauma.

We know that the baby arrives into this world "programmed", ready for lively social interaction (Trevarthen, 2001).

The baby is born with the capacity to hear, see, to feel and to communicate. Babies can reach out to us and make connections if we are there, ready, and receptive. The baby uses gaze, voice and their hands, arms, and body to let us know something about what they are feeling and experiencing. They want to let us know.

Imagine yourself face-to-face with a young infant, who looks straight at you curiously, and then smiles... You have no option but to smile back! This is the process of starting to know the mind of the other at work, right from the beginning. Babies have the capacity for reading our emotional expressions, not quite reading our thoughts, but trying to figure out how we are feeling, where we are at, as we engage in lively conversation with them.

As ordinary "good enough" adults, we have the capacity to enter the inner world of a baby and toddler especially through free, playful communication even before the wonderful explosion of language occurs for the young child.

Of course, it's not always like this for many infants around the world. It's

not like this for many children and adolescents around the world.

What happens if the baby reaches out to us and there is no response, or a response that is regularly devastatingly empty or disorganised and frightening? Infants and children experience mental health problems, with similar frequency and in many ways, with similar phenomenology to those experienced problems by adolescents and adults (Skovgaard et al., 2007).

This is the experience of many infants and young children, who receive an absent or confusing response, when their parents or carers have experienced severe trauma and distress in their own lives as children or young adults.

Families are also being traumatised in our present day through the impact of war, conflict and mass displacement in many areas such as the Middle East, Syria, Ethiopia, and Ukraine.

Families can be traumatised by a history of cultural persecution and intergenerational trauma. There is also death and dispossession as a consequence of war and conflict as in places such as Syria, Palestine, Ethiopia, Afghanistan, Yemen and Ukraine at the moment. "War is a public health emergency" (Goto et al., 2022). Huge populations of children face homelessness, food insecurity, starvation, and stunted growth, physical and developmental and infants and young children facing these crises require interventions on a very large-scale, including to ameliorate the associated emotional impact (Richter et al., 2017).

All communities have experienced widespread illness and death as part of the worldwide Covid-19 pandemic. Because of global warming, the world is also experiencing more and more natural catastrophes such as the extensive wildfires, storms, and floods. Again, the youngest in our communities will suffer greatly from the impact of global warming.

Within the period of infancy, childhood and adolescence, lie the roots of much of the mental health problems that might belie older youth and adults. There is increasing evidence that significant psychological and relationship trauma in the early years is associated with major mental illness in adulthood (Lyons-Ruth, 2008).

Now is the time for increased public and professional awareness of the mental

health needs of infants, children, and adolescents, and of ways that we can intervene to support them.

Increasing global public awareness about child and adolescent mental health is a key goal of the **World Infant Child and Adolescent Mental Health Day**. Our other goals are to create greater mental health literacy and competencies in promoting child and adolescent mental health, also to reduce stigma. We seek to improve diagnosis, treatment and prevention of child and adolescent mental health disorders through the process of international cooperation and understanding.

It's also essential that we reach out to communities with scarce resources to develop mental health services for children and families.

The World Association for Infant Mental Health, WAIMH, shares the overall goals of the World Infant, Child and Adolescent Mental Health Day, namely to:

- increase knowledge about mental development and disorders in infants and young children
- disseminate scientific knowledge about services, interventions and prevention
- and to disseminate evidence-based knowledge about ways to support the transition to parenthood (www.waimh.org)

This involves international cooperation amongst professionals working with infants and families and to facilitate research, education, and sound interventions.

These tasks are increasingly urgent, especially as the high prevalence of infant mental health problems become recognisable and are able to be diagnosed from the first three years of life onwards (ZERO TO THREE (2016), DC- 0 to 5 TM).

Many studies show that some 16% to 18% of 18-month-old children have problems which meet criteria for classification as a mental health problem using the 0 to 5 diagnostic classification (ZERO TO THREE, 2016). For example, the Copenhagen Child Cohort 2000 study (Skovgaard et al., 2007) found that some 16 to 18% of 18-month-old children in a community survey meet criteria for a formal mental health problem diagnosis.

ideas, plans and initiatives which can lead to change for infants and families on a large scale across the globe.

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WAIMH Executive Director Corner

Dear colleagues and friends,

The year 2022 has started and it seems that this year may not be any easier than the last. In addition to the still ongoing pandemic, we now have in Europe the biggest refugee crisis since World War II with 2.5 million people having fled from Ukraine to Poland and other countries. Most of the refugees are women and children, and there are also children who are alone without their parents. Violent conflicts are still ongoing in many parts of the world, and the number of infants, children and families in need of care, support and mental health services remains large. To raise public awareness of children's needs in these difficult times, WAIMH has teamed up with IACAPAP, the International Association for Child and Adolescent Psychiatry and Allied Professions, the World Association for Infant Mental Health, the World Psychiatric Association Child and Adolescent Psychiatry Section and the International Society for Adolescent Psychiatry and Psychology, to sponsor World Infant, Child and Adolescent Mental Health Day on April 23rd, initiated to acknowledge the mental health needs of infants, children and adolescents.

Our webinar series **LAYING THE PATH FOR LIFELONG WELLNESS — INFANT AND EARLY MENTAL HEALTH**, with its 15 webinars produced in collaboration with Sick Kids Toronto, WAIMH and Tampere University, is progressing at full speed, and several webinars are already launched and ready for viewing. The speakers include some of the pioneers and experts of infant and early mental health practices, such as Dr. Alicia Lieberman, Dr. Charles Zeanah, Dr. Arietta Slade, Dr. Hiram Fitzgerald, Dr. Joy Osofsky, Dr. Diane Phillip, Dr. Sheri Madigan and many more. We are all really excited about the opportunity the webinar series offers to attendees all over the world, and as you may remember, WAIMH members will get a discount on the registration fee. WAIMH Affiliates can also purchase a group license for their members.

The preparations for the 18th WAIMH World Congress 15–19th July, 2023 in Dublin, Ireland have also progressed and the call for papers will be out soon. The Office staff is working together with the Local Organizing Committee chairs Catherine McGuire and Audrey Lonergan and the professional congress organizer InConference concerning the practicalities and management of the World Congress.

You can take a peek at the website at www.waimh2023.org. The Program Committee chaired by Dr Elisabeth Hoehn is preparing the scientific content of the Congress, and we will soon be able to present the plenary speakers to all of you. We do hope that we will be able to have a full in-person congress in Dublin, but at the same time we are also preparing an online part of the Congress. Naturally we will be able to change the Congress to a full online event if need be. We have learned a lot in these past few years!

I am also really happy to be able to tell you that the WAIMH eBook project has progressed well under the leadership of our former WAIMH President Miri Keren. Other participants in the WAIMH eBook project include Maree Foley, Deborah Weatherston, Patricia O'Rourke and Kaija Puura. The first volume of the WAIMH eBook is currently being edited by Hi Fitzgerald and will be released soon. The WAIMH eBook is based on articles on different themes from issues of Signal and Perspectives in Infant Mental Health that the eBook group has chosen to form chapters of the eBook. The members of the eBook group have written short synopses of the chosen articles and enhanced the chapters with introduction and conclusion sections. We hope that this way you can make better use of Perspectives and enjoy reading papers by many great names in WAIMH history.

With warm wishes to you all,

Kaija



Welcome to the World Association for Infant Mental Health (WAIMH)

By WAIMH

The World Association for Infant Mental Health (WAIMH) is a non-profit organization with an interdisciplinary membership (www.waimh.org). Currently, there are 63 Infant Mental Health Affiliate organizations from around the world; the Irish Association for Infant Mental Health is one of these affiliates.

WAIMH's central mission is the promotion of the mental health and wellbeing of infants and toddlers throughout the world, taking into account cultural, regional and environmental variations and to generate and make accessible the latest cutting-edge scientific knowledge. There are many facets to the work which WAIMH progress on behalf of infants and toddlers and their families.

A central goal of WAIMH is to disseminate scientific research and knowledge and it does this through its two excellent professional publications.

The first is *Perspectives in Infant Mental Health*, which is a free to access publication and provides a wonderful way to share the latest research and practice. The Editor of *Perspectives* is Maree Foley and she welcomes members to share research and practice of interest. Maree also provides a supportive experience to authors when they are preparing their work for submission.

The other excellent publication is the *Infant Mental Health Journal*, which is the official journal of the World Association for Infant Mental Health; Holly Brophy-Herb is the Editor. The *Infant Mental Health Journal* (IMHJ) was created by the Michigan Association for Infant Mental Health (MI-AIMH) and is copyrighted by the Michigan Association for Infant Mental Health. It is the official peer-reviewed journal publication of WAIMH and, by special agreement with MI-AIMH, members of WAIMH can subscribe to the IMHJ and receive a reduced WAIMH member subscription rate with access to the Wiley database of the electronic journal. The current Editor-in-Chief is, Holly Brophy-Herb. The journal can be accessed here: [Infant Mental Health](http://InfantMentalHealth.com)



[Journal - Wiley Online Library](#). This Journal is published 6 times a year, it publishes a wide range of peer-reviewed research articles, clinical studies, and reviews, programme descriptions and evaluations, reviews on the latest books and much more. It is an exceptional cutting-edge journal.

WAIMH has also prepared very important statements and position papers. They include:

- a) The WAIMH Position Paper on the Rights of Infants [May 13 2016 1-2 Perspectives IMH corr.pdf \(waimh.org\)](#);
- b) A further key publication on the World Wide Burden of Infant Mental and Emotional Disorders: <http://onlinelibrary.wiley.com/doi/10.1002/imhj.21674/full>; and
- c) The WAIMH Position paper in Infant's Rights in war times. Here is the open-source link: <https://onlinelibrary.wiley.com/doi/full/10.1002/imhj.21813>

These are important papers, and I would encourage you to read them. They are also comprehensive resources and are available at a time when the voice of the baby is still so hard to hear. These papers are also supportive when we need the most up-to-date research and literature resources at our disposal to make representation on behalf of this pivotal period of infant and early childhood development, whether is at practice, research, or policy levels.

WAIMH Board's official headquarters and Executive Office are based at Tampere University, in Tampere, Finland. The Executive Director of the WAIMH Organisation is Kaija Puura and with her team, Kaija provides very skillful leadership and overall administration of the WAIMH Organization.

The WAIMH Board has worldwide representations - five continents are represented, Africa, Asia, Australia, Europe, North America. Eight members make up the full representation of the WAIMH Board Executive Committee. Campbell Paul from Victoria, Australia is the current WAIMH President and Astrid Berg, from Cape Town, South Africa, is President-Elect.

Other members include the Affiliate Council representatives, the Chair of the Affiliate Council, Anna Huber from Canberra, Australia and Jane Barlow, based in Oxford, is the Affiliate Council Representative. Both Anna and Jane support the development of all the Affiliates around the world. The At-Large members are Hisako Watanabe from Yokohama, Japan and Catherine Maguire from Cork, Ireland, both elected by the At Large general WAIMH membership. Chaya Kulkarni, from Toronto, Canada is the Presidents At Large member. This member was chosen by the current President and the WAIMH Past President who is Kai von Klitzing, Kai is from Leipzig, Germany.

We would like to encourage you or your organization to consider becoming a

member, if you are not already one. The membership fees are very reasonable; 75 (USD) dollars for professional membership, and 45 (USD) dollars for student membership. For an additional 40 (USD) dollars you can order the excellent online IMH Journal.

Why should you become a WAIMH member? Here are some of the main benefits:

- To promote principles of infant and child health, development and mental health.
- To become part of a global learning community and professional network that speaks for infants, young children and families around the world.
- To have access to resources that promotes infant mental health.
- To learn from world experts about the health, mental health and optimal development of infants, toddlers and their families across cultures and around the world.
- To expand your professional, social network.
- To exchange information about infants and infant-family programs, contribute to the protection of health and well-being in infancy, and early childhood and parenthood on a global level.
- To avail of opportunities to keep pace with new findings and innovations in scientific, clinical, and educational research and programs involving infants and their caregivers.

One of the chief ways WAIMH pursues its role is through the hosting of a biennial Congresses throughout the world. The next WAIMH World Congress will be held in Ireland. I-AIMH will be the host Affiliate and it will be held in Dublin. The Congress is a 5-day event, taking place from 15th – 19th July 2023, it will be held at the Convention Centre Dublin. Another reason to be a WAIMH Member; there are very good reduced rates for Congress registration.

Hosting a World Congress is a unique event; anyone that has ever had the opportunity to attend this international event will tell you the WAIMH Congress is a very sociable event. Our WAIMH international colleagues are among the warmest, most generous, and engaging people you will ever likely meet at an international congress.

The Congress will bring together the most progressive research and world-class practice in infant and early childhood. Preparations have indeed commenced; it will be a hybrid event. We hope the Covid pandemic will have settled to allow us to have the maximum face-to-face interaction. However, having access to a Hybrid online event is also important too for the many practitioners who may not be able to attend.

There have been significant learning's from hosting the WAIMH Brisbane and managing a Congress during a pandemic. Their Local Organising Committee and WAIMH did an exceptional job to host the Congress this year during the pandemic.

We will keep you updated as plans unfold. For now, it is an important date for your diary and an opportunity to begin planning about what aspect of your research or practice you might like to present or simply to make plans to attend this world-class event

Furthermore, WAIMH is creating professional training opportunities through, for example, the upcoming 15-part webinar series in collaboration with Infant and Early Mental Health Promotion (IEMHP), Hospital for Sick Children in Toronto, Canada, through Chaya Kulkarni and Kaija Puura of the WAIMH Office in Finland (<https://imhpromotion.ca/Learning-Centre/Expert-Lectures/Lecture-Series-2022>)

Please watch the webpage at www.waimh.org for ongoing information about WAIMH.

From the Editors

By Maree Foley, Switzerland
Patricia O'Rourke, Australia
Jody Todd Manly, USA
Azhar Abu Ali, United Arab Emirates
Salisha Maharaj, South Africa
Chaya Kulkarni, Canada
Minna Sorsa, Finland
Neea-Leena Aalto, Finland

Welcome to this Spring (2022) edition of *WAIMH Perspectives in Infant Mental Health*. Since the last issue, COVID-19 remains a constant for many of us across the globe. The impact has been and continues to be harshly indiscriminate, especially for families with infants, toddlers, and young children. Amidst the COVID-19 pandemic, atrocities of war continue with the most current attack on Ukraine resulting in the largest humanitarian population displacement in recent history. The UNHCR Refugee Brief (25 March 2022) stated that nearly one quarter of the Ukraine population have been displaced. UNICEF identified more than half of Ukraine's children have been displaced <https://www.unhcr.org/refugeebrief/latest-issues/>.

WAIMH is in the process of engaging with a multilevel response which includes the WAIMH statement on war, that was released on 1 March and heads this Spring 2022 issue ([Infants and War Statement - Perspectives \(waimh.org\)](#)). This statement is followed by addresses, from the president of WAIMH Campbell Paul and from the WAIMH Executive Director, Kaija Puura. Next is an open letter from WAIMH providing an overview of our organization to those who are new to WAIMH. A letter to the Editor, by Kathleen Mulrooney, Miri Keren, and Charles Zeanah, then responds to the previous President's address on the rights of infants ([Presidential Address: The Rights of Children - Perspectives \(waimh.org\)](#)).

This edition of *WAIMH Perspectives in Infant Mental Health* includes a special section focused on Infant and Early Childhood Mental Health (IECMH) promotion and policy. The promotion of IECMH is central to the aim of WAIMH:

WAIMH's central aim is to promote the mental wellbeing and healthy development of infants throughout the world, taking into account cultural, regional, and environmental variations, and to generate and disseminate scientific knowledge (waimh.org)

There are six interdisciplinary papers (all submitted before the current crisis in Ukraine) with a focus on infant mental health promotion, including training, and policy, across organisational level.

The special section begins with a paper from our Irish colleagues (Rosarii O'D Connorton, Aine Herlihy, and Ruth Cleary) who provide readers with a view on IECMH health promotion via training and practice reflections regarding *Practitioner views and reflections on applying the Newborn Behavioural Observations (NBO) System within an Irish Context*. Next, colleagues from Minneapolis, Minnesota, USA (Katherine A. Lingras, Amanda Schlesinger, Christine Danner, Jerica M. Berge, Emily Borman-Shoap, Cheri Friedrich, Mary Benbenek, Andrew J. Barnes, Kathryn R. Cullen, Hannah Balder, Greta Alquist, and Catherine J. Steingraeber) report on their experiences regarding IECMH workforce development in their paper *A Mental Health Crisis and a Workforce Solution: Bringing Together Interdisciplinary Teams to Improve Infant and Early Childhood Mental Health Education and Treatment in Primary Care*.

The focus then turns to IECMH service development with a paper from colleagues in Glasgow, Scotland (Alicia Weaver, Andrew Dawson, Fionnghuala Murphy, Fifi Phang, Fiona Turner, Anne McFadyen, and Helen Minnis) who report on a qualitative study: *Prioritising infant mental health: A qualitative study examining perceived barriers and enablers to infant mental health service development*. IECMH health promotion in community centred practice is the topic of the next paper, written by colleagues in Australia (Linda Campbell, Deborah Costa, Rebecca Stacey, and Rickie Elliott) where they share about their practice endeavours regarding *Embedding infant mental health promotion practices within community-centred parent-infant interaction activities*.

IECMH promotion and policy are integrated in the following paper by colleagues (Susan Galloway, Helen Minnis, and Anne McFadyen) in Scotland who report on a study that was conducted in response to new national level policy informing strategies regarding IECMH in Scotland. Their paper reports on, *Social inequality and infant wellbeing in one area of Scotland*.

Next, in *Policy, practice and infant mental health - how well do we support parents, who are living with a mental illness*, Australian colleagues (Carol Clark, Hannah Jewell,



Cheree Cosgriff, and Michelle Hegarty) review primary documents that reflect the policy context in Victoria, Australia.

After this special section, the issue turns to news from the WAIMH affiliate, the Japanese Association of Infant Mental Health (JAIMH). They provide readers with a *Report on the First Scientific Congress of Japanese Association for Infant Mental Health (Japanese Affiliate of WAIMH) in Koriyama in Commemoration of the Unification of JAIMH*.

Readers are then invited to participate in a new initiative; a virtual *WAIMH Perspectives online Book Club*. The first book that we will focus on is *Therapeutic Cultural Routines to Build Family Relationships: Talk, Touch & Listen While Combing Hair*©. This book is edited by Marva L. Lewis and Deborah J. Weatherston.

News from the WAIMH Office by Minna Sorsa and Neea-Leena Aalto (Finland) follows with a reminder of the forthcoming *Lecture Series - Laying the Path for Lifelong Wellness 2022*; a 15-part Lecture Series, presented jointly by Infant and Early Childhood Mental Health Promotion (IEMHP) at the Hospital for Sick Children and the World Association for Infant Mental Health (WAIMH) and Tampere University, Finland.

Finally, the issue closes with general information about *WAIMH Perspectives* (including the paper submission process) and *WAIMH Congress 2023*, in Dublin, Ireland.

As a reminder, *Perspectives* papers can be accessed online, with past issues dating back to 1993 currently available by following this link: <https://perspectives.waimh.org/perspectives-archive/>. Also, past articles are available online in text format, which in turn can be shared: <https://perspectives.waimh.org/>.

May you and your families and friends, stay safe and well. Our warmest wishes to you all.

The WAIMH Perspectives in Infant Mental Health editorial team

DC:0-5™ Diagnostic Classification of Mental Health Disorders of Infancy and Early Childhood and the Rights of Infants and Young Children

By Kathleen Mulrooney, USA

Miri Keren, Israel

Charles Zeanah, USA

On behalf of [ZERO TO THREE](#) and as members of the diagnostic revision task force responsible for the development of *DC:0-5™ Diagnostic Classification of Mental Health Disorders of Infancy and Early Childhood* (ZERO TO THREE, 2016), we congratulate Dr. Campbell Paul on his appointment as President of the World Association of Infant Mental Health (WAIMH) and are grateful for his insightful “Presidential Address: The Rights of Children” in the January 2022 issue of *Perspectives*.

Dr. Paul presented a compelling address shining a spotlight on the need to recognize that not only are infants and very young children around the world exposed to a variety, and often culmination, of adverse, stressful, and traumatic experiences but that these experiences can negatively impact the infant’s/young child’s mental health and well-being. Dr. Paul made the case that babies come into this world with an emotional life and capacity for intersubjectivity and are to be afforded human rights as would be afforded older children and adults. Acknowledging that infants and young children possess mental health that is largely predicated on the nature of their earliest relationship is critical in recognizing when infants and young children are experiencing mental health challenges, which for some will manifest as impairing clinical symptoms that may be diagnosed as a disorder.

