



The First 1000 Days in the Nordic Countries

A Situation Analysis

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SIGRÚN DANÍELSDÓTTIR AND JENNÝ INGUDÓTTIR

About this publication

The First 1000 Days in the Nordic Countries: A Situation Analysis

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Executive summary

The First 1000 Days in the Nordic Countries is a three-year Nordic collaborative project, launched as part of the 2019 Icelandic Presidency of the Nordic Council of Ministers. Its overall aim is to support healthy emotional development and good mental health during the first 1000 days of life (i.e. from conception to the age of two). The project has three main deliverables. The first of these is this Situation Analysis Report; the second is an Evaluation Report, in which psychosocial interventions and assessment instruments for parents and young children in the Nordic countries are evaluated in terms of scientific evidence; and the third will be policy recommendations for further development to support the wellbeing of all children in the Nordic region.

The project is managed by the Directorate of Health in Iceland. A network of Nordic partners has been established with representatives from the Norwegian Directorate of Health and the Regional Centre for Child and Youth Mental Health East and South (RBUP Øst og Sør) in Norway, the Danish Health Authority (Sundhedsstyrelsen), the Public Health Agency of Sweden (Folkhälsomyndigheten), and the Iltia Children's Foundation and the Institute for Health and Welfare (THL) in Finland. The situation analysis, which took place in 2019, gathered extensive information and data from across the Nordic countries about practices to support wellbeing and identify risk factors among young children and their families within prenatal care, infant and child healthcare and early childhood education and care (ECEC). The results are presented in this report, with detailed country profiles and a comparison of the situation across the Nordic countries.

The report reveals significant strengths, as well as important challenges, when it comes to supporting young children's wellbeing and healthy start in life within the Nordic region. All the countries have strong infrastructure and universal healthcare and social services, based on the notion of health equity and social justice, and this offers their citizens extensive public health benefits and social security. Prenatal and infant and child healthcare are firmly established systems that are free of charge and available for all families. Great emphasis is placed on ensuring continuity of care and personalized service, and establishing a warm and trusting relationship between healthcare staff and expectant and new parents. Usually, families will see the same professionals throughout the pregnancy or infant and toddler period. There is also a strong focus on supporting young children's healthy emotional development and the parent-child relationship from pregnancy onwards, as well as responding early to any risk factor in the child's first years of life. All the Nordic countries offer substantial parental benefits after the birth of a child, with a specific quota for each parent, as parenting is generally seen as a gender equality issue. The Nordic countries all have well-established, universally accessible ECEC systems, with the majority of countries having defined ECEC as a legally protected right for all children.

Numerous areas for improvement are also identified in this report. In general, data registration, quality monitoring and the dissemination of evidence-based practices can benefit from further strengthening in the Nordic countries. Also, while all the countries emphasise the early detection of risk factors in prenatal and infant and

child healthcare, it may not always be done in a systematic manner, or via validated screening instruments. Prevention and early intervention also typically focus primarily on the mother, and so important opportunities for securing child and family wellbeing can be found in greater efforts to include both parents in prenatal and infant and child healthcare. All countries reported some limitations in the availability of various services, such as early intervention for milder mental health problems or family difficulties. Unequal access to services was also reported in most countries due to factors such as community size and the administrative autonomy of service providers. In all the countries, more extensive, specialized services are provided in larger urban areas than in smaller rural locations. Since regions, municipalities and sometimes even individual providers are highly independent in terms of their service provision, it can also be difficult to draw general conclusions about how the Nordic countries ensure and support the quality of care in their services to parents and children.

Common challenges in the Nordic ECEC system include shortages of professionally trained staff, large group sizes in ECEC centres, high levels of stress and a lack of budget and resources. Great opportunities lie in improving cross-sectoral collaboration in all countries, including strengthening the links between ECEC and child healthcare, which both play an instrumental role in young children's wellbeing. The results of this situation analysis will be used for further development within the First 1000 Days in the Nordic Countries project and the formation of policy recommendations to secure a healthy start to life for all children in the Nordic region.



Introduction

The First 1000 Days in the Nordic Countries is a three-year Nordic collaborative project, launched as part of the 2019 Icelandic Presidency of the Nordic Council of Ministers, with the overall aim to support healthy emotional development and good mental health during the first 1000 days of life (i.e. from conception to the age of two). The first phase of the project involved a situation analysis in which extensive information and data were gathered about practices to support the wellbeing of young children and their families and identify early risk factors in prenatal care, infant and child healthcare and early childhood education and care (ECEC) in the Nordic countries. The results are presented in this Situation Analysis Report with an overview of the situation in each participating country and comparison across countries. The report also offers examples of good practice from each country and discusses areas for further development.

Main objectives

The main objective of *The First 1000 Days in the Nordic Countries* is to support healthy emotional development and good mental health in young children so that all children in the Nordic countries have the best possible start in life. This is in accordance with many of the United Nations' Sustainable Development Goals (SDGs), including SDG 3 on health and wellbeing, SDG 4 on quality education, SDG 5 on gender equality, SDG 10 on reduced inequality and SDG 16 on peace, justice and strong institutions. The project will look at how Nordic countries: promote mental health and wellbeing in prenatal and infant and child healthcare; support healthy emotional bonding between parents; identify and respond to early risk factors in the lives of young children and their families, and support healthy social-emotional development and positive relationships in ECEC. The project has three main deliverables. The first of these is this Situation Analysis Report; the second is an Evaluation Report in which psychosocial interventions and assessment instruments for parents and young children in the Nordic countries are evaluated in terms of scientific evidence, and the third will be policy recommendations for further development to support the wellbeing of all children in the Nordic region.

Background

The first years in a child's life are critically important for lifelong mental health and wellbeing.^{1 2} During the early years, brain development is at its peak and foundations are laid for neural pathways and brain regions that influence learning, language development, emotional development and behaviour.^{3 4} Through supportive relationships and secure upbringing, children develop the ability to regulate their emotions, manage their behaviour and develop the skills to form positive relationships of their own in the future. This lays the foundation for good mental health, which is central to quality of life and wellbeing throughout the course of life.⁵

Adversity during the first years of life, such as lack of warmth, love and a secure relationship with parents, neglect, violence or other serious threats, can permanently weaken the foundations of mental health. Government policies and actions that support parents in their upbringing role can, therefore, have far-reaching, positive effects that go well beyond health and wellbeing, also contributing to successful schooling, higher educational attainment, lower crime rates and improved social-economic status.⁶ Most children in the Nordic countries attend early childhood education and care (ECEC) from the age of one, and it is, therefore, important to strengthen the role of mental health promotion and prevention in ECEC as well. It is essential that ECEC promotes positive social-emotional development and meets young children's need for security, stability and stimulation, as well as strong, nurturing bonds with caregiving teachers and staff.

The nations of the world are increasingly waking up to the importance of investing in early years,^{7 8} and the establishment of the UN's Sustainable Development Goals has further underscored societal responsibility to support healthy development and wellbeing for all children.^{9 10} As evidence accumulates to indicate negative developments in young people's mental health^{11 12 13 14} it is imperative that the Nordic countries strengthen their ability to support a healthy emotional start in life for all children. It is important to gather, evaluate and disseminate the extensive knowledge and resources that exist in these countries so that we may learn from each other and help bring about a situation in which all children born in the Nordic countries receive a similar healthy start in life.

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Partners

The project is managed by the Directorate of Health in Iceland. A network of Nordic partners has been established, with representatives from the Directorate of Health and the Regional Centre for Child and Youth Mental Health East and South (RBUP Øst og Sør) in Norway, the Danish Health Authority (*Sundhedsstyrelsen*), the Public Health Agency of Sweden (*Folkhälsomyndigheten*) and the Itla Children's Foundation and the Institute for Health and Welfare (THL) in Finland. As it was not possible to secure participation from the autonomous territories of Greenland, Åland and the Faroe Islands, for the purposes of this report, the term "Nordic countries" refers to the nations involved in the project, i.e. Iceland, Sweden, Denmark, Norway and Finland. However, all countries and autonomous territories are represented in the project's reference group, the role of which is to support the project's success and facilitate the implementation of its outcomes (e.g. the policy recommendations). The main network of partners includes Sigrun Danielsdottir and Jenny Ingudottir from the Directorate of Health in Iceland, Hege-Maria Aas from the Norwegian Directorate of Health, and Gun-Mette Røsand and Kari Slinning from Regional Centre for Child and Adolescent Mental Health (RBUP Øst og Sør) in Norway, Ann-Cristine Jonsson from the Public Health Agency in Sweden, Camilla Krogh and Jens Kristoffersen from the Danish Health Authority, and Susanna Rautio, Petra Kouvonen and Marjo Kurki from the Itla Children's Foundation in Finland.



Methodology

A questionnaire was collaboratively developed by the network of partners in order to collect information and data for the project (see Appendix 1). Partners were individually responsible for the collection of data within their respective country and the selection of examples of good practice. The partners agreed that, since conditions that affect data collection (e.g. geographical size, population size, system structure and availability of information) vary between countries, each country would gather information for the report in the manner best suited to them. The same information may, therefore, have been collected by different means in each country (i.e. from national reports, internet searches, consultation with experts or stakeholders, field visits, etc.). Also, while country profiles presented in this report provide a general overview, they should not be taken as exact analyses of the situation within each municipality or region in that particular country. Nordic municipalities and regions, of which there are hundreds, have considerable independence in terms of their organisation and management, and so the information presented may not always be applicable to every location within a particular country. A more detailed description of data collection for each country is found below.

Data collection took place in 2019, and therefore much of the information (e.g. statistical data) dates back to 2018. Once each country had completed its data collection, project managers at the Directorate of Health in Iceland compiled the information into a comprehensive text, which was reviewed by the project's network of partners. Telephone meetings and video conferences were conducted with partners from each country to address any lack of clarity in their chapters, and this was followed by further revisions and rewriting. Project managers at the Directorate of Health also drafted a chapter comparing the situation across the Nordic countries, and this was sent to the network's partners for review and approval. A final version of the report was discussed and approved at an annual meeting of the partners in 2020.

Denmark

The information from Denmark in this report was collated by the Department of Health Promotion at the Danish Health Authority. The team that collated the data included a health visitor and a paediatrician. The data stems from sources such as national legislation and guidelines, reviews of surveys, research studies, internet searches and searches on websites run by various associations, commercial companies and institutions. The Health Authority worked closely with the National Board of Social Services, the Ministry of Social Affairs and the Interior and the Ministry of Health on the data acquisition phase. The Ministry of Employment, the Ministry of Education and the National Association of Children and Youth Educators were also involved. Statistics were obtained from Statistics Denmark. The steering group took an active part in the project and assessed the quality of the work, from data acquisition to editing and reviewing the final version of the report.

Finland

The information on Finland in this report is based on existing literature and other references (e.g., national laws, guidelines, reports and research studies) that were gathered via internet searches, review of existing data and consultation with experts. The Itla Children's Foundation was responsible for data collection. In addition, experts from the Finnish Institute for Health and Welfare (THL) and the Ministry of Education and Culture established a steering group for the project consisting of four experts in relevant fields. The steering group played an active part in the project, assessed the quality of the work from data collection to editing, participated in extensive discussions via email, telephone and meetings, and reviewed the final version of the report. External experts in the field from Helsinki University Hospital and THL (*the Barnahus Project*) were consulted when collecting data, and a joint working group was also organized at the Children's Rights Forum in collaboration with the Federation of Mother and Child Homes and Shelters.

Iceland

The information for this report in Iceland was gathered via internet searches for public information relating to the structure and interventions of different services, and a review of pre-existing surveys, reports and other grey literature, legislation and clinical guidelines. A team of experts was established with representatives from the Development Centre for Primary Healthcare in Iceland and consultations were made with various specialists and government experts in the field, such as Icelandic primary healthcare, the National University Hospital, the Directorate of Health, the Ministry of Social Affairs, the Ministry of Education and the Icelandic Association of Local Authorities. Visits were also made to healthcare facilities in each of Iceland's seven health regions, and interviews were conducted with representatives from prenatal care and infant and child healthcare, and with representatives from welfare and preschool services within the municipalities where healthcare facilities are located. Statistical information was obtained from Statistics Iceland and the Directorate of Health.

Norway

The Norwegian Directorate of Health and the Regional Centre for Child and Youth Mental Health East and South (RBUP Øst og Sør) were responsible for data gathering. Resources within these agencies were used to obtain relevant data and literature reviews were supplemented by interviews in the field of child health centre and daycare. The Directorate of Health and the Directorate for Children, Youth and Family Affairs established a team that includes representatives from relevant organisations such as Drug and Alcohol Competence Centres (KoRus), the Regional Centre for Child and Youth Mental Health (RBUP), the Regional Centre for Child and Youth Mental Health and Child Welfare (RKBU), the Regional Resource Centre on Violence, Traumatic Stress (RVTS) and the Office for Children, Youth and Family Affairs (Bufetat). The team contributed to the work by quality assessing the data, as did Senior Advisor Solvor Bäcklund and her team in the Directorate for Children, Youth and Family Affairs, Department of Childhood and Adolescence. The Directorate of Health, in cooperation with RBUP East and South, summarized the information and incorporated it into the report.

Sweden

Data collection in Sweden was performed through online searches and consultation with professionals by a senior researcher at the Public Health Agency of Sweden. Available statistics, reviews and compilations of national data were identified through searches via Google, Google scholar and LIBRIS. This work was combined with searches on the websites of national agencies/organizations, regions and professional associations. The material identified was used as a starting point for group discussions with representatives from prenatal care, infant and child healthcare and national agencies, focusing on topics relevant to the situation analysis. Specifically, the reference group included a midwife from prenatal care, a child health nurse, a child health doctor, a child and maternal health psychologist, a speech therapist from infant and child healthcare and analysts from national agencies. The group discussions were held in two sessions and two complementary individual interviews. A senior researcher at the Public Health Agency of Sweden conducted the group discussions and took notes, which were used to answer questions pertaining to the situation analysis in combination with identified publications. The answers were then reviewed by participants in the group discussions, and a final, revised text was submitted by a senior researcher at the Public Health Agency of Sweden.



Denmark

Prenatal care

The task of providing prenatal care in Denmark is shared between self-employed general practitioners (GPs) at a regional level, and midwives' clinics, which are either run in hospitals, i.e. at regional level, or in some cases privately. Typically, during her pregnancy, a woman has three appointments (one per trimester) at the GP's office, between four and seven appointments with a midwife and two ultrasounds¹⁵. She will usually see the same midwife and GP throughout her pregnancy, with her first appointment normally at the GP's office between weeks five and ten of the pregnancy. The GP provides information about further prenatal care and refers her to a midwife and, if necessary, an obstetrician. Prenatal care is free of charge, and there are no major geographical limitations to the service. The other parent is invited to take part in prenatal visits, but they are not offered separate appointments on their own. The other parent usually attends ultrasounds and at least the first prenatal appointment. According to a 2017 survey, the majority of the other parents attended at least one midwife appointment. Around 20% attended a single appointment and 70% attended several¹⁶. The Danish Men's Health Society has developed a website, "Father for Life" (www.farforlivet.dk), which offers insight and guidance on issues such as how to prepare for fatherhood and post-partum depression among fathers. Another resource is the "Far" ("Father") app, which was developed by the Danish Committee for Health Education (*Komiteen for Sundhedsoplysning*) for men during pregnancy and the first two years of the child's life.

The prenatal system is well-established, and the public is well informed about it, which ensures high levels of attendance. The GP is a family doctor who usually has a patient-doctor relationship with them already, so pregnant women do not enter a 'new' system for prenatal care but continue with the same GP and the midwifery service is added to their care. The Danish Health Authority has produced leaflets and

15. Sundhedsstyrelsen (2013). *Anbefalinger for Svangreomsorgen*. Retrieved September 14, 2020, from www.sst.dk/da/udgivelser/2015/anbefalinger-for-svangreomsorgen

16. Forum for Mænds Sundhed (2017). *Fædre og sundhedsvæsenet*. Denmark, 2017. Retrieved September 14, 2020, from <https://farforlivet.dk/wp-content/uploads/2019/01/F%C3%A6dre-og-sundhedsv%C3%A6senet.pdf> Copenhagen: Forum for Mænds Sundhed.

online resources about prenatal care in different languages for refugees and immigrants. A recent study by the Authority indicated that only in about 1 out of 2500 births had the mother never been to prenatal care¹⁷, and in the majority of these cases there were major social or psychiatric difficulties.

Prenatal services are supported by the Danish Health Authority's (*Sundhedsstyrelsen*) national guidelines¹⁸ and the Danish Healthcare Act (*Sundhedsloven*). The national guidelines were developed in 2009, but the section on postnatal care was partly renewed in 2013. The guidelines are based on international guidelines (e.g. NICE guidelines) and local expertise. They are currently under revision and updated guidelines are expected in 2021. Each of the five administrative regions in Denmark is responsible for healthcare in its area, including the implementation of clinical guidelines. The regions are required to develop a plan every four years on how they will manage prenatal care in their municipalities and submit to the Danish Health Authority for approval. There is no coordinated surveillance or training for healthcare providers to support or monitor adherence to the guidelines. Administrators at individual health clinics are responsible for the implementation of new practices.