Dr. Paul acknowledged the contribution of [DC:0-5](#) as a diagnostic classification approach that can provide a deeper understanding of the infant/young child’s psychological, emotional, and relational development and experience, all within the context of family, community, and culture. The DC:0-5 approach to diagnosis is developmentally appropriate, relationship-based, contextually driven, and culturally sensitive. The approach recommends a comprehensive, multi-session diagnostic assessment and maintains a multiaxial framework in diagnostic classification providing not only a description of the clinical disorder but also describing the young child’s relational context, physical



health conditions and considerations, psycho-social and environmental stressors, and developmental competencies. Cultural formulation is an integral element of the DC:0-5 diagnostic process. Developing a cultural formulation during diagnostic assessment requires critical reflection about the socio-cultural, historical, and political influences on the child and family as well as exploration of issues of power, privilege, and oppression. This is especially important in minimizing the risk of implicit bias in the diagnostic process. It is critical to use the diagnostic framework to honor how families see themselves and their babies in the context of their socio-cultural identifications (Noroña, Lakatos, Wise-Kriplani & Williams, 2021).

We believe that the DC:0-5 multiaxial framework and cultural formulation along with culturally responsive treatment and healing interventions align with Dr. Paul’s call that young children deserve to be noticed, nurtured, and understood in response to crises such as the pandemic, natural disasters, civil and social unrest, racism, and other forms of trauma and family crisis. Culturally responsive assessment, diagnosis and treatment rely on a diverse and culturally responsive clinical workforce that embraces diversity and inclusion in that workforce and a field that can evolve beyond its white, Euro-centric roots to center and embrace non-dominant bodies of knowledge, practice, study, and leadership. While composing the Infant’s Rights Statement, the WAIMH board members (who represent different

countries and continents) acknowledged the potential problem of assuming that all cultures and countries around the world could embrace the same standards of care and policies regarding infants and parents. They reached a consensus of about seven basic rights of the infants that should be implemented universally. One of the basic rights is access to diagnosis and treatment of both the infant’s and parent’s clinical symptoms.

The ZERO TO THREE December 2021 *Journal* issue marked the 5th anniversary of the release of DC:0-5. In those 5 years, nearly 18,000 copies of the manual have been sold worldwide including translations to nine languages—Chinese, Dutch, French, German, Hebrew, Hungarian, Italian, Portuguese, and Turkish. Other translations of the diagnostic manual are underway. DC:0-5™ trainings for clinicians and allied early childhood professionals have occurred across the United States and North America, Europe, Middle East, Africa, Australia, and Asia. It is clear from this global appetite for the DC:0-5 manual and clinical training, that mental health and allied professionals are seeking to identify mental health disorders early in life so that developmentally appropriate and relational interventions may be put into place to mitigate distress and impairment.

ZERO TO THREE had the privilege of bringing an international panel to present virtually at the WAIMH Congress in June 2021. Our presentation was entitled, “DC:0-5™: How a multiaxial, contextual

framework captures the impact of the pandemic and reflects the child's and family's story." Presenters Lynn Priddis and Nick Kowalenko (Australia), Catarina Furmark (Sweden), and Kathy Mulrooney (United States) addressed recognizing mental health issues for young children and their families in a troubled world, specifically considering the impact of the pandemic. The panelists used case-based presentations to highlight that diagnosis goes beyond "labeling" and that a multi-axial approach to diagnosis in infancy and early childhood helps to tell the story of the experience of mental health disorder for the child and their family. ZERO TO THREE's Diagnostic Classification of Mental Health Disorders, from DC:0-3 through the current DC:0-5 has been clear in the position that while we assess young children and families, we diagnose disorders – not children. A child is NOT their disorder.

In developing DC:0-5 the diagnostic revision task force strove to reach a balance between early identification of impairing symptomatology and access to supports and interventions versus over-pathologizing that could represent the broad range of normative development or cultural norms and expectations. To that end, DC:0-5 developers hoped to mitigate the risk of overdiagnosis by encouraging a comprehensive diagnostic assessment and by using strict criteria for clinical disorder through the diagnostic algorithm, including the necessity to demonstrate that the symptom picture resulted in significant distress and impairment for the young child or family or both.

DC:0-5 exists primarily because more commonly used nosologies such as DSM-5 (APA, 2013) and ICD-11 (WHO, 2019) do not adequately describe early childhood psychopathology. Although research on early childhood psychopathology is newer and less developed than research on psychopathology in older children and adolescents, the task force was able to identify several large data sets, including longitudinal studies, that we used to construct or refine criteria for new and existing disorders. The task force attempted to provide evidence-informed criteria for all disorders.

One of the hopes for DC:0-5 was that it would inspire more research than its predecessors, although published research to date has been limited. There are many potential areas of investigation that will hopefully be explored:

- o Community studies of prevalence and patterns of comorbidity of various disorders defined in DC:0-5 to contribute to the determination of the

burden of psychiatric disorders in young children worldwide.

- o Studies of predictive validity, especially "new disorders," as well as data about the course, response to treatment, and vulnerability factors.
- o DC:0-5 includes several reconceptualizations of disorders, for example, disorder of dysregulated anger and aggression replaced oppositional defiant disorder and the eating disorders. It would be useful to examine the usefulness of these newly constructed disorders.
- o Studies on the use and validity of relationship-specific disorder of infancy/early childhood. This disorder represents a radical departure from the tradition of conceptualizing disorders as existing within rather than between individuals.
- o Prevalence of "Other" disorders. Because they represent cases that do not meet the diagnostic threshold, the more "other" disorders the more clinical presentations do not match current algorithms, suggesting revisions may be necessary.

As we move forward in this work, resources such as the WHO Nurturing Care Framework (World Health Organization, 2018) the WAIMH Position Paper on the Rights of Infants (WAIMH, 2016), and the Irving-Harris Foundation Diversity-Informed Tenets for Work with Infants, Children and Families (Thomas, et. al., 2018) are essential for asserting the rights, needs, and capacities of infants. ZERO TO THREE is proud to collaborate with Dr. Campbell Paul and WAIMH in advancing the field of infant mental health globally for ALL infants, young children, and their families.

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Practitioner views and reflections on applying the Newborn Behavioural Observations (NBO) System within an Irish Context

By Rosarii O'Donnorton, Dr Aine Herlihy, Ruth Cleary

Abstract

This study sought to examine participants' experience of attending a Newborn Behavioural Observations (NBO) training and implementing it into community services, within an Irish context. Semi-structured interviews were conducted with participants of the training (n=6, female=100%), while Thematic Analysis (TA) was utilised to analyse qualitative data. Three main themes emerged along with their related subthemes: 1) Parallel experience between training experience and application into practise, 2) Deeper understanding of a baby's capacities and value of a relational approach, and 3) Ruptures and Connections. The findings suggest that participants felt empowered, with an increased level of confidence when working with babies and parents following the training. Future research could usefully focus on accessing a wider range of service providers. While future NBO training might consider the need for ongoing peer support groups to sustain and develop NBO learnings.

Introduction

The quality of the early relationship between parent and infant is crucial for the long-term social, emotional, physical, and cognitive development of children (Alvares, 2014). However, it can be difficult to understand the needs of babies and what they are trying to communicate. The Newborn Behavioural Observations (NBO) System is an interactive, infant-focused, relationship-based tool (Nugent, 2015). The NBO consists of 18 neurobehavioural observations (usually 15-20 minutes), used with infants from birth to 3 months. While few in number, studies exploring practitioner experiences of applying the NBO have yielded positive preliminary results (McManus & Nugent, 2011; Hawthorne & Nicolau, 2017).

Holland and Watkins (2015) researched the use of the NBO by Flying Start (FS),



an early year's programme in Wales. The study used a questionnaire of fixed choice questions, to research health visitors (N=12) view of implementing the NBO. All respondents believed the NBO enhanced parental understanding of their baby's behaviour and how to meet their baby's needs; with 75% of respondents indicating that implementation of the NBO helped to build the parent-infant relationship. Furthermore, eleven respondents reported that the NBO helped to build and enhance the therapeutic alliance between parent and practitioner. However, the study highlighted barriers such as language, when time was short, when a particular family's home environment was chaotic or the family was in crisis, or when the birth was a multiple one, and the need to develop an NBO champion role within the locality in order to facilitate the sustainability of the NBO.

Kristensen et al. (2019) utilised a cluster randomised design to compare 56 Danish health visitors who had completed NBO training, with 55 who had not. They found significant differences with regard to knowledge about infant self-regulation between the two groups. Significant differences were not observed on the other competencies measured (intention, self-efficacy, and observation skills). However, generalisability of the results beyond Denmark remains to be seen.

Kristensen and colleagues' (2019) results are broadly consistent with the findings of Hawthorne and Nicolau (2017) who surveyed the use of the NBO by practitioners (N=133), approximately seven months after the NBO training course in the UK. The cross-sectional study was made up of a variety of professionals. The study found that practitioners were using the tool in a flexible manner; some were using it as a whole routinely, while others were using just parts of it. 84% of practitioners reported carrying it out with both fathers and mothers. Overall, the study found that the training had a positive impact on upskilling practitioners working in infant and perinatal mental health. The study highlighted the need for more practice in order to become proficient using the tool and the need for continued professional development.

In 2011, McManus and Nugent compared the experiences of two groups of practitioners working with 'high risk' newborns and their families who were engaged with early intervention service providers in the United States. One group provided usual care, while the NBO was utilised with the other group. The group of early intervention providers who were in the NBO group reported higher perceived confidence working with high-risk newborns than those who provided usual care.

Appleton, Nickell, and Nicolau (2016) in their unpublished study compared three groups of Health Visitors from NBO training courses according to preparation prearranged by their facilitator. Results of the study found that the NBO training can be more effective for practitioners with a strong background in infant mental health, but short training preparation can also be beneficial. This has important implications for the preparation of practitioners ahead of NBO trainings.

No other known study has examined the experiences of practitioners training in and applying the NBO within an Irish context. It is hoped that upon completion of the study an enhanced understanding of the experiences of practitioners applying the NBO, within an Irish context, will be obtained and inform future training needs.

Procedure

The Tipperary Infant Mental Health Steering Group (TIMHSG) hosted specialist training in the NBO. The training was provided by the Brazelton Centre UK and was attended by 26 practitioners. A convenience sample was utilized to complete the semi-structured interview. All 26 participants who attended the training, were invited to self-select and 'opt in' to the study, by contacting the researchers by email. In total, six practitioners consented to participate in the study. Participants were female (100% and worked across a range of community services.

For the purpose of this study, Thematic Analysis (TA) was utilised to analyse qualitative data, as it also offers a flexible, inductive and exploratory approach that fits with the aims of the

research (Braun & Clark, 2006). Issues in relation to research reflexivity were addressed and considered throughout the analysis process.

Results

Three main themes emerged. These were (1) Parallel experiences between NBO training and application into practise, (2) A deeper understanding of a baby's capacity and value of a relational approach, and (3) Ruptures and connection. These are defined below along with their related subthemes, which are supported by illustrative quotes. After each quote, "Ppt" indicates a participant number in order to protect the anonymity of the participants. Table 1 illustrates the Primary Themes and Subthemes identified in the qualitative analysis.

Theme 1: Parallel experience between NBO training and application into practise

Parallel experience refers to the participant's experiential experience attending the training and applying the same key experiences into their work with babies and parents; experiences such as collaboration, respect, non-judgmental, supportive, and enthusiasm. It also referred to the teaching methods and how they were experienced and in turn how participants integrated the NBO into their respective services. This theme transpired in the following subthemes.

1.1 The experience of being heard was reported by most participants and it described a deep sense of feeling listened to, and validated during the training, which left a lasting impression, as one participant noted "Everyone was

listened to, you could see if you asked a question, you really felt listened to, very comfortable to ask questions that you thought were silly, or obvious or something you should have known it was a lovely, lovely training" (Ppt 4). Similarly, in turn, participants spoke about using the NBO to really listen to, and give voice to the baby, as one participant reflected "You are going in to be with that baby and if you see the baby is crying then you are making an observation and you are wondering well, I wonder if she is a bit over stimulated. Saying things from the babies perspective" (Ppt 3).

Participants reported feeling 'held' by the concrete teaching methods pre and post-training. One participant commented, "what I really liked is that you got sent stuff (NBO materials) beforehand, so it was not all cramped into one day. I remember we watched those presentations that the trainer had done, that was good to get you into the space beforehand, so that was very helpful, so it wasn't overburdening you on the day" (Ppt 1).

1.2 Not the expert referred to participants experience of observing the trainer adopting a non-expert stance when interacting with the parent and infant, during the training, as one participant commented, "I remember her (trainer) first asking the mam what she noticed about the baby, actually what she learnt about the baby so far, so even from the beginning having that sense of we don't have all the answers, you have answers on your baby and your baby will show us" (Ppt 1). This experience was mirrored by practitioners when they applied this experience in their practise, as one participant reflected "We are not the

Table 1. Themes and Subthemes.

Theme 1	Theme 2	Theme 3
Parallel experience between training experience and application into practise	Deeper understanding of a baby's capacities and value of a relational approach	Ruptures & connections
Sub themes 1	Sub themes 2	Sub themes 3
Feeling Heard and Held	Honouring the baby	Challenges implementing NBO
Not the expert	Honouring the parent	Power of Connection
Passion for IMH	Honouring the service provider	

experts we are the learners. We are not going in as an expert and saying, "Let's see if your baby can do ABC, we are working with the parent and with the baby and we are learning with the Mom, so it is good in that sense" (Ppt 4).

1.3 Passion for Infant Mental Health (IMH) refers to the participant's experience of the trainer's passion for the NBO and IMH work, which resulted in a renewed sense of enthusiasm and passion in the participants work with infants. One participant reflected, "it was their personalities too, of the people that delivered the training and their passion, I think it was their passion that came through so well" (Ppt3). With one participant commenting that the passion she experienced both at the training and applying the NBO was the "missing link" for her (Ppt 3).

Theme 2: Deeper understanding of a baby's capacities and the value of relational approach with parents

It comprised of three subthemes which focused on the uniqueness of each baby, the therapeutic alliance with the parent and the effect of the training on the service provider.

2.1 Honouring the baby referred to participants appreciating the unique capacity of each infant, and using the tool as one participant noted, to wonder and begin to explore alongside the parent, "who is this baby? Who is this little one? What's the little character here? We are talking about the little person in there. We are not talking about what the two-month-old should be doing, we are talking about who is the little person in there, who is the little character, what is the temperament, how unique they are" (Ppt 4).

2.2 Honouring parent referred to participant's experience of implementing the NBO in order to establish a relationship, as one participant described, "it (NBO) really helps with the relationship with the parent, and sometimes it (NBO) can be the building stone for the relationship" (Ppt 5). Honouring the caregivers also referred to meeting the parent where they are at, and being mindful of same as one, participant noted, "for the mom then that has so much else going on, you are really looking and trying to indirectly say 'oh your baby is yawning or he is looking away, or does he always jump in his sleep'" (Ppt 3).

2.3 Honouring the service provider this was reflected in how the

participants experienced their value as service providers as one participant noted, "I wouldn't be academic but I would be confident that I can read a baby and the NBO has been so instrumental in that for me. It really opened up a whole way of working for me" (Ppt 4). While one participant reflected that she felt "more reassured when you are pointing something out, you have something to back up what you are saying" (Ppt 6).

Theme 3: Ruptures and Connecting

Ruptures referred to barriers for participants in their attempts to integrate the NBO into their services. Connecting was a parallel theme that referred to participants renewed values on the power of connections when faced with ruptures. This theme transpired in the following subthemes: (3.1) Obstacles implementing NBO and (3.2) The Power of connecting

3.1 Obstacles implementing NBO refers to the two main obstacles reported by participants when trying to implement the tool; not having regular access to babies between 0-3 months and the COVID-19 pandemic. One participant noted, as her service works with a broad range of ages (0-18 years) she had difficulty accessing babies under 3 months, "I actually didn't do any NBO unfortunately. I didn't have anybody with that age bracket" (Ppt 2). Participants who had access to babies noted that doing it over zoom was an obstacle with one participant reporting, "never really, because the baby is rarely ready at that time and the mom is concentrating on the baby and it just doesn't seem to work" (Ppt 4).

3.2 Connection refers to linking in with other service providers, with parents and babies, and this theme emerged throughout all the interviews as one of importance. One participant reflected on the post-training video group meetings, "For me, it meant when I was doing the NBO I'd have questions, and then I could bring them to the group and then I could hear other people's questions so that was really helpful" (Ppt 1). Video calls were also used by some participants with babies and their parents as a way of helping them stay connected. One participant reflected, "It's very difficult. Even to do it on zoom. But what I do is talk the mom through it. Talk to parent about how the baby is doing" (Ppt 4). Post-training supports via group Zoom calls were also noted as a great support to keep the interest and motivation alive as one participant

reflected, "being linked in with Boston and what they have to offer in terms of the lectures and training is really, really important" (Ppt 3).

Discussion

This is the first Irish study to explore participant's experience of attending an NBO training and integrating it into services. The present study allows us to understand the perspectives of participants experience attending the NBO training, how it informed their practice and how they applied it to their work.

The findings in this study provide a lens to understand the power of relationships. Theme 1 "Parallel Experience" described how the experience of receiving the training and how it was delivered was equally as important as the NBO teaching tool in and of itself. Captured in three subthemes the 'parallel' speaks to the participant's experience of the trainers, the training, and the same experience shared between participants and the families they work with. This theme illustrated the participant's emotional reaction to the trainers, the pace and organization. Holland and Watkins (2015) research also referenced relationship themes in so far as they found that respondents believed the NBO enhanced parental understanding of their baby's behaviour, built the parent infant relationship and helped build relationships between the practitioner and parent.

The present study also illustrated the participant's deeper understanding of a baby's capacity, the importance of observing the baby, and honouring the parents as experts of their baby. Participants particularly identified their increased confidence working with babies and how the NBO was an extra tool they have to back up existing IMH informed service delivery and this seemed particularly important given the challenges faced during COVID-19. This is broadly consistent with Hawthorne and Nicolau's (2017) study which found that the NBO training had a positive impact on upskilling practitioners. Findings by McManus and Nugent (2011) also reported higher perceived confidence working with high-risk newborns than those who provided usual care.

Similar to other research studies (Holland & Watkins, 2015), challenges were identified with integrating the

NBO into services. In particular, we learned that not all participants were able to apply the NBO as they did not have access to babies within their services. This has important implications for service providers and practitioners ahead of NBO trainings. Holland and Watkins (2015) in their study also highlighted the need to develop an NBO champion role. Similarly, we learn in this study the importance of connecting with other service providers and the need for ongoing peer support groups to sustain and develop NBO learnings.

A strength of the present study is its qualitative design which allowed access to the personal reflections of participants and their insights, which will be helpful for future training, particularly within an Irish context. There is a limitation in basing views of an NBO training for participants, where there is a small sample size. Future research could use a longitudinal research design, focusing on the medium to long terms impact of the training to determine whether participant's reflections are sustained and integrated after an extended period of time.

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A Mental Health Crisis and a Workforce Solution: Bringing Together Interdisciplinary Teams to Improve Infant and Early Childhood Mental Health Education and Treatment in Primary Care

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Background

The awareness of Infant and Early Childhood Mental Health (IECMH) as a field has increased in recent years (e.g., Clinton et al., 2016). Yet, too frequently, young children's needs are not identified until after the optimal time for early intervention has passed. Up to 20% of U.S. children (<5 years) experience social-emotional problems that negatively affect functioning, development, and school readiness (Brauner & Stephens, 2006). IECMH problems can significantly impact parental mental health, which can, in turn, affect parent-child interactions and contribute to further social-emotional concerns (Bernard-Bonnin et al., 2004). Left untreated, early social-emotional and/or parent-child interaction concerns can lead to behavioral, emotional, and pre-academic concerns that persist into adulthood. Thus, early intervention in IECMH is critical to positive short- and long-term physical and mental health outcomes for children with developmental or social-emotional delays and for parent-child dyads that exhibit relationship challenges (Karoly, et al., 2005; Ramey & Ramey, 2004). Interventions with young children also present opportunities to assess and support the entire family system. These early interventions are important to longer-term outcomes for individual children and families, yet 70% or more of children who experience developmental disabilities and mental health concerns are not identified until school entry, by which point many



opportunities for effective intervention have been missed (Glascoe, 2005).

Well-child visits in pediatric primary care are a natural and relatively unexplored opportunity to prevent, identify and treat, or refer children with IECMH concerns. It is estimated that over 90% of children in the United States regularly visit a pediatric primary care provider (PCP) (NCQA, 2022). Moreover, most children under five receive care from a PCP prior to school enrollment (NCQA, 2022), which makes well-visits a natural entry point for increasing access and reducing barriers (e.g., stigma) to mental healthcare. The American Academies of Pediatrics and Family Physicians guidelines recommend screening for social-emotional concerns beginning in infancy. Despite these recommendations, consistent and effective screening, particularly for social-emotional development, remains variable (Wissow et al., 2013). Additionally, detection rates can be low, as medical providers may not be trained to utilize screening results and/or to identify mental health concerns (Wissow et al., 2013). Unfortunately, PCPs often lack in-depth training and knowledge to assess and intervene in IECMH concerns, despite their interest in doing so (Olson et al., 2002; Horwitz et al., 2007).

Despite the importance of early identification and access to mental health care, few pediatric primary care have access to experts in social-emotional problems within their settings who could otherwise enhance PCPs' IECMH expertise, provide resources for supporting IECMH, and/or address implementation barriers/facilitators. While some training programs require behavioral health education across the lifespan as part of their core curriculum (e.g., Baird et al., 2017), this is not true of all primary care disciplines. To enhance access to care for at-risk children and families, several models of integrated behavioral health (IBH) programs have been developed (e.g., Healthy Steps; Briggs et al., 2014). However, these programs are often costly and require hiring additional staff, which may make them inaccessible to smaller clinics/systems. Programs may also be variable with some more focused on clinical care than PCP education or vice versa. Given the breadth of information that must be covered in primary care training, even programs which provide PCP education around IECMH may be under-resourced. Thus, opportunities exist to deepen and broaden existing curricula. Further, few programs work across disciplines (e.g., family medicine, pediatrics, nursing) to

simultaneously train learners on topics related to IECMH.

The current manuscript presents a model utilizing an interprofessional team developed to support the education of PCPs (residents, learners, and faculty) in multiple primary care settings. Specifically, providers in pediatrics, family medicine, nursing, psychiatry, and psychology built a pilot system for children's mental health consultation within primary care settings. The history of the current program, model details, and case examples will illustrate the potential impact of this approach as an intervention in children's mental health and the implications it has for IECMH specifically. Modifications to the model during the COVID-19 pandemic and lessons learned will also be discussed to inform others who may seek to implement or fund similar programs.

Project History

Prior to the current project, several children's mental health education opportunities existed for primary care providers, residents, and nurse practitioner learners in the team's system. For instance, pediatrics residents had a psychiatry consultation-liaison service available for inpatient units and could discuss cases with the child psychiatrist on call. Additionally, monthly mental health cross-disciplinary case conferences were available to pediatric residents (Collaborative Office Rounds; Sajady et al., 2019) and family medicine residents (Interprofessional Team Meetings). Preceptors (i.e., faculty) and residents brought challenging cases to discuss and to receive suggestions from attendees regarding diagnosis, assessment, intervention, and referrals; in some but not all programs, these meetings were led by a behavioral health director. Not all providers were in the presenting role at every case conference, so the opportunity to receive case-specific feedback was often limited. Additionally, when discussions were after the fact, and/or limited by time, 'real world' practice opportunities were not as robust/available.

Clinical content related to mental health was also integrated into didactics within resident and nurse practitioner education programs via academic half-day blocks. The depth of content varied by program and was often curtailed by limited time and/or the specific expertise of available faculty. Some sites

also had integrated behavioral health services, but this was not consistently available across disciplines. Additionally, "hands-on" practice opportunities with real, nuanced patients were limited because of the didactic context. To expand children's mental health education during training and to work across disciplines, the current project sought to build a sustainable model for educational consultation in IECMH for PCPs.

Project Model

The project has two core content features: educational training and case-based educational consultations. The consultations build on real-time learning moments, in-depth discussion of cases, and discussion/demonstration of IECMH intervention and caregiver interview techniques. The focus of these consultations is two-pronged: children's mental health content and how best to support parents and caregivers in these efforts. Essential to this model is its interprofessional design. At the outset, the project team intentionally sought faculty from Pediatrics, Family Medicine, and Nursing to ensure utility across fields. Consultants involved in direct education for residents and trainees also represent multiple disciplines (i.e., psychology and psychiatry) to encourage multiple angles of discussion. Additionally, the project team integrated a sustainable, capacity-building mindset from the start so that the model would ultimately be viable in the long-term.

Educational Consultations

Consultants from psychology and psychiatry disciplines are engaged with learners (and faculty supervisors) in their primary care continuity clinics five half-days per week. Initially, the model was designed as on-site consultation, but due to the COVID-19 pandemic, virtual options were created as well. During pandemic surge periods, the virtual consultation room was used when in-person visits were limited. The virtual 'room' ultimately became an opportunity for serving multiple sites simultaneously, even as pandemic restrictions eased, and in-person consultation resumed.

Consultants review clinic schedules to identify patients that may have mental health questions and can access medical charts to guide both teaching points and clinical recommendations. Consultants model history-gathering

(e.g., performing trauma or mood disorder screens), treatment planning (e.g., explaining different therapy modalities and stepwise medication adjustments), and psychoeducation (e.g., teaching about common behavioral concerns by developmental stage). In these conversations, tips are provided for building relationships with parents and caregivers in order to partner with them in addressing children's mental health needs.

Educational Training for Residents, Nurse Practitioner (NP) Learners and Faculty

Consultants develop a monthly newsletter called 'Pediatric Pearls for Children's Mental Health' (Pearls) which are distributed in hard copy at the clinics involved in the project and via email to each training program. In total there are more than 50 NP learners, 25 family medicine residents, and 115 pediatric residents. Over 50 faculty preceptors also receive these Pearls. In each issue, suggestions are given for identifying a concern, proactively addressing the topic within a visit, guidelines for discussing concerns (e.g., questions to ask families), and additional resources (e.g., articles, books, podcasts, online videos, and social media accounts). The topics are determined based on questions that arise during consultations and are tailored to be timely based on seasonal or societal circumstances. For example, in November, when vaccines became available for children aged five to eleven years, the topic was focused on anxiety. The newsletter also included suggestions to address vaccine anxiety, as younger children became eligible for the COVID-19 vaccine. In December, the Pearls included discussion of holiday celebrations, routines during school breaks, and supporting families through uncertain times. January, a month when COVID-19 began another surge, focused on building resilience in both children and providers.

Consultants also created "smartphrases" which can be typed into the medical records system and provide populated resources for commonly asked questions/concerns. These smartphrases are commonly used within the healthcare system and are designed to assist in tailoring commonly placed referrals such as therapy, psychiatry, or case management for a specific patient. In this case, project smartphrases allow

for a provider to type in a short phrase like “IECMH transitions” to bring up tips and tricks for easing transitions with young children.

Additional (iterative) tools

This project is designed to be iterative in nature, which has proven to be especially important during recent years. Additional tools and adjustments are regularly implemented to enhance the effectiveness of consultation. For instance, when virtual consultation uptake lagged, reminders were developed for faculty supervisors and clinic huddles. Additionally, a flier with a QR code was created and circulated digitally and placed in clinics to remind providers of the service. The flier also links to a calendar that lists consultant availability and coverage if a consultant is out of the office. In turn, the availability of live updates allows for morning huddle reminders to providers regarding which consultants are available that day. Smartphrases, described above, were also created as a point of care reference for PCPs to remind them how to access the virtual consult room or route consultation questions via the electronic health record if they did not have time to discuss the case during a busy clinic morning or afternoon.

In the next section, case examples are presented to illustrate the impact of pediatric mental health educational training and consultation work in a busy residency clinic.

Brief Case Examples

Case 1: “Xavier” was a 2½-year-old boy whose parents had felt his behavior was appropriate and easily managed, until the birth of their second child. Once his sibling was born, Xavier became aggressive toward his parents and began having disruptive tantrums. Xavier’s parents raised these concerns during a well-visit. The mental health consultant reviewed the nature of the tantrums and provided psychoeducation regarding typical toddler responses to large life changes. They also discussed tracking and assessing new toddler behavior problems over time as possible markers of developmental delays or unrecognized medical problems, versus a response to a stressor. In this case, the tantrums appeared to be closely linked to the new sibling and no regressions were noted in other areas of development. The consultant and

learner discussed topics for parental psychoeducation and reviewed behavioral interventions to share with parents. This included scheduling “special time” for Xavier to spend with each parent focused on 1:1 play to decrease jealousy, reading about a new sibling to normalize the experience and allow expression of feelings, and providing labeled praise and positive reinforcement for desired behaviors (e.g., interacting appropriately with the baby). Ultimately, Xavier and his parents benefitted from this brief consultation by both providing interventions for currently concerning behavior and preventing longer-term concerns from developing.

Case 2: “Gabe” was a three-year-old boy who presented for a telehealth visit with pediatric resident “Jamie.” Gabe’s parents raised questions regarding sensory concerns and increasingly aggressive behaviors that were causing problems at home and school. Jamie shared this case with the mental health consultant and described several symptoms that sounded consistent with an autism spectrum disorder. The consultant helped Jamie formulate follow-up questions designed to clarify the symptoms and their onset as well as to plan for the next steps. Jamie and the consultant agreed that an in-person follow-up visit would be important to conceptualizing the concerns and making appropriate referrals. A week later, Gabe and his parents arrived at the clinic. Initially, Jamie was confused about what should happen in this follow-up visit, given that a preliminary referral had already been placed for parent-child therapy. The consultant reviewed with Jamie observations that might help inform the current questions. Jamie learned behaviors and interactions to look for in the clinic room between Gabe and his parents, as well as small interactions she could try herself with Gabe (e.g., pointing, engaging in conversation/play to gauge reciprocity). During the visit, Gabe’s parents also noted that he had more limited interactions with other children due to the COVID-19 pandemic extending over his early years. Jamie returned from the visit to review the case with the consultant and her faculty supervisor, who also gleaned suggestions for evaluations of autism symptoms. The interactions that Jamie shared appeared to be *inconsistent* with autism. The team also reviewed the COVID-19 pandemic context and its impacts on early social-

emotional development. Based on this experience, Jamie better understood the importance of in-person follow-up as well as the impacts of the pandemic and characteristics that might be present in a young child with autism.

Case 3: “Maddie” was a 12-year-old with a history of ADHD and early life trauma while in her birth mother’s care. She and her adoptive mother presented to the clinic to see “Jill,” a pediatric resident, just prior to a scheduled trip to visit her birth mother. After returning home from past visits, Maddie has struggled with emotional dysregulation and aggression to the point that crisis services and use of the emergency room have been required. With hopes to prevent similar episodes this time, they requested medication that could be used to calm Maddie for the week after her trip. Jill discussed this case with the behavioral health consultant who was able to shift the frame of Maddie’s case from a purely behavioral lens requiring psychopharmacologic treatment to one that may be seen through a developmental lens with consideration for how Maddie’s early life trauma and attachment were contributing to her clinical picture. The consultation also included discussion of the impact of COVID-19 restrictions that led to reduced predictability of visits. These lenses expanded Jill’s understanding of Maddie’s behavioral outbursts as well as the scope of treatment. Instead of focusing only on medications, treatment was broadened to include strategies such as increased therapy sessions pre/post-trip, mindfulness, and self-identified coping strategies such as exercise, yoga, and journaling to prepare for her trip, process intense experiences during the trip, and proactively prepare for the return home. While medications were included in the treatment plan, they were an adjunct to the plan, if needed, rather than the primary component.

Lessons Learned

Throughout this project, the team has learned several lessons, and incorporated changes through an iterative process. One challenge was helping residents find time for consultation within a busy clinic day. This was particularly relevant when only virtual consultation was offered (opportunities and challenges of the virtual modality are discussed further below). An initial observation was that of the “spillover effect”; once a given learner or faculty engaged

in a consultation, they tended to consult again on future cases, which increased utilization. The team also found that combining informal consultation with formal didactics and organized meetings increased impact. For example, topics raised in lectures led to follow-up questions in clinic, or conversations about patient cases generated new ideas for lecture content. In addition, consultants began joining complex case team meetings. The presence of the consultants at these regular targeted meetings resolved the time pressure barrier and created another opportunity to build relationships and familiarity with the consultation team, which contributed to additional consultations down the road.

As discussed above, the COVID-19 pandemic prompted the introduction of a virtual modality for consultation. The virtual consultation experience afforded many opportunities to expand reach and flexibility, while also creating some challenges. The main advantage to virtual consultation is the ability to reach multiple clinics with a variety of learners simultaneously – particularly for a large metropolitan area with widely dispersed clinical sites. Virtual consultation also increased opportunities for interprofessional learning because trainees from across programs (family medicine, pediatrics, nursing) were able to join the same consultation session and share (de-identified) cases. Finally, it became easier for consultants to review charts of scheduled patients quickly and ahead of time, providing further mechanisms for consultation (i.e., direct messages to providers prior to consultation time).

The virtual room also presented challenges. Initially, and particularly on busy days for residents, consultants could be “out of sight, out of mind”; it was easy to overlook the access to a consultant when mental health may not have been top of mind, and other visits were pressing the afternoon forward. Additionally, if technological barriers were encountered, residents were more likely to abandon the attempt at consultation rather than wait and have to prolong their patient’s visit. Whereas, in person, residents were more likely to circle back later in the day and persist in their efforts to connect with a consultant. Additionally, when in person, consultants were easily able to join spontaneous conversations about behavioral health concerns, and this became difficult when consultation was virtual. Although the virtual room

allowed consultants to “listen in” on preceptors reviewing cases, it was hard to pick out opportunities to engage residents in conversations about mental health without the social cues of the in-person setting. Some preceptors also felt uncomfortable with a consultant continuously listening in virtually, so they would mute the sound on the clinic end. Finally, it became difficult to model discussions with caregivers and demonstrate techniques that could have otherwise been used in the moment. Once in-person consultation was again feasible, and residents and faculty were familiar with engaging the consultant, it was easier to have an occasional virtual day when needed. Going forward, it will be important to determine how best (and how much) to keep virtual options available, particularly when considering expansion to more sites.

Conclusion

As the gap continues to widen between increased need for children’s mental health services and limited availability of practitioners, it is essential to expand IECMH education for pediatric primary care providers. Providers have a great deal of interest in this area, as families increasingly use primary care visits to raise questions about emotional and behavioral functioning. This is increasingly essential and an even more frequent need, as the COVID-19 pandemic continues to impact child development and well-being. Well-child visits offer an important opportunity for assessment, early intervention and prevention, as well as continuity of care for young children and their families, for whom the primary care clinic is a consistent point of contact and source of advice. Ultimately, by building IECMH skills in primary care providers, child and family mental health will be positively impacted at a larger scale.

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Prioritising Infant Mental Health: A Qualitative Study Examining Perceived Barriers and Enablers to Infant Mental Health Service Development in Scotland

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Background

The consequences of not investing in the mental health needs of children at the earliest stages of life means denying thousands of children the opportunity to reach their life potential as well as accumulating huge financial costs (Segal et al., 2018:172).

Infancy is when children are most vulnerable to psychological harm, but also when they are most malleable to positive intervention (Nix et al., 2016). Studies have consistently shown that infants have a similar prevalence of mental illness as their older peers, with estimates ranging from 10-22% (Egger & Angold, 2006; Wichstrøm et al., 2011; Skovgaard, 2010); yet infants



are rarely referred to mental health services in Scotland. For example, in the area studied here, only 0.3% of referrals to child and adolescent mental health services were for under 3's; amounting to 17 referrals for the 20,700 under 3's living there (National Records Scotland, 2018).

Early intervention reduces symptoms, reverses negative developmental trajectories, and improves academic/socio-emotional outcomes (Knapp et al., 2007; Wiefel et al., 2005). Infancy is a time of rapid brain development in which interactions with caregivers are crucial and relationship-focused interventions may be helpful (Ilyka et al., 2021). Interventions provided in the early months and years have a greater impact than those aimed at older children (Carter et al., 2004).

In 2019, the Scottish Government committed resources to 'implement and fund a Scotland wide model of infant mental health provision' (Scottish Government, 2019). However, various studies report that there is a belief that infants are too young to suffer from mental health issues, and hence are too young to benefit from a service; they also report a parental fear of blame if they were to seek help (Harwood et al., 2009; Nelson & Mann, 2011).

We conducted a systematic literature review (details available on request from the authors) which identified little previous research on barriers or enablers to infant mental health (IMH) service development. In spite of a wealth of IMH literature that supports the case for parent-infant services (Fivaz-Depeursinge & Philipp, 2014; Fraiberg, 1980; Lieberman & van Horn, 2011; McArthur et al., 2021; McHale, 2007; Osofsky & Lieberman, 2011), the writings of Gesell (1941) through to Harwood et al., (2009) indicate two key points: 1. that infant mental health service development has rarely been sustained over time and 2. an ongoing narrative about service development being parent focused and not *infant* or (parent-infant) *relationship* focused.

Following the identification of these gaps in the literature, we conducted a qualitative study with the overarching research question:

"Why is it challenging to build IMH services, despite the fact that we know that the baby's brain is developing so rapidly?"

Manager, Children and Families Social Work	Consultant Child and Adolescent Psychiatrist with Special Interest in IMH	Child and Families Officer VAL (Third Sector Organisation)	Consultant Child and Adolescent Psychiatrist (Neurodevelopmental Disorders Team)	Depute Principal Educational Psychologist
Head of Child and Adolescent Psychotherapy & Lead for IMH	Consultant Adult Psychiatrist: Perinatal and Eating Disorders	Early Year Quality Officer	Family Nurse Partnership Supervisor	Advanced Specialist Midwife in Perinatal Mental Health
	Neonatal Psychologist	Service Improvement Co-ordinator, Early Years	Project Manager, Mental Health & Wellbeing Strategy	

Figure 1. Professional roles of participants in qualitative interviews.

Methods

Study Design

Ethical approval was obtained from the University of Glasgow College of Medical, Veterinary and Life Sciences. The research team was made up of 7 members, including child and adolescent psychiatrists and psychotherapist, a health psychologist, and a medical student. All researchers took part in a recorded interview to examine any preconceptions or potential biases. A semi-structured interviewing format was used, with open questions to allow the interviews to be guided by participants.

Participants

Participants were drawn from a local IMH stakeholders group whose task was to advise on the development of a new IMH service in one area of Scotland. It comprised 31 health, local authority and third sector professionals, and parents/carers. Individuals were purposively sampled from this list by the research team to cover a range of professions (see Figure 1). Thirteen stakeholders were interviewed, and a further three were contacted with no response.

Parents and carers are key stakeholders of IMH services but, for the purposes of this study were not interviewed because the services were not yet up and running at the time the study was conducted. There are plans to explore views of service users after they have had time to experience the new services and it is important that these

include wider family members such as grandparents.

Consent and interview process

An information sheet was sent in advance by email and permission for recording was obtained at the beginning of the interview, followed by reading of the consent form.

Each participant was interviewed by a pair of interviewers to minimise bias; one would act as a 'guider', inquiring around the topic guide, whilst the other would act as an 'inquirer', probing follow-up questions. Each interview lasted approximately one-hour.

The interviews were transcribed verbatim and anonymised to maintain confidentiality. For data protection, each participant was given a study ID number, and a document tracking this system was kept separately.

Analysis

Thematic analysis, according to the methods of Braun and Clarke (2006) was deemed the most appropriate method of analysis to systematically examine the data and interpret meaning.

Phase 1 – Familiarising

6 members of the research team independently read and re-read two transcripts allocated randomly, reflecting, and noting points of interest.

Phase 2 - Generating Initial Ideas

Each researcher independently generated initial codes for these

transcripts, shared initial findings, and these were combined into a coding rationale table identifying similarities and differences.

The 3 members who had performed the interviews then followed phases one and two for a further two transcripts, chosen purposefully to contrast with the first two in the hope of generating any remaining themes. Very similar codes were identified; these were compiled into a further coding rationale table.

Phase 3 - Searching for Themes

Each interviewer independently generated preliminary coding frames based on these coding rationale tables, clustering related codes within an overall heading that captured their essence; these were the initial themes.

Phase 4 - Reviewing Themes

The interviewers then discussed the benefits of each independent preliminary coding frame to develop a combined coding frame.

Each of the remaining transcripts were coded independently by one of the interviewers using the agreed coding frame. The interviews with the researchers were also coded to aid reflexivity and identify any further themes that may have impacted data collection/handling.

Phase 5 – Defining and Naming Themes

Names of themes, and their sub-themes were discussed and agreed; systems,

barriers to change, enabling factors, training and education, gaps in current services, and professional and personal interests. Sub-themes will be further explored in 'results' and are displayed in Figure 2.

Results

Six over-arching themes were identified. These are outlined in Figure 2 with their sub-themes. This paper will focus solely on perceived barriers and enablers to Infant Mental Health Service Development in Scotland and will explore each sub-theme identified within these themes, alongside quotes from participants. Other papers will follow as other research questions are addressed.

Perceived barriers to Infant Mental Health Service Development

Twelve perceived barriers to the development of an IMH service were identified; these are shown in Table 1.

We will now discuss each sub-theme in detail.

1. Societal Stigma & Lack of Understanding

This was the only sub-theme amongst 'Perceived Barriers to Change' to be mentioned by all participants. Participants perceived a lack of professional understanding – one psychiatrist who had trained elsewhere noted, in contrast with other countries in Europe, IMH is not a familiar concept

to UK clinicians, or parents: delaying diagnosis and treatment.

All participants noted stigma surrounding IMH: IMH is not discussed, and the public do not want to accept the idea of 'babies' needing a mental health service.

2. Lack of Synergy

Participants spoke of a lack of communication between current services, and between professionals and a fear of this continuing. This is exacerbated by different ideologies about what an IMH service should look like.