The registration of standard information about prenatal care (foetus growth, blood pressure, etc.) is coordinated nationally. Maternity records are currently held separately by GPs and midwives, and each records progress in a file held by the expectant mother, who takes it to appointments. The records are then transferred to a national electronic log. However, developments are now underway to establish a national electronic system for pre- and postnatal care (i.e. pregnancy and the first eight weeks after birth). This new system will allow health professionals in different settings, such as general practice, hospitals and municipality services, to communicate with each other. It will also allow pregnant women to access parts of their files and communicate directly with health professionals. Midwives, GPs, health visitors (*sundhedsplejersker*), physicians and other professionals providing care to expectant mothers have access to maternity records.

Mental wellbeing and preparation for parenthood

Mental health and wellbeing are a routine part of prenatal care, and national guidelines include defined procedures on how to provide pregnant women with information on how to support their mental wellbeing. New clinical guidelines on prenatal care will include a stronger and more systematic focus on mental health and offer clearer instructions for healthcare providers on how to address it. The guidelines will also include a stronger focus on the other parent's mental health. The aim is to make the information more readily available and deliver it to expectant parents more systematically, to help both mother and the other parent to support their mental health during pregnancy. Danish municipalities also offer courses during pregnancy, primarily for first-time parents, to help them prepare for the parenting role. Furthermore, local councils can determine where health visitors should offer home visits in cases where there is a need for extra support, for example, because

17. Det nationale forsknings- og analysecenter for velfærd (2019). Skjult Graviditet: Omfang, årsager samt mulige forebyggelses- og informationsindsatser. Retrieved September 14, 2020, from www.vive.dk/media/pure/14424/3525884

18. Sundhedsstyrelsen (2013). Anbefalinger for Svangreomsorgen. Retrieved September 14, 2020, from www.sst.dk/da/udgivelser/2015/anbefalinger-for-svangreomsorgen

of disability, social circumstances or other challenges. Health visitors are nurses with additional training who work with health promotion and prevention at the community level. Some municipalities also collaborate with birthing centres to offer these visits to vulnerable women or families. Finally, in collaboration with the Health Authority and the Danish Association of Midwives, the NGO 'Committee for Health Education' (*Komiteen for Sundhedsoplysning*) has produced apps such as 'Pregnant', 'Baby' and 'Father', to help prepare for the parenting role where there is some focus on mental wellbeing. The apps cost DKK 10–25.

Risk factors in pregnancy

Prenatal services are divided into four levels to ensure the right care and referral regarding obstetric, social and mental health risk factors. The procedures for referral are described in the regional plans for pre- and postnatal care. Levels 1 and 2 are for normal pregnancies, and those who need some added support that can be provided by healthcare professionals in standard prenatal care. Level 3 is for pregnancies that need extended support, involving multidisciplinary collaboration with other professionals in the health sector and/or regional and municipal services. Prenatal care is offered at this level when there are more complex medical, social or psychological problems. Level 4 involves cooperation with specialized institutions that offer support for pregnant women with serious problems, such as substance abuse, serious mental illness and/or severe social difficulties, which predict potential difficulties in the contact between mother and child. The purpose of specialized efforts for vulnerable women at level 3 or 4 is to reduce the risk of obstetric complications, support the birth of a healthy baby and ensure a coordinated response to psychosocial issues or other difficulties so that preventive measures and early intervention can be initiated. If issues are solved, or if new problems arise, resulting in women needing care on another level, the plan and services offered during the rest of the pregnancy are revised.

According to national guidelines¹⁹, psychosocial difficulties (e.g. mental health difficulties, history of violence or trauma, alcohol or substance use) should be addressed at the first prenatal appointment with the GP and midwife, and again later in pregnancy. Women should also be asked about their work environment, housing, financial situation and relationship with their partner, including their partner's mental health and alcohol or substance use. At present, there is no nationally coordinated screening for risk factors in prenatal care, although some birthing centres use systematic methods to identify these issues among women giving birth. The aforementioned national registration system currently under development will also include a standardized list of questions about psychosocial difficulties that all pregnant women will be asked to answer online before their first prenatal visit.

For some expectant parents, social or psychological issues may call for additional interventions alongside routine prenatal care, both before and after birth. It is recommended that all pregnant women with special needs are offered a visit by a health visitor before birth. For more serious psychosocial problems, the obstetric

19. Sundhedsstyrelsen (2013). *Anbefalinger for Svangreomsorgen*. Retrieved September 14, 2020, from www.sst.dk/da/udgivelser/2015/anbefalinger-for-svangreomsorgen

ward establishes a cross-sectoral team with the municipality and other relevant parties. This interdisciplinary and intersectoral cooperation between healthcare providers and social services at municipal level is considered of the utmost importance when it comes to early efforts to ensure the child's health and wellbeing. Typically, this involves a collaboration between midwives, obstetricians, GPs, health visitors, mental health professionals (e.g. psychiatrists or psychologists), social services and specialized outpatient clinics for vulnerable families ('familieambulatorierne'). The family outpatient clinics were initially introduced as prenatal centres for alcohol and substance abuse problems but have developed into a wider resource that also includes mental health and social difficulties, domestic violence and other serious or complex issues that can cause problems for the unborn child and family. The clinics also assume the role of competence centres in the area of alcohol and substance abuse and their effects on young children.

Family outpatient clinics coordinate the efforts of different health and social services during pregnancy and beyond. At their core is an interdisciplinary team that collaborates to strengthen early, cohesive and holistic efforts for the pregnant woman, the child and the family. The team is at a minimum composed of a medical specialist, a midwife, a social worker and a psychologist. Family outpatient clinic services also include neonatologists to treat newborns for drug withdrawals symptoms, as well as social paediatricians and neuropaediatricians to monitor, support and treat children on a long-term basis. Social workers provide counselling and guidance relating to social issues and family law, and psychologists help with issues around adjusting to motherhood, attachment and understanding the child's needs. Psychologists also contribute to the team's overall assessment and recommendations, as well as providing crisis support for parents in connection to serious complications during pregnancy and birth, serious illness of the child or when a child has to be placed outside the home. During the neonatal period, psychologists also examine the newborn's behaviour and support early parental contact. In the ensuing years, they take part in the ongoing monitoring and care of the child at the family outpatient clinic, including neuropsychological testing.

The Healthcare Act states that there must be an interdisciplinary team in each municipality to accommodate children and young people with special needs. Furthermore, to coordinate services between sectors or different service levels, national guidelines recommend that each region and/or municipality should appoint a health professional as a contact person for each case, who coordinates the work and contact between services. In prenatal care, the contact person is usually the midwife. After birth, it will usually be a health visitor but can also be a social worker or other professional. The follow-up and continuity of these services is good. They are linked to prenatal care through GPs, midwives, health visitors and social workers, who are responsible for follow-up and continuity. Where there are severe problems, paediatricians are already involved in early pregnancy, and this ensures continuity from prenatal care to the handling of possible health problems after birth. Social workers have the role of maintaining an overview of the overall need for support and the consistency of services, as long as problems persist.

Mental health difficulties

Risk factors should be assessed at the first prenatal appointment. The Edinburgh

Postnatal Depression Scale (EPDS) has not been validated for use during pregnancy in Denmark but is administered in some municipalities around gestational weeks 24–28. If problems arise concerning the mental health of expectant parents, primary care can offer services from GPs, health visitors, social workers, pedagogues and other professionals depending on the problem at hand, although services may differ between municipalities. If needed, GPs or obstetricians can also send referrals to secondary care, for example, psychologists or psychiatrists. Psychological services are not part of primary care and are not free of charge unless they are arranged via referrals from a GP, which are only made under certain circumstances (e.g. serious illness, violence, trauma, death of a family member or significant clinical problems). If a pregnant woman or new mother experiences mild depression or anxiety, it will thus not warrant a referral, and in such cases she would need to seek private psychological services, for which a fee is charged. Vulnerable families may be referred to a specialized team at a hospital maternity unit for milder problems or, if necessary, the aforementioned family outpatient clinics. As has been mentioned, home visits from health visitors can also be offered during pregnancy when women are experiencing mental health difficulties and, when needed, social services are informed and involved. Social services may also refer women to psychologists within the municipality, in which case the service is free of charge.

There is no specific referral route for the other parent's mental health, but they receive the same service as the general public. They can be referred to a psychologist or psychiatrist by GPs or obstetricians if warranted, according to the aforementioned conditions. Family outpatient clinics can also handle the other parent's mental health, and home visits can be used to support their mental health and wellbeing. These services are mostly free of charge, as is all general healthcare in Denmark except psychological treatment. There can be waiting lists for psychological or psychiatric services or other specialized services at hospitals, but not if problems are urgent. Mostly, however, pregnant women are a prioritized group and would not have to wait for services.