Participants explained that this fragmentation delays referrals, so

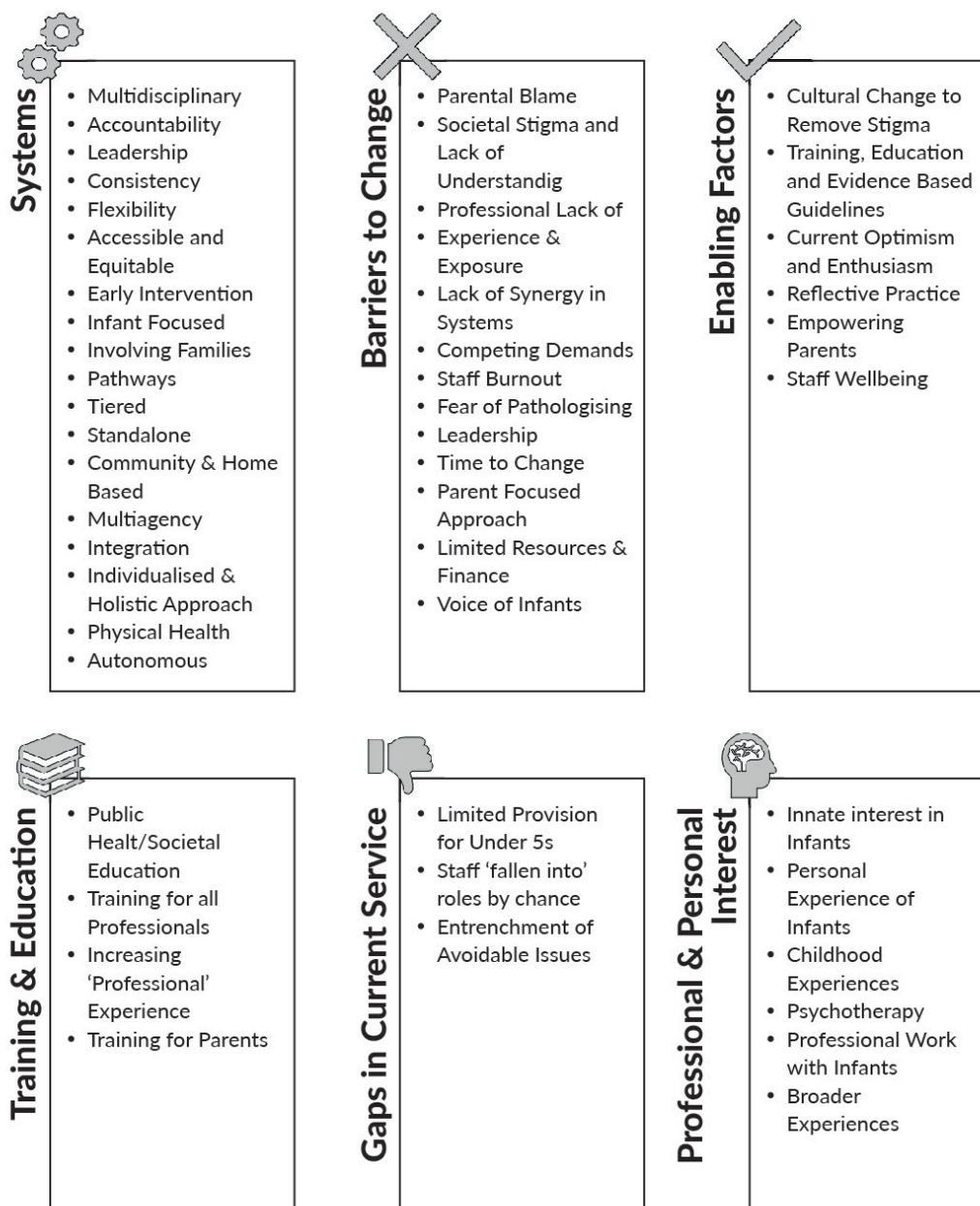


Figure 2. Overview of thematic analysis themes and sub-themes.

Table 1. Perceived barriers and enabling factors and their endorsement by participants.

Perceived Barriers to IMH Service Development	
Sub Theme	Number of Transcripts Identified
Societal Stigma & Lack of Understanding	13
Lack of Synergy	11
Lack of Resources/Finance	9
Competing Demands	9
Time to Change	8
Parent Focused Approach	8
Parental Blame	7
Leadership	4
Fear of Pathologising	4
Staff Burnout	4
Professional Lack of Exposure	3
Voice of Infants*	1

Perceived Enabling Factors to IMH Service Development	
Sub Theme	Number of Transcripts Identified
Current Optimism & Enthusiasm	13
Training, Education, Evidence Based Guidelines	12
Cultural Change to Remove Stigma	9
Empowering Parents	8
Staff Wellbeing	6
Reflective Practice	5

* ‘Voice of Infants’ encompasses the idea that infants are unable to formulate words and sentences, and hence their thoughts and concerns often go unheard.

professionals are unable to offer infants what they need at the right time. Concern was expressed about how different services would access IMH without effective communication and clear timely pathways; and that those making the referrals to services would not receive the correct training to identify those in need.

3. Lack of Resources and Finance

Participants referred to the impact of limited resources and finance resulting in the need for strict criteria, allowing only the most severe cases to be addressed. Some spoke of bouts of funding which supported services to start but not be sustained. There were concerns about a limited number of trained staff.

4. Competing Demands

Two participants, each with a service development background, focused on the impact of other health priorities and competition for funding. Participants explained that the current strain in services for older children makes it difficult to prioritise infants.

“If you have concerns about an infant but there’s a child who’s displaying suicidal tendencies then you’re going to respond to that immediate need.” [Local Authority Worker]

5. Time to Change

Participants mentioned the time required to improve societal understanding and to implement

services; the commitment that this necessitates has previously been absent. Development of services is likely to be a long process, requiring considerable resources and commitment.

6. Parent Focused Approach

Another barrier highlighted was that a focus on parents may lead to the infant being forgotten. A neonatal psychologist explained that this is due to the misconception that infants struggle only because their parents are struggling. A midwife explained that recently developed services had repeated this mistake.

7. Parental Blame

A culture of parental blame was described which was seen as preventing parents from seeking help and risking

losing their engagement. A Project Manager explained that, regrettably, a parent may be apprehensive to raise concerns in the fear that they may be blamed, and that their child may be taken away.

8. Leadership

Participants spoke of the detrimental impact of constant changing leadership, and hence varying prioritisation. Historically some leaders have shown interest and progress is made but following leadership change, interest diminishes, and progress is erased.

9. Fear of Pathologising

Participants spoke of societal apprehension about turning dysfunction into disorder, and the effect that this has on professional and parental approval of IMH services; likely a repercussion of stigma.

10. Staff Burnout

Participants explained that with previous attempts at IMH service development, professionals had difficulties getting referrals accepted, so eventually become exasperated and stopped referring.

11. Lack of Professional Exposure

Participants explained that a lack of exposure to infants impedes professionals' understanding. One psychiatrist was surprised that, unlike in some European countries, it is rare to see under-5s in psychiatry in the UK. Without this exposure, it can be challenging for professionals to develop the necessary skills.

12. Voice of Infants

One professional explained that infants' inability to verbalise their thoughts has prevented them from advocating for themselves, and hence infants being overlooked.

"The origin of the word infant means without speech." [NHS Clinician]

Perceived enablers to Infant Mental Health Service Development

Six perceived 'Enabling Factors' were identified, as shown in Table 1. These encompass factors that participants believed would facilitate the development and maintenance of an IMH service.

1. Current Optimism & Enthusiasm

All spoke optimistically about current progress in the field; there was excitement and confidence that change was happening. One participant noted the UK's strength of working well in teams. Participants also referred to the hope that comes from working with infants due to the positive impact of early intervention.

"When you come back to working with infants there is so much hope." [NHS Clinician]

2. Training, Education, Evidence Based Guidelines

A psychiatrist whose European training had encompassed infants felt that their comprehensive understanding of IMH was a result of their exposure to infants during training. Many participants noted the importance of both professional education and public health campaigns. One participant focused on education around infant brain development and a midwife explained that, though midwives know what to do, they do not have the knowledge to understand why. Participants also explained the need to implement 'indicators', particularly for less experienced professionals, to help them recognise infants in need and gain confidence doing so.

Some participants explained that evidence demonstrating clinical need was required to access funding, alongside quality assessment to show impact, to maintain funding.

3. Cultural Change to Remove Stigma

There was a consensus about the importance of viewing IMH with positivity, tackling stigma, and using of awareness-raising campaigns. A neonatal psychologist spoke of previous normalisation of adult mental health services; the same needs to happen with IMH.

"It is about creating a new culture." [NHS Clinician]

4. Empowering Parents

Participants spoke of the importance of supporting parents to give them the tools to help their child. There was a belief that all parents want the best for their children, but do not necessarily know how to provide that. The importance of working with parents in a non-judgmental, non-threatening way,

and ensuring practical supports such as finance and help with access, was emphasised.

5. Staff Wellbeing

Participants spoke of the importance of staff wellbeing. One participant spoke of a previous service which had a support team for staff, which in turn boosted morale.

6. Reflective Practice

Participants also noted the importance of reflecting on their experiences and responding to the increasing amount of evidence.

Discussion

As found in previous research, as outlined below, we found several perceived barriers to IMH service development. We were also able to identify perceived enablers to IMH service development, something that, to our knowledge, had not previously been identified in the literature.

The perceived barriers identified demonstrate why it is so difficult to implement IMH services. For example, 'parental blame' (Harwood et al., 2009; Nelson & Mann, 2011), 'professional lack of exposure' (Egger & Angold, 2006; Nelson & Mann, 2011) and 'voice of infants' (Egger & Angold, 2006; Hoagwood et al., 2021) have been explored in previous literature, which was congruent with the findings in this research. The concept of 'voice of infants' represents the wider thinking of many professionals who are involved in providing direct services to infants; though babies are unable to verbally communicate, they are born ready to relate, with innate behaviours that allow them to communicate (Murray & Andrews, 2005).

By contrast, 'time to change', 'competing demands', and 'leadership' were referenced much more in this study.

Both participants and existing literature emphasised 'societal stigma', 'lack of synergy', 'parent-focused approach' and 'lack of resources', indicating the magnitude of their impact.

Many participants discussed parental concerns about being referred to IMH services for fear of judgement, as well as their belief that infants were too young to have mental health problems - findings supported by various studies (Harwood et al., 2009; Nelson & Mann, 2011). One contrasting study found that stigma had 'minimal salience', with over

74% of mothers not reporting it as a problem (Frankel et al., 2020). However, that study was based in the USA, where IMH services are more common, and hence there may be cultural differences in attitudes to IMH. For example, the state of Michigan alone has more IMH services than the whole of the UK (*Community Mental Health Infant & Early Childhood Mental Health Services in Michigan*, 2022).

Another study explained that stigma causes professionals to minimise infants' problems, searching for protective factors for fear of pathologising them (Harwood et al., 2009).

A 'lack of synergy' was confirmed by international literature, indicating that fragmentation is a global problem. A parent-focused (as opposed to infant-focused) approach is also apparent worldwide. Even if the therapeutic task is to address the relationship, attention is often exclusively on the adults in the room. This has been commented on by Beebe (2005):

'Even in current approaches to mother-infant treatment, the infant is in danger of being the "forgotten patient".'

Two previous evidence syntheses (Smith et al., 2019; Webb et al., 2021) identified very similar barriers in perinatal mental health, suggesting that both perinatal and infant mental health services experience the same barriers, which may perpetuate the challenges for service development. Unsurprisingly, the barrier highlighted most often in each of these papers was stigma.

Previous literature has identified similar barriers to those evidenced in this study, though this is the first to our knowledge to directly identify factors to combat these barriers and facilitate effective service development.

As stated previously, perceived 'Enabling Factors,' to our knowledge, have not been clearly identified in the IMH literature. This could be because the evidence is dispersed and hence not easily identified.

The enabling factors elicited here reflect the perceptions of a group of stakeholders actively engaged in the task of building an infant mental system in their part of Scotland. They encompass their attitudes, values, and beliefs, and they also make practical suggestions about what supports they believe will ensure success. Their optimism, enthusiasm, and positivity may be related to the very fact that

resources have been made available to develop an area of work which they value. Their narratives show that they understand why addressing infant wellbeing and relationships during pregnancy and the early years is important, but they are challenged by an awareness that many professionals and parents find this difficult to understand. Nonetheless, they value collaborative working and seek to empower parents and carers, and also tackle the wider stigma which prevents many people from accepting that infants have a mental life and experience not only emotional distress, but also disturbance and disorder. They suggest that both professional and public education are important in this regard.

Their observations about the importance of attending to staff wellbeing, and allowing time for reflective practice, may relate to the emotional impact of working in this area. When babies, for whatever reason, are not part of a close attuned relationship with their primary caregiver, their development is impaired, they experience distress and they are more likely to be abused or neglected (Zeifman & St. James-Robert, 2017). Acknowledging the toll that this takes on clinicians and thinking positively about how to address this can be seen as a positive step to ensuring services succeed.

Reflective practice can also be seen as an enabling factor in the context of the need in this specialist area to take account of the inherent complexity of our models of understanding which integrate the neurobiological with the psychosocial. The dynamics of the baby's life and relationships are often reflected in the systems around them and taking time to consider these and the feelings they stir up is more likely to lead to a successful outcome.

Attending to the perceived barriers and enabling factors which underpin infant mental health service development is likely to be important in ensuring that these services are created in a sustainable way. This study contributes towards further highlighting and understanding these factors.

Limitations

There was a gender imbalance in this research: 12 of the 13 participants were female.

The use of a pre-existing stakeholder group means that these participants will not be representative of all professionals or the general public, as they are more engaged in IMH.

All participants were White; reflecting the population of the area, where the last census recorded 98.1% as White (Office for National Statistics, 2016). The views of parents and carers have not been included but will be explored in future studies.

Reflexivity

Six of the seven researchers were female and most had a clinical background; all had a personal interest in IMH, as evidenced in the researcher interviews. The researchers' professional status may have contributed to the level of trust engendered at interview allowing some participants to feel comfortable, though others may have felt intimidated.

Strengths

The participants interviewed had a diverse range of professional and personal backgrounds. The majority had broad training experiences, with many previously working in different professions and some working split-roles, resulting in extensive knowledge and experience from the 13 participants.

Conclusion

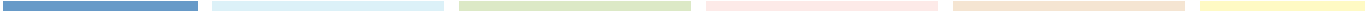
The perceived barriers identified in this research reflect what is known in the global literature, with stigma always at the forefront. Without a change in this perception, it will remain challenging to build services, even if all other barriers are removed. The perceived enabling factors identified in this study will contribute towards the overarching goal to be better at identifying and understanding how to implement IMH services. All healthcare professionals should have a basic understanding of IMH, through training and education. A public health initiative to normalise the term 'IMH', combat the stigma surrounding it, and increase awareness is imperative. Whilst services must focus on infants and their relationships, it is also important that parents and carers are supported.

Though this research is specific to one area, it is likely that these perceived barriers are not, and hence it is important to build an evidence base for these barriers, and enabling factors both in Scotland, and worldwide.

Historically, IMH service development has not been sustained; initiatives have come and gone. It is essential that this time, IMH services are developed and maintained, in Scotland and worldwide.

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Embedding infant mental health promotion practices within community-centred parent-infant interaction activities

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Abstract

The Australian Government's policies and action plans referencing infant mental health have coincided with calls from infant mental health professionals seeking greater support within the infant mental health sector. Broadly, infant mental health refers to an individual's ability to respond physically and emotionally to their surrounding environment, encompassing regulative behaviours and social and cognitive abilities. This paper considers the impact of optimising parent-infant relationships on the applicability of public health science when implemented within a community-based setting by exploring a proof-of-concept, innovative practice model in promoting infant mental health. This novel infant mental health promotion program was delivered as a weekly intervention over ten weeks. It was conceptualised using public health science to promote infant and maternal mental health. The program sought to capitalise on existing infant-parent interaction activities embedded within community activities, which for this case study included a baby learn to swim class.

Introduction

Increasing recognition of the influential role of the parent-infant relationship, and infant mental health needs more broadly, represents a landmark for opportunities to advance infant mental health promotion (NMHC, 2019; 2021; NSCDC, 2020; Priddis et al., 2018; Schore, 2001; UK Gov, 2018). The parent-infant relationship has long been recognised as fundamental to enhancing infant mental health



(Fraiberg, 1980). Everyday parent-infant interactions support the development of the attachment relationship, forming foundations for lifelong mental health (NSCDC, 2020; Schore, 2001; Zeanah, 2019). Following recommendations from recent Australian frameworks such as the 'National Children's Mental Health and Wellbeing Strategy' and the 'Brighter Beginnings: First 2000 Days of Life' strategy, it is important to explore how infant and maternal mental health can be supported within the community.

This paper describes an innovative practice model for promoting infant mental health and optimising parent-infant relationships in the first year of life. The case study explores the applicability of public health science at a foundational level when informed by community-health and community-centred frameworks. This proof-of-concept study was designed to examine the feasibility and acceptability of a psychoeducational program implemented in conjunction with a parent-baby swim class.

Background

The early emotional interactions between infants and their primary caregivers, and the attachment relationship they form, shape infants' neurological and psychosocial development in ways that influence

their developing capacity for stress adaptation and resilience (Newman et al., 2016). A comprehensive body of evidence indicates that disruptions in these early caregiving relationships are associated with reduced positive short and long-term outcomes for the infant (Stolper et al, 2021; Newman et al., 2016; Stein et al., 2014).

The inaugural Australian National Children's Mental Health Strategy (NMHC, 2021), launched in September 2021, is focused on promoting the mental health and wellbeing of children beginning in the perinatal period, and supporting all children in their communities to thrive. The strategy's brief is to establish an Australian context that supports the shared role of families, communities, services, and educators in nurturing, promoting, and supporting child mental health. This landmark strategy represents an attempt to actively promote child mental health and wellbeing using child-centred, universal, and targeted approaches, situated within a climate of burgeoning and multidisciplinary interest in early life relationships, parent-infant interactions, and experiences for positive developmental trajectories.

The strategy articulates the importance of promoting quality early life relationships to optimise developmental trajectories using the

relational framework approach of infant mental health and the 'science of experience' (NMHC, 2021; Zeanah & Zeanah, 2019). A relational framework acknowledges that parent-infant interactions provide the context for infants' growth and development and the foundations for developing a secure infant attachment relationship (Newman et al., 2016; NSCDC, 2020).

Much of the multidisciplinary work of infant mental health has taken place within a healthcare services framework. Ten years ago, results of the first comprehensive, nationwide longitudinal study of Australian children's mental health prompted calls for a public health perspective beginning in infancy. Simultaneously, in the public health space, Nelson and Mann (2011) and Miles et al. (2010) outlined the importance and benefits for social and emotional wellbeing, of enhancing early relationships.

The application of public health science within the field of infant mental health can grow the availability and accessibility of infant mental health promoting initiatives and settings. Providing communities with opportunities and support for promoting infant social-emotional wellness can create conditions favourable for optimising infant mental health (NMHC, 2021, Miles et al., 2010, Nelson & Mann, 2011). Nelson and Mann (2011) endorsed this concept by supporting approaches that capitalise on the daily responsive interactions between children and their primary caregivers. Communities centred around daily interactions between an infant and their caregiver represent an ideal location for building, embedding, and promoting infant mental health. Furthermore, as recently as 2020, the Executive Director of the National Mental Health Commission acknowledged the role of communities in the experience of mental health and wellbeing and the importance of the system responding at this level.

Despite the continued growth in support for this model of care, practical implications require embedding practices within the communities where infants and their families live. Community-based parent-infant activities provide a valuable platform offering parents and caregivers education and support in the importance of providing nurturing, responsive environments, fostering relationships, and promoting mental

wellness (Nelson & Mann, 2011; NRCIM, 2000; Zeanah et al., 2005; NMHC, 2021; NSW Gov., 2019).

The 'National Children's Mental Health and Wellbeing Strategy' (NMHC, 2021) first focus area is Family and Community. This area emphasises community-based approaches as fundamental in empowering families to promote the mental health and wellbeing of their children through everyday parenting. Similarly, the NSW Government's 'Brighter Beginnings: First 2000 Days of Life' strategic framework (NSW Gov., 2019) focusses on supporting all children in NSW to have the best start in life through building a better understanding of the lifelong importance of the first 2000 days of a child's life, connecting services and supports and providing easy access to timely information and services. These overarching strategy commitments highlight the importance of community-based activities.

Both the community-health and community-centred promotional and preventative models incorporate public-health science through the involvement of supports outside of the healthcare system to deliver information and services in trusted environments without the involvement of medical or pharmaceutical therapy (Heath, 2020; UK Gov., 2018). This delivery model engages skilled community members, local groups, networks, and physical, environmental, and economic resources to promote, encourage and influence health-related behaviours (UK Gov., 2018). A review of this model of support has revealed robust, meaningful results at the population level when delivered within the context of public health education, social marketing, health promotion and policy change in recognition of the multiple determinants of health (IOM, 2012).