Social difficulties

For some expectant parents, there may be social or psychological issues that require social interventions along with healthcare – both before and after birth. Special support and care for children and their parents are regulated through the Danish Act on Social Services²⁰. If social problems arise during pregnancy, the GP, midwife, health visitor or birthing centre are obliged to refer expectant parents to municipal services and notify the local council. Municipalities are responsible for social services and have a general obligation to monitor the living conditions of children and young people, including unborn children, in the community. According to the Act on Social Services, all healthcare professionals have a duty to notify local councils if they become aware of or have reason to assume that a child or young person under 18 years old may need special support, for example, due to their parents' circumstances²¹. As part of their early preventive work for children, Danish municipalities must provide free, family-oriented counselling for family difficulties,

20. Serviceloven LBK nr 798 af 07/08/2019. Retrieved on September 14, 2020, from www.retsinformation.dk/eli/ta/2019/798

21. Serviceloven LBK nr 798 af 07/08/2019. Retrieved on September 14, 2020, from www.retsinformation.dk/eli/ta/2019/798

including for expectant parents. Municipalities must also offer various preventive procedures, such as family-focused interventions, social networking, support groups and other interventions aimed at preventing family difficulties. If a municipality assumes that an unborn child will need special support immediately after birth, the parents' circumstances must be examined, and the municipality has a legal responsibility to offer the child or family social interventions according to their needs. Social interventions can range from preventive efforts to the placement of the child in foster care. Specific resources will depend on the needs of each particular child or family. Social services are free of charge, and usually there is no waiting list for resources.

Relationship difficulties

If indicators of relationship problems arise during pregnancy, GPs, midwives and other health professionals can guide expectant parents to a psychologist in secondary care for couples therapy. Early intervention couple or family counselling, e.g. for mild communication problems or disagreements, is available for a fee in private practice. For more serious problems that pose a risk to the wellbeing of child and family, municipalities must by law provide free, family-oriented counselling as part of their preventive work for children. This also includes expectant parents. The offer must be open and anonymous, meaning that there is no pressure to accept it, and parents can request that no information be registered about the appointment. This is done to avoid stigma and increase the likelihood that the counselling will be accepted. Family counselling can also be part of social services where a child or family has a special need for help, in which case the offer is not anonymous.

If relationship problems affect the wellbeing of the child, municipalities are obliged to conduct an examination of the child's circumstances and take social measures in line with the needs of the child. If this brings to light a need for special support, the municipality must provide assistance in accordance with the needs of the child. This can be in the form of practical, educational or other support at home, family therapy, family daycare or a regular contact person to support the child.

Alcohol and substance abuse

The Danish Health Authority recommends using the TWEAK scale to screen for alcohol use in prenatal care, in addition to a short locally developed questionnaire. This should be done at the first prenatal visit, but it is not done systematically. If pregnant women have problems with alcohol or substance use, they are referred to specialized prenatal care in the regional family outpatient clinic. Family outpatient clinics offer substitution treatment (e.g. methadone) as well as rehabilitation after detoxification, which includes specialized help with physical and socioeconomic issues and comorbidities that can endure after prolonged alcohol or substance abuse. The treatment is free, and there are no waiting lists. Referrals can come from GPs, midwives, obstetricians, health visitors or social services, but pregnant women can also attend the clinics without referral. The other parent can also receive counselling at family outpatient clinics for their alcohol or substance use.

According to the Danish Act on Social Services and the Healthcare Act, all

municipalities are obliged to offer alcohol or substance abuse treatment to both pregnant women and their partners. They are responsible for guiding and referring people with alcohol or substance use problems to a treatment centre and offer additional help if needed, such as housing assistance. Treatment must be offered and initiated within 14 days from the person's first enquiry and must be based on individual needs. Thus, treatment can vary in both intensity and therapeutic approach. In general, there are three categories with different intensity levels: outpatient treatment, day treatment and inpatient treatment. According to the Act on Detention in Substance Abuse Treatment, municipalities must offer pregnant women in inpatient care a voluntary contract with a detention option. If they enter into the contract, it allows treatment centres to detain them against their will under certain conditions when less intrusive measures prove inadequate. The women can withdraw from the contract at any time, as long as the conditions for detention are not met. If they decide not to enter into such a contract, they will still have complete access to treatment.

The alcohol and substance abuse treatment offered by regions and municipalities is free of charge. Availability depends on the severity of the case and the number of people in need in different regions and municipalities, but treatment must be initiated within 14 days from the person's first enquiry. A person offered treatment can also choose to use another public or private treatment centre, in which case the 14-day deadline does not apply. GPs, midwives, health visitors and social workers are responsible for the follow-up and continuity of services and linking them to prenatal care. As described earlier, substance abuse in pregnancy is always managed in an interdisciplinary manner with social workers who maintain an overview of the overall support needs, consistency and continuity of support. In such cases, paediatricians are also involved in early pregnancy to ensure there is continuity from prenatal care to the handling of any health problems the child has after birth.

Violence and trauma

According to national guidelines, during prenatal care, all women should be asked about violence, not just once but repeatedly, as it may take some time to build enough trust for them to open up about such matters. Women should be asked about any history of incest, rape, torture and adverse childhood experiences. According to the Danish Act on Social Services, healthcare providers are obliged to inform the municipalities if pregnant women are exposed to violence and trauma. Expectant parents with a history of violence or trauma should be offered services and assistance in accordance with the Act on Social Services, the Health Act and the Executive Order on Preventive Healthcare for Children and Young People. This can include extended counselling and, if needed, further psychological assessment and treatment. The service is mostly free of charge and has no major geographical limitations or waiting lists. The healthcare provider (GP, midwife, social worker, etc.) who initiates the treatment or services is responsible for the follow-up; and a contact person at a regional or municipal level, as previously mentioned, links the municipal services to prenatal care.

Municipalities in Denmark are legally obliged to provide women's shelters where women can be granted temporary residence, possibly with their children, in cases of violence or threats of violence. Women's shelters are usually open around the clock and have trained staff who provide counselling and support, as well as volunteers

assisting in day-to-day work. The women's shelters offer protection, security, emergency support and guidance on social and practical issues, such as housing, finance, employment, education, daycare, healthcare, and so on. Children who accompany their mothers to the shelters have a legal right to psychological treatment, and legislation is being drawn up to ensure that psychological treatment is available for the women as well. GPs, midwives, social workers and other professionals in healthcare and social service may refer pregnant women to a women's shelter, but they can also go there by themselves. As a general rule, women pay a small amount towards the costs of their stay, but they would not be denied access for financial reasons. The availability of women's shelters varies across the country, but usually there are no waiting lists.

Infant and child healthcare

Similar to the prenatal system, infant and child healthcare (ICH) in Denmark is managed by GPs at the regional level and by health visitors in primary care at the municipal level. Despite GPs and health visitors operating at different levels of management, child healthcare services are well-coordinated, and families usually see the same health visitor and GP throughout the child's infant and toddler years. According to Danish law^{22 23}, children must be offered preventive health examinations at GPs' clinics at the ages of five weeks, five months, 12 months, and two, three, four and five years. During the child's first year, health visitors in infant and child healthcare (ICH) provide their services almost exclusively through home visits, and some municipalities offer home visits during the toddler years as well. Cooperation with pedagogues in daycare centres may also offer further guidance to parents. The Danish Health Authority recommends there should be five or six home visits during the child's first year²⁴, but each municipality is free to decide the number (anywhere from two to eight) and these are supplemented with group activities at the health visitor's office. It is optional for municipalities to offer visits and group activities after the first year. Vulnerable families are entitled to more visits, and these can be extended for as long as needed. Often, these families have already been identified in prenatal care and will continue to get the supportive services they received during pregnancy after the baby is born.

Registration into the infant and child healthcare (ICH) system happens automatically at birth. The service is voluntary, and statistics show that 98–99% of families in Denmark accept home visits during the first year. The first visit takes place between two and seven days after the family has returned home from hospital after the birth. If the family stays in hospital for less than 72 hours, the health visitor will make sure to make a home visit by day five at the latest to check up on breast- or bottle-feeding and the wellbeing of the mother and newborn. If the mother or baby need services before the first home visit happens, the family can contact the maternity unit through a 24/7 hotline or contact the health visitor in primary care to seek advice or ask for an earlier visit. Women receive specific counselling and training regarding breastfeeding, during pregnancy, at the hospital maternity unit and during home visits. Telephone consultation is also available, but personal counselling and

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22. Sundhedsstyrelsen (2011). Vejledning om forebyggende sundhedsydelse til børn og unge. Retrieved September 14, 2020, from www.sst.dk/da/Udgivelser/2011/Vejledning-om-forebyggende-sundhedsydelse-til-boern-og-unge
 23. Sundhedsloven LBK nr 903 af 26/08/2019. Retrieved September 14, 2020, from www.retsinformation.dk/eli/lta/2019/903
 24. Sundhedsstyrelsen (2011). Vejledning om forebyggende sundhedsydelse til børn og unge. Retrieved September 14, 2020, from www.sst.dk/da/Udgivelser/2011/Vejledning-om-forebyggende-sundhedsydelse-til-boern-og-unge

training is the norm. Although ICH services are voluntary, health visitors will contact social services if they are worried about a family or cannot make contact with them. Parents receive reminders regarding vaccination, and if they repeatedly fail to show up for appointments or cannot be contacted, obligatory notifications are issued in line with the Danish Act on Social Services. The ICH services are free and accessible and are available in any language the mother or family prefers.

Danish national guidelines for infant and child healthcare were issued by the Danish Health Authority in 2011²⁵. These were developed based on international guidelines, such as the NICE guidelines, local expertise and the Danish Healthcare Act, and are scheduled to be revised from 2021. Similar to the prenatal guidelines, it is the responsibility of each municipality and region to implement ICH guidelines, but there is usually no routine training for health visitors regarding implementation in clinical practice. The guidelines call for the registration of standardized information, such as the child's growth and development, but currently there is no coordinated system to ensure this or monitor whether it is done. As in the prenatal system, GPs and health visitors have their own ICH records, and they need parental consent to exchange information.

Children's emotional wellbeing

During routine home visits, health visitors offer parents information about the child's healthy social and emotional development and how to support it. There are no defined procedures for giving such information – although national guidelines for infant and child healthcare offer an indication – and there is no system to monitor whether it has been done. There are also booklets and online resources for parents on how they can support their children's wellbeing and emotional development, such as the "Healthy Children" booklet published by the Danish Health Authority.

Children's social-emotional development is one of the main topics that health visitors discuss with parents during home visits and at GP examinations, where certain developmental milestones are also monitored. At the moment, there are no systematic, national measures available for monitoring children's behaviour for signs of age-appropriate social and emotional development during routine visits. However, a standardized evaluation scale to aid health visitors in identifying emotional problems and mental vulnerability in infancy (*Psykisk Udvikling og Funktion*, PUF) has recently been piloted in 17 municipalities across Denmark and is now ready for widespread implementation. Evaluating children's emotional development is also part of the overall assessment of the child's wellbeing and its interactions with parents via the Alarm Distress Baby Scale (ADBB) used by most municipalities to monitor parent-child attachment. The ADBB is a systematic and standardized method to detect persistent social withdrawal as an indicator of emotional distress in infants and young children.

25. Sundhedsstyrelsen (2011). Vejledning om forebyggende sundhedsydelse til børn og unge. Retrieved September 14, 2020, from www.sst.dk/da/Udgivelser/2011/Vejledning-om-forebyggende-sundhedsydelse-til-boern-og-unge

Parents' emotional wellbeing

Health promotion and parental mental wellbeing are topics that are routinely raised by health visitors during home visits and by GPs at periodic health examinations. Many municipalities also administer the EPDS scale to screen new mothers, or both parents, for post-partum depression during home visits. Furthermore, national ICH guidelines include sections on mental health after birth. Currently, however, there is no system to assess if and how these issues are addressed in ICH, but evaluation methods are being developed to ensure a more systematic focus on this. As with prenatal care, if there are concerns about a parent's mental health or social circumstances, the GP or health visitor can refer them to psychological services, social support and other appropriate departments.

To support parental wellbeing after birth, parent groups are also facilitated by health visitors throughout the country. These supplement home visits and offer a venue for new parents to learn more about the parenting role, get support and establish social contact with other parents. The groups are free of charge and managed by health visitors, who meet the groups regularly to discuss topics such as child development, the parenting role, emotional bond with the baby and mental wellbeing. The groups are often formed around factors that the parents have in common, such as being a young parent, being a first-time parent, having premature babies or twins, and so on. Sometimes there are also special groups for fathers.

Family wellbeing

Municipalities can offer counselling and help with common issues in parenting or family life, such as marital problems, upbringing and communication in the family. As stated before, municipalities are also legally obliged to provide free, family-oriented and anonymous counselling and interventions for family difficulties. Family centres are not widespread in Denmark but a model called "Familiens Hus" (family house), which draws on the Nordic family centre model, has been implemented in two municipalities. Family houses offer courses in prenatal care, preparation for the parenting role, guidance and training in establishing a healthy emotional attachment with the baby, employment and educational counselling, and so on. It is a free, low-threshold service that is accessible to all parents. Midwives, health visitors, social workers and employment counsellors work in the family house, and there is easy access to them. The staff also guide and support parents if they need counselling from other services, such as social services, and collaborate with ICH and other relevant entities. Different types of family centre can also be found in other Danish municipalities, often established to meet local needs.

Parenting skills

According to national guidelines for infant and child healthcare, all parents should be given information about the importance of emotional bonding and guidance on establishing a healthy attachment with their child. The guidelines include suggestions about what subjects to focus on and what questions to ask during home

visits, but there is no monitoring of whether this is done. However, health visitors are well aware of the importance of this topic, and it is one of the main purposes of their home visits. During home visits, health visitors offer practical advice and personal training through modelling and feedback. As previously stated, most municipalities administer the Alarm Distress Baby Scale (ADBB) to monitor parent-child attachment between the ages of two months and 24 months. Health visitors administer the scale and are certified to use it.

If there are problems with attachment and parenting, there are courses that can be offered, but health visitors in primary care decide what approaches to use. Courses include Marte Meo, which is a video-based approach based on the principles of development-supportive communication, the International Child Development Programme (ICDP) and the Circle of Security Parenting (COS-P), which is a treatment approach aimed at promoting a positive and secure relationship between child and parent. COS-P is primarily for parents with children aged 0–5 who are at risk of developing, or have already developed, attachment difficulties.

The Danish Health Authority also recommends that hospital maternity wards offer birth and parenting courses to expectant and new parents in collaboration with health visitors in primary care. However, these resources can vary widely in quality and intensity. Some municipalities offer courses to all expectant and new parents, some only offer special courses to parents at risk and some small municipalities (e.g. the small islands Ærø, Langeland and Fanø) do not have enough parents in the target group to offer a course. The courses can be standardized programmes (e.g. COS-P, ICDP or Marte Meo) or locally developed resources. The topics that are typically covered include emotional attachment, building a positive relationship with the baby and reading the baby's needs. The courses are usually led by health visitors, sometimes in collaboration with family therapists (e.g. when parents are at risk). Techniques involve mentalizing (i.e. understanding one's own and the baby's feelings, behaviour and needs), reflective responding, role play, vignettes and group discussion.

Parental skills training is usually part of general primary care or social services rather than the infant and child healthcare system. For the most vulnerable parents, someone from primary healthcare (the GP or health visitor) will make a referral to social services, who will ensure that there is continuity of services for the family. Social services can offer parenting courses for children at risk, such as Minding the Baby, the Incredible Years, or locally developed programmes. There is no national competence centre to guide the choice of programmes, so it is up to each municipality to decide what programmes to offer, provide staff training and evaluate effectiveness.

Risk factors in the early years

Danish municipalities use different methods to identify children with, or at risk for, psychosocial difficulties. Some methods are locally developed while others are established measures that have been documented and evaluated, such as the Alarm Distress Baby Scale (ADBB), Psykisk Udvikling og Funktion (PUF) and "Opsporingsmodellen", a systematic approach for the early detection of children in vulnerable situations. There are also standardized questions and screening methods

that are used in ICH to identify psychosocial difficulties among parents, including the EPDS and the Gotland Scale for postnatal depression. If problems arise that are outside the scope of the service provided by ICH or primary care, the previously mentioned interdisciplinary team will be involved.

There are predefined risk groups in Danish infant and child healthcare, such as parents with alcohol or substance use problems, parents affected by a severe crisis, parents without a social network, parents with mental illness and parents who themselves have experienced severe neglect or traumatizing events in their upbringing. Predefined child risk groups are children who are born prematurely, children with disabilities (e.g. Down's syndrome, autism, physical disabilities) and adopted children. Vulnerable parents and children (regardless of whether they are in a predefined risk group or not) get extra support according to their individual needs. This can be extra home visits from health visitors for milder problems, or, for more significant difficulties, specialized care such as the previously mentioned family outpatient clinics or other relevant services.

If municipalities have a reason to assume there is a need for special support for a child, they must conduct an examination to identify the need for support and, if the examination reveals such a need, provide assistance in accordance with the needs of the child. According to the Social Services Act, there is a stricter notification obligation for health professionals, which means that they must notify the local council if they become aware of or have reason to assume that a child may need special support (e.g. due to the circumstances of the parents). The obligation to provide information to the municipality applies in all cases where the healthcare professional (e.g. the GP, midwife or health visitor) becomes aware of parents or future parents with difficulties of a nature that gives reason to assume that the child will need special support. Support can be in the form of practical, educational or other support at home, family therapy, family daycare or a contact person to support the child. Danish Health Legislation ensures that parents and children at risk receive the services for which they are eligible. For example, children who have been exposed to alcohol and/or drugs in utero are followed up by paediatricians and neuropsychologists at the regional family outpatient clinic until they reach school age.