A case study of a community-embedded infant mental health initiative

In Australia, parent-baby swim classes are often well-known and attended activities within communities involving both parents and their babies. Parent-baby swim classes have traditionally aimed to provide babies with water familiarisation opportunities, to build baby's comfort, interest and confidence in the water and develop simple water safety skills. It is not uncommon for some babies to experience difficulties with settling in the 'class' and well-

intended, uninformed, and unhelpful socio-cultural explanations and tactics may be applied to an unsettled infant in swim class. Socio-cultural expectations may contribute to a parents' felt experience of 'inadequacy' or 'judgement' from peers when their baby is not settled in the class and there are low levels of awareness/confidence of the skills and abilities for settling a baby in a social environment. Swim teachers of babies do not currently receive training in parent-infant mental health, although they are working directly with parent-infant dyads.

The program 'Mums and Bubs Get Wet for Wellbeing' was conceptualised from these observations and from an understanding that infants' everyday experiences, moment to moment, in their world are continuously contributing to their meaning-making about themselves in relation to their world (Tronick & Beeghly, 2011), in turn, shaping their ongoing engagement with the world. The infant-parent dyad represents a mutually regulated system of communication continuously operating to provide scaffolding of the infants' engagement with the world around them (Tronick & Beeghly, 2011). The potential for these weekly 30 minutes sessions to be truly dyadic in nature and capitalise on the availability of skin-to-skin contact in a warm soothing body of water, face to face interaction, as well as play and exploration, was realised; Mums and Bubs Get Wet for Wellbeing was 'born'.

The aims of the program were to support and improve, 1) maternal psychosocial wellbeing, 2) sensitive and responsive parenting skills, 3) mother-infant connection and bonding, and 4) infant social-emotional development experiences. The proof-of-concept design with a focus on feasibility and acceptability would allow our intervention to serve as a new model for developing community-embedded mental health initiatives reflecting an infant mental health promotion initiative addressing the action areas of the Ottawa Charter for Health Promotion (WHO, 1986). For example, by creating supportive environments, strengthening community action, developing personal skills, reorienting health services, and aligning with overarching current healthy public policies.

Method

Setting

The pool where (Mums and Bubs Get Wet for Wellbeing) the program was implemented is a recognised community gathering place (pool and centre) for individuals and families of all ages and backgrounds. The program was implemented in the Lake Macquarie region of New South Wales, Australia, with around 200,000 people, including >32,000 families with children. The pool centre has an established community swim school, located within Toronto's 'First Splashes' swim centre, offering Learn to Swim programmes and Aquatics Survival Skills to ~12,000 parent-baby dyads annually. All swimming instructors are AUSTSWIM accredited, the Australian industry standard for Swimming and Water Safety Teachers™.

The strong and positive presence of the pool and centre within this community of Aboriginal (4.45%) and non-Aboriginal and peoples and people born overseas (3.34%) (LMCC, 2022) provided an ideal setting to deliver a family and community mental health and wellbeing initiative, as emphasised in the National Children's Mental Health and Wellbeing Strategy (NMHC, 2021). Parent-infant swim classes are well attended (~12,000 parent-baby dyads annually) in this highly regard family-friendly community setting. This initiative, capitalised on this established parent-infant activity in the community to embed an infant mental health promotion initiative that aligns with current healthy public policy including addressing programme/services accessibility; a known common barrier to treatment and social determinants of health (Pearn et al., 2020, NMHC, 2021).

The embedding of infant mental health promotion initiatives within existing community-based parent-infant activities represents an incredible potential for wide-reaching accessibility/availability of infant mental health promotion action. One such community-based activity is parent-infant swim classes, with an estimated 4.2 million Australian children participating in swimming lessons each year. Incorporating a focus on both the child and the parent is a key component in the 'National Children's Mental Health and Wellbeing Strategy's' (2021) objectives of supporting families, increasing mental health literacy through community-driven approaches.

Recruitment

Over four months, recruitment invitations were shared via local mental health services (private, public, NGO), GP surgeries, mothers' groups, and the Toronto Swim Centre. Inclusion criteria were mothers and babies (aged between 4-12 months) from the Lake Macquarie region of New South Wales, Australia. The inclusion criteria were broad to increase accessibility as per a universal public health perspective.

Participants

Twenty-three mothers expressed interest in the program, with fourteen participants enrolling. The infant age range was 4 to 11 months; 11 babies were female, one baby was from a culturally and linguistically diverse background, and one was of Aboriginal and Torres Strait Islander background. Most had found out about the program from friends or their mothers' group or the swim centre. One participant withdrew after week one. Thirteen participants completed the program. Out of these 13 participants, 12 completed pre-program questionnaires, but only eight completed post-program questionnaires. All 13 participants indicated a willingness to be interviewed when providing consent, with eight participants completing interviews at the conclusion of the program.

Program

The community-embedded program 'Mums and Bubs Get Wet for Wellbeing,' designed by the authors DC, RE, LC, and VM, targeted 1) maternal psychosocial wellbeing, 2) sensitive and responsive parenting skills, 3) mother-infant connection and bonding and 4) supported infant social-emotional development experiences in each phase of the study through psychoeducation sessions, attachment-focused swimming classes and peer support seen within a three-phase approach.

Phase one

Nine AUSTSWIM instructors completed two days of training based on attachment theory, perinatal mental health, and infant development to enhance knowledge of healthy mother-infant interactions during swimming sessions. Teachers were taught to coach and support mothers to notice, observe, and attune to their baby's needs.

Phase two

The mother-baby dyads participated in ten weekly 30-minute swimming lessons facilitated by a program-trained swimming instructor. Two groups including seven dyads, were offered. The program was delivered free of charge with classes focusing on mother-baby interactions (including activities encouraging face-to-face, skin-to-skin, and touch) and uninterrupted time for babies to experience mutual play, communication, and reciprocity. An accredited mental health social worker (VM) joined the teachers in the pool and supported the swim session by observing the dyads and reflecting on infant behaviours to lead mothers in exploring, interpreting, and appropriately responding to behaviours displayed by their children. The support worker used questions such as "Do you think they enjoyed that?" "Why/why not?"; "How do you know?" to highlight non-verbal communication used by the infants to encourage deeper interaction and subsequent bonding.

Phase three

Mothers and their babies were invited to attend a tea and coffee catch-up education session following each water-based session. Sessions ran for ~45 minutes and were facilitated by a mental health social worker (VM). The session began with a semi-formal, 20-minute presentation on maternal mental health and wellbeing topics, including postnatal depression (see Table 1). Subsequently, participants were encouraged to engage in unstructured social discussions with the other mothers.

Program evaluation

To undertake the proof-of-concept evaluation, a three-step mixed methods design was used. The evaluation process was approved by the Human Ethics Committee at the University of Newcastle (H-2021-0136).

- 1) Feasibility was assessed by collecting data on recruitment and retention rates (number of participants who accessed and completed the program), adherence rates, recruitment (time required to recruit), the feasibility of testing procedures, and data collection methods including completion rates.
- 2) Following informed consenting procedures, mothers were asked to

Table 1. Topics for Mums and Bubs Tea & coffee catch-up.

Week	Content
1	Broad information about brain development in the first three years of life and the importance of relationship in this process.
2	Learning how to interpret baby cues – slow down the pace - watch what babies are telling us with their bodies.
3	Introduced the concepts of self-care and self-compassion. Resources about perinatal mental health including self-care and adjustment as a new parent.
4	Use St Luke's 'Baby Strengths' as a tool to reframe children's behaviour. Discussed the roles of caring being more than just physical cares and babies have varied needs.
5	Motherhood Myths - pressures of expectations - own, others, social and cultural. Discussion around guilt and birth trauma.
6	Adjustment to partner relationships in post-natal period and paternal mental health. Mental health resources for fathers.
7	Quote to prompt discussion about being 'present' with the child. "There are moments as a parent where I might not know exactly, the "right" thing to do or say ... but I know the answer is always to show up. When I/m present, and when I show up in that moment, emotionally attuning to what's happening emotionally for my child, that is always the right thing to do." -Tina Payne Bryson PHD
8	Child Development including separation anxiety, importance of transitions, babies' needs for repetition for brain development.
9	1 thing you discovered about your baby in the last 9 weeks group? 1 thing you discovered about yourself in the last 9 weeks of mothering? 1 thing you would tell a new parent about coming to this group ?

complete a survey before and end of the program:

a) The pre-program survey contained questions related to participant demographics and parent experiences of psychological distress; and

b) At the end of the program, the participants completed a measure of psychological distress and an evaluation form. The 21-item Depression Anxiety Stress Scale (DASS-21; Lovibond & Lovibond, 1995) included a standardised and well-validated tool to measure psychological distress.

3) After completing the program, consenting participants completed semi-structured individual interviews, consisting of open questions about the pre-planned research questions relating to feasibility and acceptability, including maternal psychosocial wellbeing, sensitive and responsive parenting skills, mother-infant

connection, and bonding, and supported infant social-emotional development experiences.

The questions were designed to elicit information leading to practical recommendations and evaluations of the program. Individual interviews were determined to be the most appropriate data collection method due to the richness of data available from first-hand accounts of participant experience (Poole et al., 2012).

The questions explored participants' expectations, experiences, satisfaction, and feedback, with follow-up questions and prompted for clarification and elaboration as appropriate. Interviews were completed by the author R.S via the teleconferencing tool, Zoom for Education. The video function was optional. Interviews were password-protected to ensure security. Verbatim interview transcripts were obtained,

with a preliminary transcript provided by Zoom software and manual audio file cross-referencing. The average duration of each interview was 15 minutes.

Data Analyses

Primary feasibility data, including recruitment, retention rates, adherence rates, and survey data, were analysed using the statistical software JASP (version 0.14.1) with simple frequencies and descriptive analysis exploring the pre-and post-test survey data.

Transcripts were imported into NVivo (version 12) for coding and thematic analysis by RS to explore acceptability. Thematic analysis was chosen as it is a transparent and systematic approach to identifying shared themes. The analysis was conducted within a realist/essentialist paradigm (Boyatzis, 1998). It included identifying, analysing, and reporting patterns identified within interviews, where patterns indicated

reoccurring concepts as potential themes (Braun & Clarke, 2006). Inductive and deductive thematic analysis was used (Guest et al., 2012).

Familiarity with the scripts was attained by the repeated active reading of each transcript, revealing preliminary themes. An iterative process of refining the themes was carried out by reviewing the data set, ensuring internal and external representativeness (Braun & Clarke, 2006). A re-reading of the scripts was carried out to ensure the validity of the data by establishing that the themes accurately represented the data set. The process and themes were reviewed and agreed upon by the other authors. Evidentiary quotes taken from participant interviews support the themes. Deidentified quotes are presented verbatim.

Results

Survey results

Eight of the 12 participants who completed the pre-program questionnaires scored in the 'normal' range on each DASS-21 subscale in the pre-program questionnaires. Three women scored in the mild-moderate range for depression and anxiety, and three scored in the mild-severe range for stress. Of the eight participants who completed the post-program DASS-21, 5 had 'normal' scores across the subscales. Two women scored in the mild-moderate range for depression, and three scored in the mild-moderate range for stress.

Interview results

All 13 participants indicated a willingness to be interviewed when providing consent, with eight participants completing interviews at the conclusion of the program.

The views and experiences of the participants are collated in Table 2, with the thematic findings presented under a series of headings with illustrative quotes. Briefly, the themes included Attachment, Engagement, Educators, Learning and Relationships. All the participants reported positive experiences with opportunities to bond with their children through supportive playful activities, although a few women indicated that it was at times a bit anxiety-provoking to be observed. All women found the information provided was useful and relevant and all women enjoyed the opportunity to share

experiences and connect with other new mothers. A few women suggested that it is important to consider the timing and structure of the classes to reduce barriers to participation e.g., considering nap times and it was also proposed by a few women to make similar training available to caregivers regardless of gender.

Discussion

The current paper describes an innovative community-embedded infant mental health promotion practice model as a case study for a public health promotion initiative that meets the Ottawa Charter's (WHO, 1986) action areas of strengthening community action, developing personal skills, creating supportive environments, reorienting health services within a context of new healthy public policy (NMHC, 2021) for infant mental health. This infant mental health promotion initiative presents an example of policy translation in a context-specific way (Foley, 2021).

The initiative operationalises both the 'National Children's Mental Health and Wellbeing Strategy's' (NMHC, 2021) Family and Community focus area objectives (supporting families, increasing mental health literacy and community drive approaches) and the NSW Government's 'Brighter Beginnings: First 2000 Days of Life (best start in life by providing parents access to universal and targeted information) within an existing, highly regarded community-based parent-infant interaction activity.

The program was designed to be an experiential infant mental health promotion initiative, conceptualised using public health science to promote infant and maternal mental health. The program's centrality on the relational framework approach (Priddis et al., 2018; Zeanah, 2019) engages the infant-parent interactions taking place within existing community activities, in this model, baby learn to swim classes. The evaluation provided proof-of-concept for this type of program with data supporting reasonable recruitment and retention throughout the program, high acceptability from the participating mothers but with some problems collating survey-based information (only 8 out of 13 completing the post-program survey).

Embedding psychoeducational programs in local settings and services

that parents are naturally inclined to seek out presents an opportunity to provide universal access to mental health promotion. The NSW Government's 'Brighter Beginnings: First 2000 days of Life', aims to give children the best start in life through providing parents and families with universal and targeted access to the right information and at the right time (NSW Gov., 2019). The National Children's Mental Health Strategy (NMHC, 2021) establishes at a national policy level the importance of supporting families beginning in the perinatal period, identifying parents who may be struggling, promoting parenting at key developmental stages to support child development, increasing mental health literacy, and reducing stigma through whole communities, developing strong and supportive relationships within and outside children's homes.

Mums and Bubs Get Wet for Wellbeing delivers on the Strategy's (NMHC, 2021) priority action areas of:

- a) Routine offering of evidence-based parenting 'programs' at key developmental milestones, emotional wellbeing modules embedded in parenting courses;
- b) Widely accessible evidence-based resources building on existing initiatives; and
- c) Campaigning to promote the value of parenting.

A broad range of recruitment methods made it possible to recruit mothers to the groups, and the retention, and engagement, of participants in the program, were excellent with only one participant discontinuing the program (although not all chose to complete the surveys or participate in the interviews). The interviews revealed that while sickness or other unavoidable commitments inevitably affect attendance, it is also important to consider what time of the day the program is delivered, with nap times and commitments for other children being considered for participation.

The program design received positive feedback. The mothers mentioned how the playfulness of the program helped in their bonding experience with their children. Mothers indicated that being 'compared' to other mothers or 'judged' by professionals can be a worry. This highlights the need for swim teachers and facilitators to be mindful of such thoughts and provide skills to communicate effectively and

Table 2. Themes for Qualitative Thematic Analysis to Evaluate Participant Views and Experience.

Theme	Findings	Example Quote
Attachment	<ul style="list-style-type: none"> The mothers reported enjoying the water activities and valued the opportunity to bond with their children. While all mothers reported enjoying the swimming component, some expressed anxiety about being in the water and being watched as they were worried about being judged (e.g., 'Am I doing it right' or 'Am I connecting with my baby'). 	<p>"...having a really nice, you know swimming session with a really nice opportunity to bond ... I really enjoyed the bonding experience" [Amelia]</p> <p>"I think doing it with [my child] was really good because it sort of helps build that bond" [Sarah].</p>
Engagement	<ul style="list-style-type: none"> Of the eight participants, four reported participating in a swimming program before, and when comparing those with the current program they found it more playful and engaging. This information suggests the 'playful' nature of the program made it an enjoyable and more desirable experience. Attendance review revealed no participant attended all ten sessions; however, reasons were unavoidable commitments such as sickness, suggesting the program was accessible. The time of day for the program was a factor to consider for the mothers with allowances for nap times being highly valued. 	<p>"We did a lot more of like the sing-song sort than what I remembered swimming lessons being, which was really nice it was like a nice time, whereas the one at [previous swimming centre] was very, very repetitive ... and like there's no sing songs, no toys, or floats ...</p> <p>"... I found [the program] better in it was more like playful, there was obviously some singing, and there was some equipment used and that was very different to the other one I've done" [Lisa].</p>
Educators	<ul style="list-style-type: none"> The participants commented on the abilities and skills of the swimming teachers and the benefits of the attachment focus. It was also reported that the support of the social worker contributed to the bonding experiences felt by the participants. 	<p>"The swimming teachers had obviously been told a bit about the program, and I think that they were very considerate of what the mums were going through" [Sarah]</p> <p>"... they were encouraging you to really look at what your baby was doing and respond to them" [Rachel].</p> <p>"I can remember [the facilitator] saying early on, like encouraging us, to just like observe our babies and how they were, how they were interacting with the water on that day, and I found it such a mindful experience" [Sarah]</p> <p>"... it was run really well and that [the social worker] was there with us the whole time and sort of floated around, and you sort of felt secure, knowing that they were always there as well."</p>
Learning	<ul style="list-style-type: none"> The mothers who attended the tea and coffee catch-up education session reported them to include useful information and to be helpful. Topics on sleep and secure attachment, mental health, developmental milestones, and guilt were particularly mentioned but participants also enjoyed sharing resources such as relevant podcasts and Instagram accounts. Participants also noted ample opportunity to raise discussion topics during group time and in private, to be addressed as a group the following week. Importantly, mothers found the informal discussions with other mothers equally, if not more, beneficial. 	<p>"I did learn some new things, it was helpful, I think when we got like handouts, and I found it really interesting when we talked about some of the statistics" [Rachel].</p> <p>"Um, I think I sort of learned a lot more things through discussions with the other mums" [Emily].</p> <p>"... I think the best part was when you could hear from the other parents and share those experiences" [Sarah].</p>
Relationships	<ul style="list-style-type: none"> Social connectedness and building new relationships are important for new mothers, with many mothers – particularly early during the COVID-19 pandemic - experiencing a sense of isolation. The interviews revealed that the program provided social opportunities and connections through shared experiences. However, the desire to seek new relationships or social connections during the program were less for those who had pre-existing relationships, instead, there was a preference to deepen those existing relationship, at times linked to poor self-confidence, although upon reflection some mothers felt regret for not trying harder to form new relationships. Interestingly, most mothers admitted to not staying in contact after the program unless they had known each other prior, and they suggested that access to a group chat might help the participants form long-lasting relationships. Constructive ideas were provided to meet their needs as new mothers. A more structured schedule and more formality during information sessions was a common recommendation. The creation of an organised network where the mothers could stay connected with each other and services was also suggested. Importantly, the mothers also highlighted the need to include, and engage, fathers in similar activities with an emphasis both on partners who share in co-parenting and for fathers who are primary carers. 	<p>"I love that we could all get together afterward. I think there are a lot of baby programs, but it goes so quick, and 20 minutes and you're in, and you're out. ... It'd be great if every swim class had that opportunity where we can just talk, that was the best bit." [Olivia]</p> <p>"I connected with other mums that ... [they are] not doing amazing either, and it just it made me feel a lot less alone" [Sarah]</p> <p>"... it was just so nice to have the time to just sit there and talk to other parents" [Rachel]."</p> <p>"I was probably more drawn to them [mothers from her mother's group,] and I chatted with them, so I guess, I mean probably didn't go out of my way to probably chat too much to any of the other participants, which is a bit of a shame" [Lisa]</p> <p>"There are definitely some of the mums in there, that in real life, I probably would hang out with but I'm not a very confident person, so I wouldn't say to them, oh hey you know what's your number" [Emily].</p> <p>"... one thing that I think would have helped would have been to maybe set up a group chat with the people in the group because we didn't keep in contact with everybody, and it would have been an easy way to share things [Rachel].</p> <p>"Yeah, I think talking about partners, there's very little support. My husband didn't have any support ... I think there's a huge hole in the market for the non-birthing partners" and</p> <p>"As a primary carer, we all have the same kind of challenges. ... he's a stay-at-home dad, and we got talking and everything we said we could relate to each other; it wasn't about gender, it's about being the main person." [Olivia].</p>

empathically through normalising validating the mother's experience.

While the structure of the sessions was generally positively reviewed, there was a desire to make the social get-togethers more organised with a specific end-time to make daily planning easier. It was also clear that mothers were seeking support, not only for themselves but for their partners, and this is an important consideration in future projects.

As with many other evaluation processes, it was difficult to obtain surveys and feedback (both via survey and interviews) from all participants to ensure the sample's representativeness. While the excellent retention and engagement, with only one participant discontinuing, support the feasibility and acceptability of the program, to evaluate the effectiveness of infant and parental mental health, this hurdle needs careful planning to scale this proof-of-concept study up.

Community embedded initiatives present an opportunity to prevent stigma arising from selection into programs based on need or risk and support families not identified in targeted and selective mental health services. This provides an avenue for further exploration on how to implement such approaches not only in learning to swim classes but in other community embedded activities that parents in the perinatal period participate in such as, e.g., play and library groups. This would facilitate universal availability in line with recommendations on the positioning and effectiveness of promotion and prevention approaches in infant mental health (McLuckie, 2019; NHMRC, 2017).