Coordination of support and resources is considered essential. Thus, according to Danish law, a healthcare professional must be appointed as a contact person who will act as a coordinator between service providers in cases where support is provided by several service systems in the region or municipality. Municipalities have implemented various different models for this intersectoral collaboration in early preventive work. In these models, municipal representatives working in the area of vulnerable children and families (e.g. social workers) collaborate with professionals working with the children and parents in other arenas such as daycare centres, including health visitors, psychologists and family therapists. The social worker handling the case decides, in collaboration with the parents, the parents' social network and the network of professionals in contact with the family, which interventions to choose. All professionals are responsible for informing social services when they are concerned about a child and collaborate with them. According to the Act on Social Services, schools, nurses, doctors, dentists and other health professionals employed in municipal health services, and the police, daycare providers and authorities working in the area of vulnerable children can exchange

information on private matters concerning a child and family if the exchange is deemed necessary as part of early or preventative collaboration on vulnerable children and the prevention of abuse.

Mental health difficulties

Mental health and general health promotion are among the main topics discussed at the GP's office and during home visits by health visitors. In some municipalities and some GP offices, all new mothers are screened with EPDS for postnatal depression. The other parent is sometimes screened as well via the Gotland Scale. If problems are identified, health visitors can offer extra home visits for milder cases, or parents can seek psychological assistance in private practice. If problems are clinically significant, municipalities can offer family counselling or psychological services (PPR) in secondary care through referrals from health visitors or GPs. There are also treatment options available for free on the internet.²⁶ If the problems are more severe, parents can be referred to a psychiatrist in secondary care, or hospitalized if needed. The follow-up and continuity of mental health services in Denmark usually function well, apart from the fact that psychological services for milder or subclinical problems are generally not offered in primary care.

Social difficulties

Municipalities have a general obligation to offer social resources for parents and children, such as counselling and assistance regarding financial matters, housing, and so on. The services are free of charge, and there is usually no waiting list. However, municipalities are free to decide what type of service they offer, as long as it is in accordance with the needs of the child. They are responsible for following up on the special needs of vulnerable children and families and adjusting the services offered in accordance with the best interests of the child. Municipal councils are also obliged to draw up a child policy designed to secure cohesion between general and preventive work, as well as targeted measures aimed at children and young people in need of special support.

Social services are linked to ICH on a referral and need basis in accordance with the provisions of the Danish Social Services Act on Support for Children and Young People with Special Needs. For the most vulnerable parents, professionals in primary care (GPs or health visitors) will make referrals to social services, who will ensure that there is continuity of services for the family. If there is a need for specific collaboration with the ICH, regular network meetings will be established between the parties involved, and a contact person will be appointed to coordinate the services, as previously described. As part of their early preventive work for children, Danish municipalities must provide free, family-oriented counselling for family difficulties. They must also offer preventative interventions, such as networking, support groups or other interventions aimed at preventing family difficulties. If the difficulties of the child or family cannot be solved with social intervention within the home, the child can be placed outside the home in foster care.

All municipalities have a social or family division that is responsible for child

26. Internetpsykiatrien (n.d.). Retrieved on November 4th 2020 from www.internetpsykiatrien.dk/wm507341

protection services, and social services offer different levels of support to vulnerable children and families. In certain circumstances, it may be relevant for the municipality to consider removing the child from the home to ensure his or her health and development. Social services are free of charge, except in cases where children are placed outside the home. In such cases, parents have to contribute to the costs of the placement as a percentage of their income.

Relationship difficulties

As previously stated, municipalities are obliged to provide free, family-oriented counselling and other resources for family difficulties, such as home support and building a social network around the family. Family counselling is usually only offered in cases where there are severe difficulties. The offer must be open and anonymous; there should be no pressure on the parents to accept, and they may request that no information is recorded about the appointment. In ICH, GPs and health visitors can also refer parents to psychologists in secondary care where they can be offered couples therapy when applicable. However, preventative or early intervention couples or family counselling (e.g. for mild communication problems or disagreements) are only available in private practice, for a fee.

Alcohol and substance abuse

Systematic screening for alcohol and substance abuse is not a routine part of infant and child healthcare in Denmark, but health visitors, GPs and other professionals in contact with the family still maintain a focus on problematic consumption after the child is born. Guidelines ("Vejledning om forebyggende sundhedsydelse til børn og unge")²⁷ recommend that parents are asked systematically about this in infant and child healthcare. When problems with alcohol or substance use are identified in ICH, primary care staff can refer parents to treatment services and social assistance. As previously stated, according to the Danish Act on Social Services and the Health Act, municipalities must provide alcohol and substance abuse treatment to both the mother and partner within 14 days of the first enquiry. Alcohol and substance abuse treatment is generally free of charge. The treatment has to be based on individual needs, and thus it may vary in intensity and method. Municipalities are also required by law to offer additional help if needed, such as housing assistance. In secondary care, as previously mentioned, family outpatient clinics for vulnerable families offer long-term follow-up for families and children exposed to alcohol or drugs during pregnancy. The follow-up and continuity of services for alcohol and substance abuse are generally good in Denmark, and the services are linked to ICH through GPs, health visitors and social workers.

Violence and trauma

There is no systematic screening for violence in infant and child healthcare, but health visitors and GPs should maintain a focus on this and respond if they notice any signs of violence or trauma. Guidelines also recommend that parents are asked

27. Sundhedsstyrelsen (2011). Vejledning om forebyggende sundhedsydelse til børn og unge. Retrieved September 14, 2020, from www.sst.dk/da/Udgivelser/2011/Vejledning-om-forebyggende-sundhedsydelse-til-boern-og-unge

systematically about violence and trauma. Resources for violence are part of both the healthcare system and social services (e.g. family therapy or home support). In primary care, referrals can be made to crisis centres; and specialized services in secondary care and university hospitals (tertiary care) offer highly specialized treatment for abused children. According to the Danish Act on Social Services, there is a stricter notification obligation for health professionals, which means that they must notify the local council if they become aware, or have reason to assume, that a child may need special support, for example, due to the circumstances of the parents or violence in the home. If there is any knowledge or suspicion that a child has been subjected to physical, psychological or sexual violence, and when police or hospital services are involved in the case, it is mandatory for municipalities to use a "Børnehus" ("children's house") for the child protection examination. In the "children's house", relevant authorities are brought together to ensure a high-quality, coordinated and multidisciplinary examination in cases of abuse. The relevant authorities coordinate examinations so that the child avoids having to repeat the report of abuse in several different settings, and all parties (e.g. police, social workers and psychologists) are specially trained in talking to children about abuse.

Parental leave

In Denmark, the right to maternity leave (of four weeks before the birth and 14 weeks after the birth) and paternity leave (of two weeks) is stipulated in the Act on Parental Leave. After the first 14 weeks, parents each have an individual right to parental leave of 32 weeks (a total of 64 weeks). During leave, parents are entitled to state benefits if they meet the employment criteria. The full benefits in 2020 amount to DKK 4,405 per week, and parents are entitled to a total of 52 weeks of benefits per child. The mother receives state benefits for four weeks before and 14 weeks after the birth, and the father or other parent receives two weeks of benefits at the birth. Both parents have the right to share the 32 weeks of parental leave benefits, which are flexible in the sense that they are free to divide them up as they see fit. Note that the right to parental leave is longer than the right to benefits. If the parents are unemployed and receive social security benefits, they will remain on these benefits during the leave. Parents may also have a right to be paid by their employer during parental leave, and this will be determined by their collective bargaining agreement or individual contract. Recent amendments to the Danish Act on Day-Care also allow parents to receive a subsidy if they mind their own children from the age of 24 weeks instead of them attending daycare.

Early childhood education and care

All children have a right to early childhood education and care (ECEC) from the age of 26 weeks until they start compulsory school. Thus, there is continuity between the end of parental leave and enrolment in daycare, which can either take place at home daycare ("dagplejemor") or in daycare centres ("vuggestue"). The child's right to daycare is protected by law. About 90% of 1–2-year-old children in Denmark attend ECEC. The average age of children when they are enrolled in home daycare is 9.7 months; the average age is 10.7 months for children who are enrolled in daycare

centres. Most attend daycare centres, and only 34% of 0–2-year-olds attend home-based provision. The Education Office within each municipality is responsible for providing and organizing ECEC in accordance with the Danish Act on Day-Care, which includes both home daycare and daycare centres.

Home daycare

Home daycare in Denmark is regulated by the Danish Day-Care Act and supervised by municipalities at local level. Each childminder is allowed to have a maximum of five children enrolled, but if two collaborate, they can be responsible for a maximum of ten children. There are no formal educational or training requirements for childminders in home daycare, and they are not provided with specific training. However, many different courses and continuing education (CE) opportunities are available to them for free, including at evening school. Childminders in home daycare also work under the supervision of the municipality's pedagogues, who meet with them regularly, offer professional guidance and make visits to the home daycare.