Universally available programs of prevention and promotion approaches for maternal and infant mental health are uniquely placed to optimise healthy perinatal periods for infants, their parents, and caregivers, supporting what is needed to set up and advance the healthy development of the future generations of children and adults.

Clinical Implications

This type of program can fill identified gaps within the perinatal mental health field, which is overwhelmingly costly when not addressed, currently considerably under-resourced, yet highlighted in the policy and funding space (NRCIM, 2000). A focus on universally available group approaches

incorporating community-health and community centred promotion and prevention approaches can strengthen maternal and infant mental health care, facilitating a widening availability of practices, activities, information, and resources into communities and providing increased options for mothers, their infants, and families, during the perinatal period.

This opportunity presents fortuitously within the presently aligned Australian (National Children's Mental Health and Wellbeing Strategy, NMHC, 2021) and NSW (NSW Government's Brighter Beginnings First 2000 days, NSW Gov, 2019) policy climate, focusing on increasing acceptability and accessibility of the beneficial opportunities and experiences for mothers, infants, and their families, during the critical period when foundations for future mental health are being constructed.

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Social Inequality and Infant Wellbeing in one area of Scotland

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Policy Context

Programmes for Government in Scotland have consistently prioritised the lives of children, and in recent years have specifically focussed on the needs of babies and young children. The Perinatal and Infant Mental Health Programme Board (PIMH-PB) was set up in 2019 by the Scottish Government (SG), and its tasks include:

Creating a Scotland wide multiagency model of infant mental health provision to meet the needs of families experiencing significant adversity, including infant developmental difficulties, parental mental illness, parental substance misuse, domestic abuse and trauma. (SG, 2019a)

The mental health needs of infants from conception to three years of age are informing the development of systems that will support families where parents may not have access to formal mental health services. These systems include both statutory (health and local authority) and third sector services, and infants, parents and carers in service design and delivery. Third sector services offer a range of support, from volunteers offering practical support to families, peer support and befriending, through to specialist infant-parent work. McFadyen (2021) gives a detailed account of this work.

Public policy in Scotland is grounded in an understanding of the impact of inequality and disadvantage on early



child development, and this informs both systems and practice in universal services. Maternity and health visiting pathways have been designed to support children and families through prevention, early identification, and intervention. Getting it Right for Every Child (GIRFEC) (SG, 2019b) provides a systemic approach to support parents, carers, statutory and voluntary agencies to work together to ensure the best outcome for every child. Routine inquiry enables maternity and health visiting services to gather sensitive data about the family circumstances of each infant and record the progress of each child's development.

This Scottish framework for working together with the child at the centre is complemented by The Promise Scotland (2020) which aims "to ensure that every child grows up loved, safe and respected, able to realise their full potential". The voice of the child (infant) is one of the 5 pillars of The Promise, and a key component of the UNCRC (Incorporation) (Scotland) Bill that was passed by the Scottish Parliament in 2021. The Fairer Scotland Duty (SG, 2018) places a legal responsibility on named public bodies to actively consider how they can reduce inequalities of outcome caused by socio-economic disadvantage.

The Social Determinants of Health

The relationship between health and poverty is bidirectional. Investing in early childhood development can boost shared prosperity, promote inclusive economic growth, expand equitable opportunity, and end extreme poverty (WHO, 2018). Children who experience poverty and other structural inequalities are more likely to experience adversities in their lives (Treanor, 2020; Shonkoff et al., 2021). Poverty and inequality can create conditions that undermine healthy pregnancy, healthy early relationships, effective support for caregivers, and a safe and stimulating early environment. Adversity in childhood is highly correlated with socioeconomic disadvantage in the first year of life (Marryat & Frank, 2019).

A study using Growing Up in Scotland (GUS) data, found that 11% of children in the lowest income quintile at birth had experienced 4+ adverse experiences by the age of 8, compared to 3% of children overall. At ages 3 and 5 years, there was a strong relationship between socio-economic inequality and gaps in children's cognitive, emotional, and social development. Children whose mothers were emotionally well during their first four years had better social, emotional, and behavioural development than those whose

mothers had brief or repeated mental health problems.

Marryat and Frank's study focused on socio-demographic risks; they suggested that future research "may wish to explore the explanatory power of factors such as attachment, neurodevelopmental disorders, parenting and parental ACEs". Tomlinson (2015) calls for research into "upstream" influences (such as socioeconomic status, discrimination, and political inequality) on infant mental health in order to "build the foundations for sustainable, equitable, and prosperous societies."

Most recently, poorer infants and families have been disproportionately adversely affected by the Covid-19 pandemic and associated restrictions (Marmot et al., 2020; Best Beginnings, 2020). *Babies in Lockdown* (Best Beginnings, 2020) reported that 68% of parents felt their ability to cope with their pregnancy or baby had been affected by the pandemic, and a third believed that their baby's interaction with them had changed.

Many families with lower incomes, from Black, Asian and minority ethnic communities and young parents have been hit harder by the COVID-19 pandemic. This is likely to have widened the already deep inequalities in the early experiences and life chances of children across the UK. (Best Beginnings, 2020: 9)

Research Study

Public Health Scotland has worked with the PIMH-PB to evaluate their programme of work and support the analysis of existing data held in the Child Health Surveillance Programme (CHSP), Family Nurse Partnership (FNP) records and maternity and mental health records (SG, 2021).

In keeping with this approach, Galloway et al. (2021) assessed the level of need for a designated infant mental health service in one Scottish Health Board area, population 655,000, comprising both urban and rural areas. Administrative data was explored at health board, local authority, and locality level about infant and parental vulnerabilities associated with the service criteria, which were to provide

a service for infants (conception - 36 months) with:

- complex and significant needs in relation to parental mental health such as perinatal mental illness, substance or alcohol misuse, significant parental historical trauma, domestic abuse
- significant infant mental health disorder and development difficulty in infancy.

To assist with identifying local population needs, the report presented data collected by services but generally not publicly available especially at a detailed level, for example, data collected through routine inquiry undertaken within universal maternity and health visiting pathways and through child protection processes. It also included referrals, admissions and outcome data routinely collected by specialist perinatal services.

It was recognised that these figures may have understated the size of this population. Skovgard (2010) found the prevalence of *serious* mental health disorders in 18-month-old infants in the general population to be 16% in a large cohort longitudinal general population Danish epidemiological study. Predictors of these serious mental health disorders in 18-month-olds were identifiable at 10 months through a Health Visitor general population screening programme.

This Paper

Where the available data permits, this paper presents the results of an analysis of risks and concerns, and use of services, as these relate to the socioeconomic circumstances of families.

Methodology

The data collection framework was based on the four key requirements (domains) for a healthy and safe start in life: a healthy pregnancy, healthy early relationships, effective care and support for caregivers, and a safe and stimulating environment which are described in Table 1 (Galloway et al., 2014). The need for an Infant Mental Health service might also be indicated by signs of concern in these areas or concerns about child protection or development. When these requirements are absent or compromised by family circumstances,

the potential for mental health and developmental difficulties is increased.

Data relating to these four domains, where available, was sourced from statutory agencies and comprised administrative data routinely recorded and collated by universal and specialist services. In addition, statutory child protection data was sourced indicating infants' experience of harm. In terms of limitations, little or no data is available in relation to the quality of care for caregivers and the home and family environment. Another main limitation is the lack of insight into complexity; individual infants may be subject to multiple factors or counted multiple times in some datasets.

Disclosure to a professional is often difficult and self-report data may not be reliable. The picture presented by child protection figures is a partial one. Families where there were concerns about care giving below the threshold for statutory intervention, may not have been detected.

The Scottish Index of Multiple Deprivation (SIMD) (SG, 2020), an area-based measure of relative deprivation, was used. The most deprived SIMD income quintiles are where there are large numbers of people living at subsistence level. In this system, quintile 1 (Q1) refers to the area with highest income deprivation.

The health board comprises two local authorities, with 'area N' having significantly more deprivation than 'area S'. Analysis looked at findings in each area in relation to the requirements for a healthy and safe start, and SIMD categorisation. It was collected over 4 years; the data reported here is for the year 2018/19, for the calendar year 2019, or as a 3 to 4 year average.

Results

This section presents a broad overview of general population data followed by a report of key findings by domain.

Broad Numbers

Table 2 shows information about the size of the population of infants whose life circumstances may undermine what they need for a healthy start, and whose odds of experiencing significant mental health disorders and development difficulties during the first 36 months of life are elevated.

Table 1. Key requirements for a healthy and safe start.

<p>A healthy pregnancy</p>	<p>Mothers' mental and physical health in pregnancy are crucially important for babies' later wellbeing and development. Adequate nutrition and the absence of toxins plays an important role in ensuring the healthy development of a fetus, as does the psychological wellbeing of their mother. Poor maternal health during pregnancy is associated with low birth weight and premature birth, postnatal depression, and longer-term cognitive and emotional difficulties for the child.</p>
<p>Healthy early relationships</p>	<p>Babies need caregivers to provide sensitive, responsive and consistent care. They thrive when their caregivers have healthy relationships with one another. An infant's brain develops through interaction with others, and it is particularly influenced by their primary care givers. Caregivers may not be able to develop secure relationships with their baby for many reasons, including domestic abuse, poor mental health, their own history of poor relationships with caregivers, childhood abuse and neglect, or the baby's own developmental difficulties, which may be related to prematurity, congenital abnormality or maternal alcohol or substance misuse in pregnancy.</p>
<p>Effective care and support for care givers</p>	<p>Parents themselves need respectful care and support in addressing the problems they face so that they can have the emotional resources to care for their baby. This is especially the case for parents who are already facing additional stressors such as persistent poverty and destitution, housing insecurity and homelessness, and domestic abuse.</p>
<p>A safe and stimulating environment</p>	<p>Babies need to be in safe and stimulating environments that supports them to learn and explore. They need an environment which provides appropriate sensory, social and emotional stimulation, for example the space and encouragement to play and explore, to learn and to be creative.</p>

Key Findings

Domain 1: A Healthy Pregnancy

28% of all maternities were to mothers in SIMD Q1; this was higher in area N (32%) and lower, 22.5% in area S. In area N, almost one half (48%) of all maternities to young mothers under 20 years of age were in the most deprived income quintile.

Despite the overall decline in teenage pregnancies nationally, the gap between the most and least deprived

areas has grown. The rate in the most deprived quintile in area N was 14.1 compared to 5.8 per 1,000 in the least deprived quintile. In area S the rate was 11.3 compared to 3.1 per 1,000. Family nurses provide support to young mothers, and their data provides an indication of the level of need, but only in relation to mothers who meet service criteria, based on age, first-time motherhood, and vulnerability. There remains a question about how much unmet need for intensive support exists, including for those having second and

subsequent pregnancies. 46% of young mothers supported by Family Nurses belonged to SIMD Q1, and 77% of mothers and babies supported lived in the two most deprived areas.

3.1% of expectant mothers in SIMD Q1 reported substance misuse at ante-natal booking compared to 1.8% of all maternities. Reported alcohol use was highest in the least deprived area. There were an average of 90 child protection cases involving under 3's, in which parental alcohol/substance misuse was involved.

On average 36% of women annually disclosed mental health issues during their booking-in appointment. Maternity data was cross-checked with data about acute psychiatric inpatient admissions in the 10 years before the date of delivery. Most of those identified lived in area N.

Referrals to the specialist perinatal mental health service varied across localities with a high rate of accepted referrals in the area of least deprivation, and low rates in the most deprived localities.

A higher percentage of newborns receive neonatal care compared with other health boards (15.4% compared with 11.1% in Scotland overall). In most localities the percentage is significantly higher for those in SIMD Q1, compared to the area as a whole, with around 40% of all babies from 3 deprived localities in area N being admitted.

Domain 2: Healthy Early Relationships

On average 4-5% of women reported domestic abuse at their antenatal booking, with a higher percentage reported in area N (5-7%). The presence of children under 3 years of age at domestic abuse incidents is reported by police to social work services. There were 879 referrals in 2019/20, with the number of incidents in area N being almost twice that in area S.

Domain 3: Effective care and support for caregivers

Data was not available to support the exploration of this domain.

Domain 4: A Safe and Stimulating Environment

A health needs assessment of children experiencing homelessness in area N was conducted by Campbell (2019). It found that a significantly higher proportion of children aged 0-5 years

Table 2. Broad Numbers (Infant and Family Population Statistics).

Indicator	Count
Number of maternities (2018/19)	6,380
BIRTH CIRCUMSTANCES/SOCIODEMOGRAPHIC FACTORS	
Maternities in the lowest income quintile 2018/19	1,813
Of whom	
First-time mothers aged 19 or under	103
Young mothers receiving intensive support from Family Nurses (2019/20)	175
Of whom	
Number in the most deprived SIMD quintile	81
Pre-birth child protection referrals (3-year average)	191
Newborns requiring special care after birth (2018/19)	991
Number of women reporting domestic abuse at antenatal booking appointment (2018/19)	267
Number of women reporting domestic abuse at antenatal booking appointment (2018/19)	267
Number of women reporting substance misuse at antenatal booking appointment (4-year median)	90
Number of women reporting alcohol use at antenatal booking appointment (2018/19)	593
Number of women referred to Additional Midwifery Service (2019 calendar year)	445
Alcohol-related	189
Drug-related	256
Expectant mothers disclosing mental health issues at booking in appointment (2019 calendar year)	2,453
Expectant or new mothers referred to the community perinatal mental health service (2019 calendar year)	526
Referrals accepted by the community perinatal mental health service (2019 calendar year)	280
Health board admissions to the regional Mother and Baby Unit (2019 calendar year)	12
HOME ENVIRONMENT & DEVELOPMENTAL CONCERNS	
Domestic abuse-related referrals to social work by police concerning children under 3 years (2019/20)	879
Infants at 6-8 week child health review needing additional input (2018/19)	1,087
Infants at 13-15 month child health review needing additional input (2018/19)	1,148
Infants at 27-30 month child health review needing additional input (2018/19)	1,236
Infants at 27-30 month review with a concern noted in the personal and social domain (2018/19)	403
Infants at 27-30 month review with a concern noted in the emotional and behavioural domain (2018/19)	411
Infants at 27-30 month review with a concern noted in the speech, language and communication domain (2018/19)	752
EXPERIENCE OF HARM	
Infants under 3 referred to the Children's Reporter on care and protection grounds (2018/19)	915
Infants under 3 years placed on the Child Protection Register (2018/19)	194
Average number per year of Child Protection cases of infants under 3 years involving:	
Parental alcohol misuse	60
Parental alcohol and/or substance misuse	90
Average number per year of infants under 3 years starting to be looked after	127
Of whom	
At home with parents	38
Foster care	50
Kinship care	43

are present in households presenting as homeless, compared to the general population of area N, and that under-fives represented 38.9% of all children in homeless households, but 29.9% of the child population.

At the 27-30 month health check conducted by health visitors, infants in homeless households had significantly higher rates of any concern. Attendance at A&E for young children (<5 years) in homeless households was 31.9% higher than for the wider cohort.

Signs of Concern

Health visitors provide each child with a developmental review at age 6-8 weeks, 13-15 months, and 27-30 months. Infants are allocated 'additional' status if significant concerns are identified requiring sustained additional input. In 2018/19 over 1,000 infants at each of the three key child health reviews needed additional input to meet their health or developmental potential. Across the three reviews, a total of 3,471 infants and their carers required additional input. Proportionately more were in SIMD Q1. However, the percentage of infants allocated additional status overall was higher in area S than area N, despite deprivation levels being greater in the latter.

Those living in the most deprived areas made greater use of unscheduled care than those in the least deprived areas. The rate of A&E attendances in SIMD Q1 in area N was 349.3 per 1,000 compared with 275.2 per 1,000 in the least deprived quintile. Out-of-hours medical attendances by children aged 0-3 years were also related to the level of deprivation.

An average of 191 infants each year were subject to pre-birth child protection referrals. Just under two-thirds of these (63%) were in area N.

Discussion

In this study, the analysis of routinely recorded data held at national and local level provided an insight into inequality and its effects on infant mental health outcomes. The data reflects the services from which it is drawn, many of which are woman- or infant-focussed. As a result, information about fathers and the wider family was not captured. Limited use was made of data linkage, to investigate the psychiatric history of new mothers and the health of young children in homeless households. This has untapped potential.

The study confirms that many parents have difficulties in their lives, and a significant number of infants have experiences that can compromise their wellbeing and development. The complex interplay between these factors merits further investigation. A clear social gradient runs through the data and provides evidence that the structural inequalities in society may predetermine unequal developmental outcomes for infants. The analysis helps highlight the relative risks of experiencing adversity, which are more likely to be experienced by infants living in socioeconomically deprived areas. However, concerns can arise unexpectedly after birth in all families if, for example, an infant is born prematurely or has significant developmental problems. Yet there are also strong social gradients for the occurrence of prematurity and neurodevelopmental problems.

The access to some services for parents in socioeconomically deprived areas appears to be challenging. This is best illustrated by the rate of referrals to perinatal mental health services which was higher in one of the least deprived areas than in more deprived localities. However, expectant mothers in the most deprived areas were more likely to have had an acute psychiatry inpatient admission in the previous 10 years, to be under 25, and to have a history of substance use.

There is a social gradient relating to substance misuse; these expectant mothers are concentrated in the most deprived SIMD quintiles. Consideration should be given to both prevention and referral to specialist services for all those affected.

Expectant mothers in the least deprived income quintiles were more likely to report alcohol consumption in pregnancy or the period immediately before conception. Alcohol is damaging to fetal development and public health initiatives to address this should be targeted at all women of child-bearing age, with interventions being available to all women.

Alcohol or substance use by expectant or new mothers may be associated with spouses' or partners' use. Enquiries by midwives, obstetricians, health visitors and others are likely to be limited to the expectant mother. A systems approach would support wider enquiry into the circumstances of those beyond the mother-infant dyad, especially as both

are associated with child protection referrals.

There is a clear relationship between SIMD category and admission to the neonatal unit. The rates for the total population were generally around 20% but elevated to 40% in 3 of the most deprived localities. It is concerning that so many newborns experienced a period of separation at a crucial time for the development of the mother-infant relationship.

17% of infants who received a child health review at 27-30 months had concerns identified, with a higher proportion being in the most deprived areas. A higher percentage in area S received 'enhanced care'. Social gradient trends were also evident for A&E and out-of-hours attendances by infants and, as with concerns about development, had a strong association with homelessness.

In practice, rates of intervention depend upon many different factors. These include the ethos and approach to delivering services, service criteria, and factors that may vary across localities such as awareness of the importance of infant mental health, the knowledge and skills within teams of practitioners, the capacity for outreach, and the quality and consistency of relationships locally. Does the presence of multiple difficulties, some of which will be difficult to mitigate, discourage midwives and health visitors from providing more intensive input or making specialist referrals? An obvious exception might be referral to Family Nurse Partnership. The characteristics of those seen by family nurses show that as well as being young, mothers often experience multiple and interrelated difficulties, with a majority residing in the most deprived areas. However, in relation to the provision of enhanced input or referral to specialist services there does appear to be evidence of an inverse care law that is worthy of further exploration.

A deeper understanding of the local factors which might ameliorate or enhance the risks to the mental health of children and their parents and carers has the potential to inform both prevention and specialist service provision. Investment in public health interventions in disadvantaged areas may help to mitigate some of the consequences of adversity while the provision of targeted specialist perinatal and infant mental health services

may alleviate distress and disorder, preventing later poor outcomes for infants.

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Policy, practice, and infant mental health - How well do we support parents living with a mental illness?

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Abstract

The perinatal period is the most vulnerable period in women's lives for relapse or the onset of mental illness. Increasing evidence demonstrates that men too experience significant vulnerabilities that may exacerbate existing mental illness or precipitate the onset of an illness in their transition to fatherhood.

The Victorian FaPMI Program (Families where a Parent has a Mental Illness) in Australia, supports the capacity of mental health services and other health and community services to provide family-focused care, that proactively supports parents with pre-existing and current mental illness, their infants and children, and other family members, alongside mental health recovery.

This paper reviews four key policy and review documents to consider the current context of Victorian (Australia) perinatal mental health policy, practice, and service planning. It explores how these policy documents provide for the particular challenges of those with pre-existing mental illness as they become parents and for their infants and families.

Introduction

Families, where a parent has a mental illness, are a statistically vulnerable group whose needs are not always well met by mental health, health, and community services. Their children are also more likely to experience adverse

outcomes in development, education, social and emotional well-being, and to experience mental health concerns of their own in infancy, childhood, adolescence, or adulthood (Rupert et al., 2013).

Research is producing a strong evidence base for a range of services and programs for parents and infants from conception to three years to support significant improvements to infant and family wellbeing and whole of life outcomes. It is here in the transition to parenthood and the first years of life, that parents with a pre-existing mental illness, with their infants and families, will benefit most significantly from universal and targeted support. Support that focuses on family wellbeing, parent-infant relationships, and mental health recovery, while reducing the likelihood of intergenerational transmission of adversity.