All ECEC facilities, home daycare included, are obliged to promote children's wellbeing, learning and development through safe and secure pedagogical learning environments, in which play is essential, and there is a focus on the child's perspective. Childminders in Denmark follow a curriculum and often collaborate within a local area so that the children get the chance to meet and play with a larger group of children. This system also allows childminders to share responsibility; for example, children can attend another home daycare if their own childminder is sick. It is the responsibility of the municipality to ensure the quality of home daycare.

Daycare centers

Daycare centres in Denmark are a part of the education system within municipalities, which are responsible for monitoring pedagogical activities and ensuring they are of high quality as per the Daycare Act²⁸. As previously stated, all ECEC facilities are obliged by law to promote children's wellbeing, learning and development through safe and secure pedagogical learning environments, in which play is essential, and there is a focus on the child's perspective. There is a significant focus on children's social-emotional development in daycare. Daycare centres are required by law to have a written pedagogical curriculum for 0–2-year-old children that is based on the common pedagogical foundation in the National Curriculum. The National Curriculum has six main themes: 1) versatile personal development; 2) social development; 3) communication and language; 4) body, senses and movement; 5) nature, outdoor life and science; and 6) culture, aesthetics and community. Among other things, these themes support children in developing social-emotional competence through play, such as the ability to cooperate, develop friendship and show empathy.

Around 59% of staff in daycare centres are university educated pedagogues. The preference would be to have at least 75% of staff with pedagogic training, but it is

28. Dagtilbudsloven LBK nr 2 af 06/01/2020. Retrieved September 14, 2020, from www.retsinformation.dk/eli/lt/a/2020/2

not a legal requirement. Municipalities are responsible for hiring ECEC staff who are considered competent and qualified, but otherwise there are no defined educational requirements for them. The mean salary for full-time, pedagogically trained ECEC staff is DKK 35,461 per month, which is 84% of the national average wage (DKK 42,169). According to the 2018 TALIS Starting Strong report²⁹, the majority of ECEC staff in Denmark are satisfied with their jobs, but not their salaries. Lack of resources and extra administrative work are considered major sources of stress in daycare and, according to daycare administrators, inadequate funding and resources are primary barriers to effectiveness.

There is no child-staff ratio regulated by law in Denmark, but the national average is 1:3.1 for 0–2-year-olds³⁰. However, political agreement has been reached that, as of the year 2025, the minimum child-staff ratio in daycare centres will be 1:3 for children aged up to two years and 10 months. On average, children aged 0–5 attend for 7.5 hours per day, but there are regional variations³¹. According to the 2018 TALIS report, the average number of children in daycare centre groups for the ages of 0–3 years is 12. This is generally considered too large by the staff, who suggest reducing group size by recruiting more staff as a top funding priority.

Social and emotional development

The head of daycare is responsible for evaluating the activities of the pedagogical curriculum at least every other year. These activities should promote children's development, wellbeing and learning, including social and emotional skills. A revised and strengthened pedagogical curriculum was issued in 2018 that has a strong focus on social and emotional development among the youngest children in daycare, and this plays an essential part in the activities in daycare. All daycare facilities must incorporate the elements of the curriculum and the pedagogical foundation in their work. Some daycare centres have implemented specific social-emotional learning (SEL) programmes, such as "Fri for mobberi" ("Free from bullying"), which promotes positive interaction, empathy and cooperation in young children to prevent the development of negative peer relations and bullying. However, many centres organize their SEL activities based on the national curriculum in general, without specific programmes. In collaboration with the Danish Evaluation Institute, the Danish Ministry for Children and Education has developed a lot of different materials and training courses on implementing and working with the pedagogical curriculum, and these support its implementation and effectiveness.

Collaboration with parents

Daycare centres, as well as childminders in home daycare, are required to cooperate with parents in providing care, supporting the wellbeing, learning and development of all children, and contributing to a positive and safe childhood. Thus, an emphasis is placed on close collaboration and communication with parents, both for individual children and in general through parental boards. Daycare administrators are responsible for establishing a parental board for each centre that, by law, must be involved in the writing, evaluation and follow-up of the centre's pedagogic

29. OECD (2018). Denmark – Country Note – TALIS Starting Strong 2018 Results. Retrieved September 14, 2020, from www.oecd.org/education/school/Country_Note_Denmark.pdf

30. Børne- og Ungdoms Pædagogernes Landsforbund (BUPL) (n.d.) Retrieved September 14, 2020, from <https://bupl.dk/>

31. Børne- og Ungdoms Pædagogernes Landsforbund (BUPL) (n.d.) Retrieved September 14, 2020, from <https://bupl.dk/>

curriculum.

Collaboration with other services

To a certain extent, there is local autonomy within regions and municipalities in terms of collaboration with other services, such as healthcare and social services. Different municipalities may have different routes to facilitating and organizing collaboration across systems, different ways to handle communication and dialogue between systems, and different ways to exchange knowledge and support at the local level. All daycare centres have access to psychological school services, known as "pædagogisk psykologisk rådgivning" (PPR), and to health visitors they can turn to for support and guidance, both for the children themselves and for daycare staff, to help them support the child. According to the 2018 TALIS report, over 20% of daycare administrators in Denmark indicate that their centre includes 11% or more children with special needs. ECEC staff rank training to work with children with special needs as a key priority for professional development.

When concerns arise about the mental, physical or social development of a child, the emphasis is on discussing these concerns with the parents unless they relate to the parents themselves (e.g. in cases of abuse). If necessary, other services, such as PPR, healthcare or social services are contacted. There is a strong requirement for ECEC staff to contact social services if they are concerned about the wellbeing and safety of a child, and there are recorded procedures in daycare centres on how to respond to signs of social or emotional distress among young children. If needed, network meetings between different sectors are organized as part of general cross-sectoral collaboration. Furthermore, in an effort to increase cross-sectoral collaboration, pilot projects are currently being undertaken in 21 Danish municipalities. These involve health visitors performing examinations of children at 1½ and three years of age in the form of home visits, and strengthening cooperation with pedagogues in daycare. This is being done both for children in general and for children and families with special needs, who can be offered a programme such as COS-P, or other resources in the municipality.



Finland

Prenatal care

In Finland, municipalities provide prenatal care and infant and child healthcare (ICH) via an integrated system, either as a separate or combined service. Usually, prenatal and ICH services are located in the same building as general primary care, albeit in separate clinics called *neuvola*. The key professional team in prenatal care consists of GPs and public health nurses, and most of the contact is with the public health nurse. Some public health nurses are also trained midwives. The aim is to offer consistency of care with the same professionals taking care of the family throughout pregnancy via a "personal nurse" model. When prenatal and ICH services are combined, the family sees the same public health nurse during the pregnancy as well as after the child is born.

The first prenatal visit should preferably be during the planning of a pregnancy, especially if there is a need for genetic counselling, but is usually around gestational weeks 8–10. Expectant parents typically have two visits with a GP and at least 8 with a public health nurse or midwife (9 for first-time mothers), with the need for additional visits assessed throughout the pregnancy. Ultrasound examinations take place at the prenatal clinic between weeks 10–14 and 18–22 (or after 24 weeks), and optional foetal screenings are offered between weeks nine and sixteen^{32 33}. It is recommended that all first-time mothers get a home visit during the pregnancy (at weeks 30–32) and within approximately one week after childbirth (with the need for additional visits continuously assessed) but there may be regional variations to the extent to which these have been implemented. Immigrant families who are expecting their first child born in Finland can also be considered first-time parents. Tailored care is offered to ensure that the service is accessible to all, by giving information and communicating in different languages or alternative formats (e.g.

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32. Klemetti, R. & Hakulinen-Viitanen, T. (Eds.) (2013). *Äitiysneuvolaopas. Suosituksia äitiysneuvolatoimintaan*. Terveystieteiden tutkimuskeskus ja Hyvinvoinnin laitos, Helsinki. [Maternity clinic's guide. Recommendations for maternity clinics, Finnish Institute for Health and Welfare]. Retrieved September 18, 2020, from https://www.julkari.fi/bitstream/handle/10024/110521/THL_OPA2013_029_verkko.pdf
33. Ministry of Social Affairs and Health. Prenatal screening in Finland. Retrieved September 18, 2020, from <https://stm.fi/en/prenatal-screening>

braille, large font or audio recordings), and offering interpreter services and additional or extended visits in the case of disability or other challenges. Statistics on prenatal visits can be compared with the information in the Medical Birth Register³⁴, which shows that less than 1% of families do not attend prenatal services before childbirth.