This paper considers four key documents that shape and influence Victorian perinatal mental health policy, practice, and service planning:

- FaPMI Standards of Practice for the adult mental health workforce (Goodyear et al., 2015)
- Inquiry into Perinatal services: final report (Family Community Development Committee, 2018)

- Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline (Austin et al., 2017)
- Royal Commission into Victoria's Mental Health System, Final Report (2021 a, b)

The documents are considered in how they speak to the identification of pre-existing mental illness, prevention, early intervention, mental health recovery, quality of family life, a strengths approach, and how they focus on parent-infant relationships.

Background - the family context and pre-existing mental illness

The transition through pregnancy to birth and parenthood is mediated by the cultural, social, emotional, and economic circumstances that families find themselves in and the hopes and aspirations they have for themselves as parents and their infants and children. Where a serious mental illness is also a feature, additional challenges are likely to be present.

Understanding the individual and family story around the onset and course of a mental illness, and how it may have influenced their developmental trajectory, including social competence, relationships, and capacity for resilience,

is the starting point for working with families. How people experience mental health treatment and recovery, develop an understanding of the mental illness, early warning signs, and management, all make a difference to the quality of family relationships, transition to parenting and mental health recovery. Social and emotional wellbeing and mental health recovery occur in and through relationships (Price-Robertson et al., 2017).

Mayberry et al. (2005) in a report for Victoria Health, identifies key risk factors associated with serious mental illness influencing outcomes for children as: the severity of the parental mental illness; conflict and disruption in family relationships including separation and divorce, family violence; and social isolation. These psychosocial circumstances and stressors around the transition to parenthood can also influence the mental health of parents. If these vulnerabilities are identified and considered in practice, it allows for all services to attend to them. In turn, it is more likely that appropriate interventions can be offered to parents, with their infants and children, to improve outcomes.

COVID-19 highlights the impact of social isolation and fewer connections on the wellbeing of all new parents and their infants. Parents living with a serious mental illness experience additional barriers to joining mainstream parent groups or playgroups. Where groups specific to the needs of parents with mental illness are available, the benefits are considerable (Northern Area Mental Health, Anglicare, 2013).

Services have different roles and tasks in the perinatal period and work best when there is clear communication, secondary consultation, knowledge of resources available, and referral pathways. The *Healthy babies for mothers with a serious mental illness: a case management framework*, developed in Western Australia, recommends the creation of a 'small known team' approach to the management of a pregnant client with a serious mental illness (Hauck et al., 2008). This enables a collaborative approach with the family and supports practitioners to share knowledge and expertise across all aspects of perinatal care in complex circumstances.

REVIEW – POLICY IN PRACTICE

The following section outlines four policy documents relevant to Mental Health Care in the Perinatal Period:

1. The FaPMI Practice Standards. These standards describe the capacity-building priorities and practices that are most likely to support good outcomes for consumer parents, their children and families (Goodyear et al., 2015).
2. The Australian Clinical Practice Guidelines (COPE) (Austin et al., 2017) address women with a pre-existing mental illness during the perinatal period and allows a clear view of the guidance provided to professionals for the care of this group, their partners, and infants.
3. The Victorian Perinatal Inquiry (Family Community Development Committee, 2018) examines a wide range of concerns and highlights gaps and practitioner concerns around supporting perinatal and infant mental health.

The Royal Commission into Victoria's Mental Health System (2021a, b). This report makes extensive recommendations to improve mental health service provision and this includes for pre-existing mental illness, perinatal, and infant mental health.

FaPMI Practice Standards

The Victorian Families where a Parent has a Mental Illness (FaPMI) program's central purpose is to build capacity in State run adult mental health services to proactively support parents with pre-existing and current mental illness, with their infants and children and other family members. The program has four strategic priorities:

- a) To collect and improve data to inform program priorities,
- b) To enhance the clinical practice of the mental health workforce,
- c) To strengthen partnerships with services relevant to FaPMI, and
- d) To flexibly respond across the state to diverse FaPMI local needs (FaPMI Strategic Priorities, 2019-2022).

The programs focus on family-inclusive practice and encourages a whole of life and whole of family approach.

The program operationalises FaPMI Standards of Practice (Goodyear et

al., 2015) using them as a benchmark for service delivery, as a guide to prioritising areas for service improvement, and as a tool for data collection to understand the level of family-inclusive practice that operates in Adult Mental Health Services.

The FaPMI Standards of Practice for the adult mental health workforce (Goodyear et al., 2015) provides a measurable and well-articulated whole of service delivery platform for family-focused clinical practice. This platform focusses on enhancing current adult mental health services practice with the aim of achieving better outcomes for FaPMI. The practice standards offer a six-stage system which looks at screening and referral, entry into the service, negotiating a recovery plan, implementing treatment, monitoring care and discharge, or the transfer of care. The standards are intended to support families where a parent has a mental illness with children of all ages, including but not exclusively, perinatal mental health.

The FaPMI Practice Standards are consistent and supported by the Royal Australian and New Zealand College of Psychiatry (position statement 57, 2021) and the Working with Families and Carers Guidelines for Adult Mental Health Services (Office of the Chief Psychiatrist, 2018). The Practice Standards also align with family-inclusive practice recommendations of the Victorian Royal Commission into Victoria's Mental Health System (2021).

Attention to perinatal family-inclusive practice is an important component of the FaPMI Standards for the mental health workforce by identifying adult mental health consumers' (or partners) planning to become pregnant. It also identifies and records pregnancy status, identifies information on current supports and family relationships, and sets the scene for parenting and children's needs to be included in any ongoing service provision. Identifying parents within an adult mental health service occurs through state-wide documentation procedures at admission, a very important first step to building family-inclusive practice.

More broadly it encourages attention to child wellbeing, family vulnerabilities, and strengths (including impact of trauma, family violence, recovery plans and family care plans). The Standards expect that a family's needs and plans (including infants /children) are included in regular mental health

treatment reviews. Although the FaPMI Standards do not provide detailed guidance in relation to perinatal mental health practices, they encourage coordinated and collaborative practice across different parts of mental health service delivery and offer a base from which other specialist programs and interventions can occur. This guidance is helpful in not only addressing service system organisation, policy, and planning but is aimed at providing a mechanism to drive practitioner competency and skills (Fixen et al., 2009; Goodyear et al., 2015).

The FaPMI program is designed to support practice improvement through capacity building and professional development. However, there are challenges in implementing the Practice Standards in Victorian mental health services. The Standards challenge a culture of individualised focus of care. "Evidence suggests that Victoria's adult mental health system primarily takes an individualist approach to treatment, care and support without consistently considering the social contexts within which most people live in the community" (Royal Commission into Victoria's Mental Health System Report, 2021b, p. 72). Implementation of models of care that support the whole family needs to be systemically considered by taking into account the family needs as well as the setting and the agency, and how they are integrated.

Practice within the Standards relies on each mental health service developing and implementing local procedures to comply. The Victorian FaPMI File Audit measures adherence to the FaPMI family-focused practice standards. It uses file audit methodology and indicates that '...family-focused practice continues to be recorded at moderate to low, rather than high levels...' (The Bouverie Centre, Latrobe University, 2020, p. 14) reflecting that implementation of FaPMI Practice Standards remains a work in progress.

Adult mental health service 'practice as usual' is influenced by an individual focussed approach. This approach might risk seeing the mental health outcomes of mental health consumers during the perinatal period. For example, the absence of a family focus lens risks ignoring the infant's perspective all together.

Those with pre-existing mental health issues who become parents have additional core challenges of needing

the best available information that considers both the risk and benefit of treatments such as medication for both the parent and the infant. They also need to be engaged by mental health services, as a soon-to-be parent, in a respectful, supportive way, recognising the importance of their parenting role. They need to be given an opportunity to discuss how they are approaching their journey to parenthood, including often strongly held guilt, myths, and stigma about parenting with mental illness. This engagement then enables parents to be connected to the strong evidence that is available which looks at ways to prepare for parenthood and manage their mental health, reduce the vulnerability of children, and support positive outcomes (Foster et al., 2019; Goodyear et al., 2018; Hosman et al., 2009; Nicholson et al., 2019; Rupert et al., 2017; Siegenthaler et al., 2012; Thanhauser et al., 2017).

The Practice Standards guide mental health practitioners to provide a balanced approach considering both the strengths and the vulnerabilities of the parents with a pre-existing mental illness and their families. "... treatment is delivered with regular review of protective factors, risk, and vulnerabilities" (Goodyear et al., 2015, p. 174). This is an important balance as families in the perinatal period are often faced with the challenge of a service system that may only consider risks. The practice standards provide adult mental health services with a starting place to make the necessary changes to 'practice as usual' by identifying both strengths and risks within a family context and including a focus on parent-infant relationships. To enable this practice, tools or screening resources for the perinatal period to support inquiry and observations similar to the Western Australian Healthy babies for mother's initiative (Hauck et al., 2008) and available in the Australian Clinical Practice Guideline (Austin et al., 2017), could be incorporated. This then enables a strengths-based approach to identification, early intervention, and mental health recovery, which addresses the parent-infant relationship and supports referrals to specialist community programs, where appropriate.

Victorian Perinatal Inquiry

In 2018, the Victorian Government completed the Inquiry into Perinatal Services (the Inquiry) to examine the healthcare and wellbeing of mothers

and babies throughout the entire perinatal period. The report provides a snapshot of the issues across perinatal health and allows a view of how perinatal mental health is located (Family and Community Development Committee, 2018).

The Inquiry devoted specific attention to perinatal mental health and included the voices of families, support groups, and health professionals. All contributors reinforced the need for improvements within the perinatal sector, particularly in mental health. The report notes that the many complexities in the provision of care, often preclude support to the specific needs of more vulnerable women and families. There are few services designated specifically for pregnant women with a pre-existing mental illness and access for them to more generalist services can be difficult.

According to Goodyear et al. (2015), mainstream perinatal services may not be best placed to address the needs of these women, due to difficulties for the women, their families, and the health professionals who are often not trained in mental health (Hauck et al., 2015). Rather, a model of care is required to be formed from the recommendations of the Inquiry, focussing on strengthening early intervention and a plan for integration of perinatal mental health services into broader perinatal services (Family and Community Development Committee, 2018, p. 134). Benefits for outcomes for both women and their infants are prioritised through the recommendation of a Victorian Perinatal Mental Health Plan that builds on the existing 10 Year Mental Health Plan. Whilst this is promising, it is disappointing that there are no specific recommendations that provide for the particular challenges of those with pre-existing mental illness and their infants.

Despite well documented increased risks to fathers' and partners' mental health during the perinatal period, there are few specific services focusing on their support. Bollard (in Sved-Williams & Cowling, 2008) highlights these issues and discussed the considerations for fathers' wellbeing, their roles in the dyad, and their caring responsibilities. Support for the mental health of fathers is discussed in the report, noting also the benefits to the health and wellbeing of mothers and their infants (Family and Community Development Committee, 2018, p. 155). Accordingly, recommendation 3.10 addresses the expansion of perinatal mental health

programs for fathers. For this to be effective, the authors note that services need to consistently consider the whole of family context and be integrated with a model of care which incorporates support within the family's community including fathers' playgroups and parent support. Online information and support are also emerging as accessible supports for parents. However, consideration for those with pre-existing mental health concerns is still required.

The Inquiry and the evidence presented recognise that addressing the needs of women who have a pre-existing mental illness, may prevent the potential exacerbation of symptoms and the impact this can have on their unborn or infant. For these women, the early postnatal period may be challenging. The 2018 Inquiry reinforces concerns about the impact it can have on the relationship with their baby and resulting emotional and developmental concerns (Family and Community Development Committee, 2018, p. 115 – 120). Unaddressed, the long-term consequences for mental health and wellbeing of infants and parents, and quality of family life are obvious.

From professional reflections of clinical practice, the authors offer anecdotal feedback regarding the benefits when dyadic work is identified, that reframes mental health concerns, and highlights the specific needs of the infant. One example comes from a Lactation Consultant who noted that after years of working with unsettled babies and distressed mothers and normalising their experience, the impact of the situation on the mother and infant from a psychological perspective, was often overlooked. Just as concerning, is when a mother's pre-existing mental illness is blamed as the cause for their perceived inability to cope with parenting demands.

The Inquiry reports on various examples of issues raised regarding perinatal mental health for parents with pre-existing mental illness and their infants. There is a significant focus on the existing guidelines and recommendations for care. In particular the Australian Clinical Practice Guidelines (Austin et al., 2017), with emphasis on early identification and intervention, and integrated, family-focused care. The Inquiry is obviously a Victorian snapshot of a state fortunate to have a variety of services. This picture varies greatly across Australia, where

there are many influences within States and nationally, that determine service delivery.

Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline

The Australian Clinical Practice Guideline's (Austin et al., 2017) stated intention is to "inform local, state, and national policy surrounding the timely implementation of appropriate tools to ensure early identification of women's needs and timely, safe (for mother and baby) and effective intervention" (Austin et al., 2017, p. 73). The guidelines specifically address women living with serious mental illnesses including schizophrenia, bipolar disorder, and borderline personality disorder.

It describes the potential complexities and risk factors that may influence pregnancy management, including medications, mental health care, relapse prevention, transition to parenthood and the early postpartum period. Each diagnosis is addressed separately, and fact sheets are available on the accompanying Centre for Perinatal Excellence website. There is a clear intention to support parent-infant relationships alongside the physical and mental health and wellbeing of mother and infant. However, little is mentioned in relation to supporting the transition to parenthood psychologically, or practically, for the mother, father, or parenting partnership. It is these areas of becoming parents that offer the most substantial opportunities to make a difference in the transition to parenthood.

For parents with a pre-existing mental illness, open discussion with partners and family to develop a shared understanding and support plans that include early warning signs and mental health relapse prevention needs to be offered rather than assumed. No attention is given to men with a pre-existing mental illness as they become fathers in these guidelines. Research and practice wisdom acknowledges that depression regularly occurs in the first trimester for men and is also increasingly recognised postpartum. For becoming fathers, with a pre-existing mental illness, any worry may precipitate increased symptoms or relapse. The implications for the start of a new family, or subsequent births, are significant. Any deterioration in mental health could affect relationships and

reduce a father's ability to participate in and support their new family. These impacts within the family could be felt for a long time.

The importance of the infant's mental health and wellbeing is first raised postnatally with the observation of mother-baby interactions supporting early identification of concerns (Austin et al., 2017, p. 34). The Guidelines suggested follow-up action is a referral to a perinatal and infant specialist. A national guideline cannot provide service details for each state. However, the Centre of Perinatal Excellence website has added a search for services function. Whilst this is very welcome, access to options that are designed to include infants with parents with a pre-existing mental illness are limited. Programs for fathers are increasing and a range of web-based supports for new dads are also a welcome first step towards developing additional guidance for working with men with a pre-existing mental illness.

The Australian Clinical Practice Guideline (Austin et al., 2017) is a substantial contribution to excellent care for women with a pre-existing mental illness in the perinatal period. There is a strong appreciation of the importance of the parent-infant relationship, and attention to good mental health treatment, and care. Key areas for development are: Establishing the most effective way to provide support in the transition to parenthood for both parents, supporting the development of the emerging parenting relationship from pregnancy, the needs of infants, and support to parent-infant relationships throughout the perinatal period.

The expected audience of the Australian Clinical Practice Guidelines (Austin et al., 2017) includes mental health and allied health professionals, consumers, and carers, alongside those delivering antenatal and postnatal care. The guidelines do not address the mechanisms for collaborative practice between these services and do not have a family-inclusive approach that would support collaboration with the whole family in the provision of services. Each of these professions would be well-served by resources and training to support collaborative working relationships. This is consistent with concerns in other reviewed documents calling for an integrated approach to perinatal health and further training of those providing services, calling

for professional development, and an integrated approach.

The Royal Commission into Victoria's Mental Health System

The Royal Commission into Victoria's Mental Health System (2021a, b) recognises the perinatal period as one of high-risk to mental health and wellbeing. Whilst poor mental health can start, recur, or worsen during the perinatal period, the Commission acknowledged that responses to parents already linked to public mental health remain uncertain in policy. This reinforces a call for action in both policy and practice and the need for models of care appropriate for parents with pre-existing mental illness.

Experiences of psychological distress during the perinatal period vary widely, although prevalence data referred to in the Royal Commission presents perinatal depression in Victoria at 10.7 percent and perinatal anxiety at 20 percent of women in antenatal and postnatal periods. There is generally less research on the prevalence of perinatal mental illness among fathers and non-birth parents, and no clear data on parents with pre-existing serious mental illness.

The Royal Commission Report (The Royal Commission into Victoria's Mental Health System, 2021 a, b) notes that primary and secondary services including General practitioners (GPs) and maternal-child health services, can screen for and support parents with perinatal mental illness. Perinatal mental health screening is recommended as part of routine antenatal care at public health maternity and newborn care services, and in postnatal depression screening by Victoria's maternal-child health nurses. GPs, maternity services, and maternal and child health nurses, can connect parents to specialised perinatal mental health and wellbeing services and specialised parent-infant inpatient units when required, provided the services are available.

The experience for parents with existing mental illness can be quite different. As indicated previously, many people with pre-existing mental illnesses do not access mainstream services. Parents with pre-existing mental illness may experience challenges in connecting to mainstream services including GPs, maternity services, and maternal-child

health care, due to their experience of illness, stigma, and concerns regarding child protection and other mandated interventions. The capacity of adult mental health services to screen for pregnancy, and support parents during the perinatal period is limited by professional and service capacity. The authors recognise limitations in the current service systems. For example, further capacity-building work is required. This includes training and support of staff and the development of a responsive and integrated model of care. A proposed model of care would ensure all mental health consumers would have access to specialist perinatal mental health assessment and support.

The Royal Commission Report (The Royal Commission into Victoria's Mental Health System, 2021 a, b) recommends that most prospective and new parents receive treatment, care, and support in their local community from primary and secondary care and related services, with specialised perinatal mental health clinicians and support workers 'reaching in' to work directly with services to build their capability to respond to needs. This recognises the important roles of family, carers and supporters, and communities of place, identity, and interest, including facilitated and informal playgroups and parents' networks. If realised, these models must also consider and respond to the capacity of service systems to support parents with pre-existing mental illness, including targeted supports specific to the needs of these parents and their infants and children. For example, supported playgroups.

The Commission recommends specialised "Community Perinatal Mental Health and Wellbeing Teams" that provide multidisciplinary treatment, care, and support in the community (The Royal Commission into Victoria's Mental Health System, 2021 a, b). Lived experience workers (with a lived experience of perinatal mental illness) will be part of the specialist multidisciplinary teams (an addition to existing perinatal services). Models of practice in rural Perinatal Emotional Health Programs (PEHP) could inform these developments as discussed in the Perinatal Inquiry (Family and Community Development, 2018, p. 144). Again, specific attention is required, to ensure the needs of parents with pre-existing mental illnesses are included.

For consumers with more complex mental health support needs and

especially in the context of perinatal mental illness, the reforms suggest that bespoke perinatal emotional health programs be extended. For example, with suitably trained and resourced staff, specialised perinatal mental health clinicians, and peer support workers, being embedded in existing models of mental health care. Such programs need consideration in a broader comprehensive model of care, yet to be formulated.

Consistent with FaPMI Practice Standards (Goodyear et al., 2015), the Commission recommends service models that integrate care for parents and their infants into routine Adult Mental Health Service delivery by; recruiting and training specialist perinatal clinicians, establishing shared care and referral pathways, and through a range of parenting supports including evidence-based family practices such as Let's Talk, Single Session Family Consultation, and specialised parenting programs (The Royal Commission into Victoria's Mental Health System, 2021 b, p. 104). In these proposed models, care planning and coordination would be delivered consistently with the rest of the adult and older adult mental health and wellbeing services.

If realised, the recommended reforms will strengthen the overall focus on families, integrate treatment, care, and support, that are sensitive to the family's dynamics, situation, and strengths. These will also focus on attending to the quality of the relationships between infants, children, their parents, family carers and supporters. For parents with pre-existing mental health concerns, the recommendations include features for a model of care which would ensure access to services that are capable of responding to their family's specific needs.

This includes but should not be limited to trained specialist staff located in services which are accessible to parents with pre-existing mental illness and connection points and processes that link with other services. Services also need to be embedded in the family's natural communities and be responsive to the developing needs of parents and their infants through the perinatal period and beyond. Co-ordinated care planning, clear referral pathways and a range of specialised parenting programs and community groups will form part of this model.

Implementation & Sustainability of New Practices

“Family-focused practices” encompass approaches, programs, interventions, models, and frameworks that acknowledge the whole family context of the person receiving services (Allchin et al., 2022). These consider the relational family context of recovery and therefore attend also to the person’s parenting role and family relationships. They provide support to the parent in the context of their children and family, while also attending to broader family mental health needs.

Public Mental Health Services are part of wider health and community systems, where various factors impact the implementation and sustainability of family-focused practices (Dixon et al., 2001; Kavanagh et al., 1993; McFarlane et al., 2003). At an individual level, training to build knowledge, skills, and confidence in family-focused practice, enhances the practitioner’s ability to identify and support the parenting role of consumer parents while also holding the children and broader family needs in mind. In addition, organisations must establish systems that routinely identify consumers’ parental status and attend to dependent children and require funding to prioritise working with whole families with a preventive and early intervention approach.

To succeed, government and organisational structures, such as policies and directives, must be mandated to create an authorising environment and leadership support for the promotion of family-focused practices as part of everyday mental health work (Allchin et al., 2022). Directives are needed that clearly articulate effective models of care which identify and respond to the complex needs of specific parenting populations. In this instance, to parents with pre-existing mental illness.

The key features in a model of care that is responsive to parents with pre-existing mental illness and their children and families include:

- A workforce of suitably trained, skilled, and supported practitioners.
- Services that are explicitly whole of family focused.
- Processes and tools to support identification, early intervention,

and engagement through strengths-based family-focused practice.

- Collaboration and partnerships between agencies working across the perinatal period.
- Clear and accessible referral pathways.
- Targeted interventions and services including supported playgroups and parenting groups.
- Parent peer support workers and meaningful connection to the community.

This reminds us of the work required at many levels to implement change, particularly family-focused practices. A policy context that provides a framework for workers to engage meaningfully with families and focus on parenting, supports mental health recovery while enabling parents to keep the needs of their infants and children central.

Discussion

Looking through the lens of parents living with a mental illness highlights the missing policy and practice frameworks that are required to support all families in the critical stages of their becoming. The evidence is clear, that a well-considered comprehensive model of care, can minimise the intergenerational transmission of adversity. To achieve this, the place of perinatal and infant mental health services in ‘the’ service system is, we argue, secondary to the conceptualisation of perinatal and infant mental health as whole of family approach over this life stage supported by connected responsive services.

Dispersed and disconnected services and systems with a focus on ‘episodes of care’ and poor connection between public and private providers and the universal systems, such as maternal and child health, are not able to provide the continuity or consistency of care required. The growth in the workforce required to meet the implementation of the Royal Commission into Victoria’s Mental Health System (2021 a, b) recommendations, provides an opportunity to build new knowledge, skills, and approaches to perinatal and infant mental health.

“Vulnerable parents across the life span accessing a range of adult focussed services present us with an opportunity to intervene and indeed to prevent the

onset of inter-generational challenges” (Cuff, 2017, p. 123). Providing appropriate services for families living with parental mental illness is complex. The evidence base for family inclusive practice is strong and supports both mental health recovery and infant and child wellbeing.

This brief review of current Victorian policy and reform repeatedly identifies themes of complex demand and disconnected service systems. Family-focused child and infant services would consider parents and parenting, mental health, and wellbeing. Family-focused adult services would consider their parenting roles, mental health and wellbeing, family relationships, and the needs of children and infants.

Proactive support of the parenting role and/or transition to parenthood alongside the parent’s mental health management provides a meaningful purpose and direction for service delivery and collaboration between services. The FaPMI Practice Standards (Goodyear et al., 2015) provide clear expectations that support the early identification of parents and their dependent children. They support family-focused engagement and interventions in adult mental health services. Challenges to implementing Practice Standards may be addressed by authorising environments which mandate policy and procedures to ensure these are embedded.

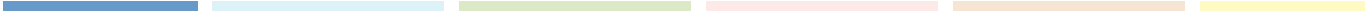
The Australian Clinical Practice Guidelines for mental health care in the perinatal period (Austin et al., 2017) provide a launching point to extend guidance to family-focused work with parents with a pre-existing mental illness. The development of resources that support family-focused practice in a range of settings is more likely to engage the wider audience it seeks to reach. The COPE website provides good material as a resource to develop this work.

The Perinatal Inquiry (Family Community Development Committee, 2018), and the Mental Health Royal Commission (Royal Commission into Victoria’s Mental Health System, 2021 a, b) produced significant recommendations that contribute to workforce development, funding, and resourcing and focus on creating collaborative and coordinated models of care. Understanding how existing services may need to reshape and find ways to connect with other elements of service provision for families

throughout the perinatal period will be a grand undertaking best done with families themselves in codesigned frameworks. The lived experiences of families alongside professional stakeholders representing the layers of services involved in the perinatal period can inform the development of models of care that support early intervention and ensure a collaborative focus on the infant, parents, and the whole family.

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A Report on the First Scientific Congress of Japanese Association for Infant Mental Health (Japanese Affiliate of WAIMH) in Koriyama in Commemoration of the Unification of JAIMH

By Kanae Narui

JAIMH Executive Committee of the first Scientific Congress in Koriyama

Congress Chair

January 31, 2022

The first scientific congress of the Japanese Association of Infant Mental Health (JAIMH) after its unification was held in Koriyama city on December 12th and 13th, 2021 with a theme, "Weaving the Future for Children: 10 years after the Great East Japan Earthquake and Tsunami." This event marked the inauguration of JAIMH as the Japanese affiliation of WAIMH. Nearly 200 people participated in the hybrid congress in consideration of COVID-19.

In the public lectures, the topics that form the foundation of JAIMH were presented such as the creation of sustainable environment for children by Prof. Ichiro Iwaki of Nihon University(1); issues surrounding children's development after the disaster by a pediatrician, Dr. Shintaro Kikuchi(2); and infant-mother reciprocity by a picture book artist, Ms. Hideko Ise(3).

We had an honor to receive a message from Her Imperial Highness Princess Akishino in the opening ceremony(4), followed by the words from Mayor Mari Shinagawa of Koriyama, and the Executive Director of WAIMH, Dr. Kaija Puura. Dr. Kaija reflected on the footprint of WAIMH with an acknowledgement of the contribution by its Japanese members including the JAIMH President, Dr. Hisako Watanabe. She also elaborated on the infant mental health program in Finland whose new efforts, she mentioned, were influenced by the post-disaster programs in Fukushima. Dr. Kaija's words confirmed the close ties and mutual influence between JAIMH and WAIMH, which enable our experiences to be shared in the world.

The first symposium(5) focused on attachment issues after the disaster. After the presentation on the efforts by the nurseries and child care institutions,



JAIMH presenters: Nobuko Sakai, Wright Nisizaka, Satoshi Brojan, Masako Yamamoto, Kanae Narui, Dr. Hisako Watanabe, Kayoko Sekino, Miho Kawaharagi, Chiaki Yasaka, Norie Munakata, and Dr. Shintaro Kikuchi. Photo taken by Dr. Toru Matsubara.

we listened to the real-life experiences of individuals who grew up in the group home for children. While we were touched by their resilience, we also reacknowledged the indispensable value of fostering attachment among children living in adversity.

Day two started with the poster sessions by JAIMH members(6). The invited lecture by Lawyer Kyoko Hasegawa on the shared custody after divorce set the tone of the day(7). The presentation by Dr. Erum Mariam on the Humanitarian Play Lab (HPL) in Rohingya Refugee Camp sparked the hybrid discussion on the importance of the provision of locally relevant, familiar play programs for refugee children in a safe place, which resonated with our experience in Fukushima(8).

In the second symposium, we stepped back a little and looked at a big picture of post-disaster intervention. A longtime supporter of JAIMH and non-fiction writer, Mr. Kunio Yanagida shared his views on how to support families regenerate their lost hometowns(9). Ms. Kaoru Suzuki of Iwaki Citizens' Radiation Measurement Center, on her

part, recounted the reality of mothers raising children with uncertainty of radioactive contamination in their own words. Finally, the chairperson of NPO Heartful Family Care Society, Mr. Takashi Tomimori, touched upon the expansion of the Infant-Parent Play and Parent Meeting in the time of the COVID-19 pandemic(10).

The congress was a great opportunity to discuss infant mental health in a very practical manner and to reconfirm our commitment as a member of the global team. Last but not least, we would like to express our sincere gratitude towards the ceaseless encouragement and support received from Dr. Kaija Puura.

Here is a program of our scientific congress. Please look at this.



Japanese Association for Infant Mental Health (JAIMH): Japanese Affiliate of WAIMH

The 1st Scientific Congress in Koriyama

in Commemoration of the Unification of the JAIMH

Theme: Weaving the Future for Children 10 years after the Great East Japan Earthquake and Tsunami (GEJET)

Date: 11th-12th December 2021

Live Online (and on-demand from February 2022)

Venue: 50th Anniversary Memorial Hall (Hat NE), College of Engineering, Nihon University

The Aim of the Congress

Japanese Association for Infant Mental Health (JAIMH) has been newly formed by unification of the national infant mental health forum, 'FOUR WINDS' (Forum Of Universal Research and Workings on Infant and Neonatal Developmental Support) and the Japanese Affiliate of WAIMH. This 1st Scientific Congress is organized in Koriyama in commemoration of this unification. (Counting from the first FOUR WINDS gathering in 1997, this will be the 23rd congress.) This year's congress theme, 'Weaving the Future for Children' conveys that if we compare the life of children to the warp, and that of us, child nurturers, to the weft, we aim to weave a fabric of happy and hopeful future for children living under whatever circumstances. We have supported babies, children and parents in Fukushima over the past 10 years in the aftermath of the GEJET and ensuing nuclear disasters. Children around the world face crises due to manifold factors, including COVID-19, trauma, child abuse, and neglect. To protect their healthy growth and development both mentally and physically, we have to keep improving our competency as infant mental health professionals. We present our ideas from Fukushima throughout Japan and to the world in the hope of developing a better Infant Mental Health community.

Local Presidential Lecture

- Kanae Narui (Director of Heartful Family Care Society, Shirakawa/

Koriyama, Fukushima) Children in the aftermath of the GEJET and beyond.

Invited Musician & Foreign Lecturers

- Atsuko Tenma Dec 12th 13:30pm
Violin Mini Concert (Renowned Violinist from Fukushima)
- Dr. Kaija Puura Dec.11th 13:30pm
Opening Message from WAIMH (Professor of Child Psychiatry, Tampere University, Executive Director of WAIMH Office, Tampere, Finland)
- Dr. Erum Mariam Dec 12th 10:30am
Humanitarian Play Lab (HPL) & Indigenous Culture (Director, BRAC Institute of Educational Development, BRAC University, HPL Rohingya Camp, Bangladesh)

Symposium

1. -We aim to protect our children --- social support for nurturing attachment

-Cultivating attachment in the field of IMH after the GEJET and the 2011 nuclear disasters.
2. Reflecting on the past 10 years of support for parents and children in the community: surviving the GEJET and ongoing COVID-19 pandemic and thinking about the future of the children.

Public Lectures, Dec 11th am

- Hideko Ise (picture book artist)
- Ichiro Iwaki Thinking about the Future of Children from the perspective of the LOHAS Engineering (Professor, College of Engineering, Nihon University, Director of the Center for LOHAS Engineering)
- Shintaro Kikuchi The Current Situation of Children in Fukushima after the GEJET (Kikuchi Clinic, Pediatrician)

Concluding Congress Lecture, Dec 12th pm

- Kunio Yanagida (Non-fiction writer)

Keynote Lecture Dec 11th 15:15pm

- Hisako Watanabe Launching the JAIMH and underlying thoughts (President of JAIMH, Executive of WAIMH, Director, Life Development Center, Watanabe Clinic)

Organizer

Executive Committee for the 1st Scientific Congress in Koriyama in Commemoration of the Unification of the JAIMH (Local Organizing Chair : Kanae Narui)

Co-organizers

College of Engineering, Nihon University, Certified NPO PEP Network of Child Care in Koriyama, NPO Association for Nurturing Future Heartful Heart, Certified NPO Mothers' Radiation Lab & Clinic Fukush

Office

c/o Kikuchi Clinic, 1-13-17 Honmachi, Koriyama City, Fukushima, 963-8871, Japan. Email: info@japan-aimh.com

The contents of the congress will be available on demand in January 2022. We welcome your joining our endeavor as well as your feedback on the contents.

References

- (1) <https://youtu.be/WjaGDumNMUM>
- (2) <https://youtu.be/K9bLojJPI7o>
- (3) <https://youtu.be/hSFtHGUtP2M>
- (4) <https://youtu.be/a0EMdaBJk1s>
<https://youtu.be/6ytVGXGsjQA>
- (5) <https://youtu.be/Sb7Zxsj31aA>
<https://youtu.be/nvNbipfS0FE>
- (6) <https://youtu.be/yzKpj8fLc3w>
- (7) <https://youtu.be/hRdlfabCivl>
- (8) <https://youtu.be/7UBWgGOAQME>
- (9) <https://youtu.be/o1GGBSsf5I8>
- (10) <https://youtu.be/Tnpq9qWvgWg>
https://youtu.be/kVVyh_zxDHs

WAIMH Perspectives in Infant Mental Health Book Club Invitation: Therapeutic Cultural Rituals & Routines to Build and Strengthen Family Relationships: Talk, Touch & Listen©

By Maree Foley, Switzerland

All readers of *WAIMH Perspectives in IMH* are invited to participate in a virtual online Book Club.

To start things off the first book that we are going to share together, is a newly released book.

Therapeutic Cultural Routines to Build Family Relationships: Talk, Touch & Listen While Combing Hair©

This book is edited by Marva L. Lewis and Deborah J. Weatherston.

You can read more about the authors by following this link: ([view affiliations](#))

BOOK ANNOUNCEMENT FROM THE EDITORS

Marva L. Lewis, PhD, Tulane University and Deborah J. Weatherston, PhD, Alliance for the Advancement of Infant Mental Health, ZERO TO THREE Graduate Fellows, are pleased to announce the publication of their co-edited book, *Therapeutic Cultural Routines to Build Family Relationships: Talk, Touch & Listen While Combing Hair*© (SpringerNature, 2021).

Contributors from a wide range of disciplines explore the simple routine of combing hair as an emotionally powerful tool for social workers and other professionals in the infant and early childhood field to use when observing and interacting with Black and Indigenous families of color. Case stories deepen the understanding of painful childhood messages of colorism regarding racial features, specifically hair type and skin tone. Self-reflective questions invite personal and professional exploration through the anti-racist lens of culture, diversity, equity, and inclusion.

WHERE CAN YOU GET THE BOOK?

1. You can buy the book (as a hard copy or as an eBook) at



the following link: [Therapeutic Cultural Routines to Build Family Relationships: Talk, Touch & Listen While Combing Hair](#)©

2. Check with your Local Library and or your University Library.
3. Ask your Local or University Library to access the book for you.
4. Google books has some of the text freely available: [Therapeutic Cultural Routines to Build Family Relationships: Talk, Touch and ... - Marva L. Lewis - Google Books](#)

HOW WILL THE BOOK CLUB WORK?

Step 1:

Each chapter in this book concludes with a series of reflective questions. These questions make an ideal springboard from which to frame shared responses, queries, and shared experiences.

Any reflections, thoughts, or questions can be emailed to Maree Foley (Editor-in-chief of Perspectives) at the following email: perspectives@waimh.org

Subject header: BookClub

Time frame: Comments to be shared by June 1.

When sharing reflections please indicate:

- a) Your consent to publish your name alongside your commentary, or
- b) Your consent to publish your commentary without publishing your name and instead to assign a pseudonym, or
- c) Your non consent to publish your commentary and your name.

Also, if you would like to be part of an online zoom call in the middle of the year, please give your consent to WAIMH so we can add your email to a group email for the purposes of inviting you to a *WAIMH Perspectives Zoom Book Club* call.

Step 2:

The reflections with a commentary from the editors will be shared in the next edition of *WAIMH Perspectives* in June 2022.

Step 3: Book club zoom

Mid-year, we will organise a southern hemisphere and northern hemisphere zoom call to meet the Editors and share reflections.

WAIMH Office News: Using feedback to improve events for WAIMH members



By Minna Sorsa and Neea Aalto, Finland

WAIMH 2023 Congress in Ireland

Save the date: the 18th WAIMH World Congress will be held in Dublin, Ireland from 15–19th July, 2023! The congress theme is “Early Relationships Matter: Advancing Practice, Policy and Research in Infant Mental Health”.

Remember that as a WAIMH member you are entitled to reduced registration fees at WAIMH World Congresses. Please watch the congress website at <https://www.waimh2023.org/> and follow WAIMH on Facebook, Twitter, and LinkedIn for ongoing information about the congress.

Laying the Path for Lifelong Wellness Lecture Series 2022

While waiting for the WAIMH 2023 congress, this year’s lecture series “Laying the Path for Lifelong Wellness” provides a great opportunity to hear directly from some of the pioneers and experts of infant and early mental health research and practice.

The web-based series includes 15 recorded lectures that can be viewed at the convenience of each participant. The lectures are available with English and French captions.

Registration is open!

- For those wishing to register as individuals, please visit <https://learning.iemhp.ca>
- For those wishing to register groups ranging in size from 10 or more participants, please contact lectureseries@sickkids.ca

Special discounts are available for WAIMH/IEMHP members and WAIMH affiliates. WAIMH members can obtain the coupon code for the individual membership discount from the WAIMH Online Community Feed by signing in at waimh.org.

For more detailed information about the series, please visit: <https://imhpromotion.ca/Learning-Centre/Expert-Lectures/Lecture-Series-2022>

World Infant, Child and Adolescent Mental Health Day 23rd April, 2022

WAIMH has connected with IACAPAP (International Association for Child and Adolescent Psychiatry and Allied Professions), WPA-CAP (World Psychiatric Association Child and Adolescent Psychiatry Section) and ISAPP (International Society for Adolescent Psychiatry and Psychology) to initiate a World Infant, Child, and Adolescent Mental Health Day (WICAMHD).

We organised a webinar on 23 Apr 2022 for the official launch of the World

Infant, Child and Adolescent Mental Health Day. In case you did not have the chance to attend, the webinar recording is available on IACAPAP’s YouTube channel:

<https://youtu.be/jgOV4WR0m7I>

For more information about the World Infant, Child and Adolescent Mental Health Day, please visit <https://iacapap.org/events/world-infant-child-and-adolescent-mental-health-day.html>

Thesis on WAIMH World Congresses’ feedback

For many years, the WAIMH Central Office has collected feedback from the WAIMH World Congress participants. As part of her BBA studies, the current administrative assistant at WAIMH Central Office, Neea Aalto, is working on a thesis on the feedback that WAIMH has collected from the congress participants in the period 2008–2021. The thesis will explore how the feedback has developed through the years, what have been some common themes in the responses, and how the collected feedback could be utilized when planning future WAIMH World Congresses. Once the thesis is completed, we will make a post about the results in Perspectives in Infant Mental Health.

World Infant, Child and Adolescent Mental Health Day 23rd April, 2022



WAIMH has connected with IACAPAP (International Association for Child and Adolescent Psychiatry and Allied Professions), WPA-CAP (World Psychiatric Association Child and Adolescent Psychiatry Section) and ISAPP (International Society for Adolescent Psychiatry and Psychology) to initiate a World Infant, Child, and Adolescent Mental Health Day (WICAMHD).

The specific aims are to:

1. Recognize the global importance of infant, child, and adolescent mental health, and
2. To advocate for the promotion of mental health and prevention of mental illness in infants, children, and adolescents.

WICAMHD webinar

We organised a webinar on 23 Apr 2022, 1.00 PM CEST for the official launch of the World Infant, Child and Adolescent Mental Health Day.

The speakers were:

- Dr Daniel Fung, President of the International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP)
- Pr Mario Speranza, President of the International Society of Adolescent Psychiatry and Psychology (ISAPP)
- Assoc Prof Campbell Paul, President of the World Association for Infant Mental Health (WAIMH)
- Dr Norbert Skokauskas, President of the World Psychiatric Association

Child and Adolescent Psychiatry Section (WPA-CAP)

- Dr Liu Jing, Professor and Chief, Director of Mental Health Center for Children, Peking University Institute of Mental Health and Sixth, China
- Dr Fusun Cetin Cuhadaroglu, Professor of Child and Adolescent Psychiatry, Hacettepe University Faculty of Medicine, Ankara, Turkey

The webinar recording is available on IACAPAP's YouTube channel:

<https://youtu.be/jgOV4WR0m7I>

How to support WICAMHD

Share the enclosed logo widely.

Use social media to spread your message about the importance of mental health in the young.

Please involve your communications teams and do it on all websites and social media platforms you are on.

We suggest the following hashtags.

#WICAMHD

#infantchildadolescentmentalhealth

#worldmindyourheart

More information

For more information, please visit <https://iacapap.org/events/world-infant-child-and-adolescent-mental-health-day.html>

2022 Ann Morgan Prize



To honour Dr Ann Morgan's contribution to infant mental health, AAIMH Victoria is again offering a Creative Writing Prize of AU\$1,500 for a work of fiction, poetry ... that explores or imagines the infant's subjective, emotional world.

We invite entries from AAIMH and WAIMH members along with interested adult writers across Australia.

What is it like to be a baby?

Please [Click here](#) to find the invitation to submit your writing and information on how to enter for 2022.

The closing date is 3rd June 2022 at 5pm.

We look forward to receiving your entry.

For more information visit AAIMH website

<https://www.aaimh.org.au/branches/vic/ann-morgan-essay-prize/>