A unique part of the Finnish prenatal system is the extensive health examination performed by a GP and public health nurse or midwife in week 13–18 of the pregnancy^{35 36}. This examination, which includes the health and wellbeing of the entire family (i.e. both parents and siblings) focuses on the parents' medical history, their relationship, communication within the family, socioeconomic status, parental childhood experiences, history of trauma and risk factors such as alcohol consumption. A similar extensive health examination is performed after the child is born, at age four months and again at 18 months. There is an emphasis on including both parents in prenatal care so the other parent is invited to all prenatal visits; national guidelines recommend offering the option of evening appointments to make it easier for the other parent to attend. However, certain issues (e.g. domestic violence) are only discussed privately with each parent. The exact percentage of fathers or other parents attending prenatal care is unknown but at least 60% attend the extensive examination.

Prenatal care in Finland is supported by national guidelines issued by the Finnish Institute for Health and Welfare (THL) in 2013 and national legislation, such as the Health Care Act³⁷, Government Decree on maternity and child health clinics^{38 39}, the Child Welfare Act⁴⁰ and the Social Welfare Act⁴¹. The national guidelines were based on international guidelines, such as the NICE guidelines, but adapted to the Finnish context^{42 43}. More specific implementation manuals have also been developed to describe evidence-based practices, with detailed examples. These include a guide on contraindicated practices⁴⁴ in order to systematically discontinue non-evidence-based, obsolete and possibly harmful practices and enhance the efficacy and safety of healthcare.

According to the Finnish Health Care Act, municipalities are required to organize prenatal and ICH services for expectant parents, families and children until the

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34. Finnish Institute of Health and Welfare. Medical Birth Register, Retrieved September 18, 2020, from https://www.julkari.fi/bitstream/handle/10024/137282/URN_ISBN_978-952-343-190-4.pdf
 35. Hakulinen, T. et al. (2018). *Ajanmukaiset käytänteet ja pitkät perinteet neuvolassa ja kouluterveydenhuollossa. Palvelujen seurantatutkimus 2016–2017*. Terveyden ja hyvinvoinnin laitos, Helsinki. [Up-to-date practices and long traditions. Follow-up study of maternity and child health clinic and school health care services 2016–2017. Finnish Institute for Health and Welfare]. Retrieved September 18, 2020, from https://www.julkari.fi/bitstream/handle/10024/137282/URN_ISBN_978-952-343-190-4.pdf
 36. Hakulinen, T. et al. (2012). *Laaja terveystarkastus. Ohjeistus äitiys- ja lastenneuvolatoimintaan ja kouluterveydenhoitoon*. Terveyden ja hyvinvoinnin laitos, Helsinki. [Extensive health examinations-guidance for maternity and child health clinics and schools. Finnish Institute for Health and Welfare]. Retrieved September 18, 2020, from http://www.julkari.fi/bitstream/handle/10024/90831/URN_ISBN_978-952-245-708-0.pdf
 37. Health Care Act 1326/2010. Retrieved September 18, 2020, from https://www.finlex.fi/en/laki/kaannokset/2010/en20101326_20131293.pdf
 38. Ministry of Social Affairs and Health. Government Decree 338/2011 on maternity and child health clinic services, school and student health services and preventive oral health services for children and youth. Retrieved September 18, 2020, from <https://www.finlex.fi/fi/laki/kaannokset/2011/en20110338.pdf>
 39. See also Wiss, K. et al. (2014). *Neuvolatoiminta, koulu- ja opiskeluterveydenhuolto, sekä ehkäisevä suun terveydenhuolto*. Asetuksen (338/2011) toimeenpanon seuranta ja valvonta. Terveyden ja hyvinvoinnin laitos, Helsinki. [Maternity and child health clinics, school and student health care and oral health care for children and young people 2014 – Follow-up and monitoring of the implementation of the Decree (338/2011). National Institute for Health and Welfare. Directions 21/2014]. Retrieved September 18, 2020, from https://www.julkari.fi/bitstream/handle/10024/125349/URN_ISBN_978-952-302-356-7.pdf?sequence=1&isAllowed=y
 40. Ministry of Social Affairs and Health. Child Welfare Act 417/2007. Retrieved September 18, 2020, from <https://www.finlex.fi/fi/laki/kaannokset/2007/en20070417.pdf>
 41. Sosiaalihuoltolaki 1301/2014. [Ministry of Justice, Finlex service. Social welfare Act 1301/2014], Retrieved September 18, 2020, from <https://www.finlex.fi/fi/laki/alkup/2014/20141301>
 42. Nursing research foundation, NRF. Care Guidelines. Retrieved September 18, 2020, from <https://www.hotus.fi/?lang=en>
 43. The Finnish Medical Society Duodecim. Current Care guidelines, <https://www.kaypahoito.fi/en/>
 44. Suomalainen lääkäriseura Duodecim. Käypä hoito- Väältä viisaasti suositukset [The Finnish Medical Society Duodecim. Smart to Avoid Recommendations]. Retrieved September 18, 2020, from <https://www.kaypahoito.fi/valta-viisaasti>

children reach compulsory school age (seven) and establish a coherent plan for how they will manage these services. They submit these plans, including sections on how they will organize and ensure cross-sectoral collaboration, to the Finnish Institute for Health and Welfare (THL) for approval on an annual basis. Thus, there is significant national monitoring of the quality of service and adherence to national guidelines in prenatal care, via these implementation plans and regular surveys sent to healthcare administrators by the Finnish Institute for Health and Welfare (THL), to ensure that the service is systematic, uniform in quality and meets the needs of the population. Reports on the implementation and outcomes of operations are also submitted annually to the municipal bodies in charge of public health work. This systematic follow-up makes it possible to implement any required changes and improvements without delay.

In some areas, prenatal care is provided at special family centres, which combine different services for families under one roof, such as healthcare, social support, and open early childhood and early care (ECEC) activities^{45 46}. According to national guidelines, prenatal and ICH services are an essential part of the family centre model, and the general aim is to have all such services provided within this model although that is not yet the reality everywhere. This is part of a larger government agenda, which aims not only to have all services for families under one roof but also to combine all primary care and social services in integrated "wellbeing clinics". When municipalities have expanded their prenatal and ICH operations into wellbeing clinics or family centres, the service may also include speech therapists, psychologists, physical therapists, family workers and experts in social work, mental health and early childhood education and care. Family workers provide various types of preventive social services (e.g. family counselling and psychosocial support) as well as practical support in daily life (e.g. help with child raising or housework). There is coordinated registration of standard information about prenatal care throughout the country, with electronic entries made in the pregnant woman's medical records and, if necessary, the other parent's records as well. This includes information concerning the pregnant woman's life circumstances, monitoring of the pregnancy and any test results. Following this, an individual pregnancy plan is prepared. The Finnish Institute for Health and Welfare (THL) has published guidelines on the content and implementation of routine health examinations,⁴⁷ as well as concise guidelines (2012) on the extensive health examination for the entire family.⁴⁸ Only healthcare professionals caring for the pregnant woman have access to the woman's maternity records, and pregnant women also have access to their own records via an electronic server ("MyKanta"⁴⁹). According to Finnish law, they can

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45. Pelkonen, M. et al. (2020). *Perhekeskukset Suomessa 2019. Kehittämisen tilanne ja työn jatkuminen*. Terveyden ja hyvinvoinnin laitos. Helsinki. [Family centres in Finland 2019. Status of development and continuing the work. Finnish Institute for Health and Welfare]. Retrieved September 18, 2020, from https://www.julkari.fi/bitstream/handle/10024/139242/URN_ISBN_978-952-343-461-5.pdf
 46. Terveyden ja hyvinvoinnin laitos. Perhekeskus. [Finnish Institute for Health and Welfare. Family center]. Retrieved September 18, 2020, from <https://thl.fi/fi/web/lapset-nuoret-ja-perheet/peruspalvelut/perhekeskus>
 47. Klemetti, R. & Hakulinen-Viitanen, T. (Eds.) (2013). *Äitiysneuvolaopas. Suosituksia äitiysneuvolatoimintaan*. Terveyden ja hyvinvoinnin laitos. Helsinki. [Maternity clinic's guide. Recommendations for maternity clinics, Finnish Institute for Health and Welfare]. Retrieved September 18, 2020, from www.julkari.fi/bitstream/handle/10024/110521/THL_OPA2013_029_verkko.pdf
 48. Hakulinen, T. et al. (2012). *Laaja terveystarkastus. Ohjeistus äitiys- ja lastenneuvolatoimintaan ja kouluterveydenhoitoon*. Terveyden ja hyvinvoinnin laitos. Helsinki. [Extensive health examinations-guidance for maternity and child health clinics and schools. Finnish Institute for Health and Welfare]. Retrieved September 18, 2020, from: http://www.julkari.fi/bitstream/handle/10024/90831/URN_ISBN_978-952-245-708-0.pdf
 49. The Social Insurance Institution of Finland. Kanta Services. My Kanta pages. Retrieved September 18, 2020, from <https://www.kanta.fi/en/my-kanta-pages>

prohibit the use of their data by anyone outside prenatal care^{50 51}.

Mental wellbeing and preparation for parenthood

Parents receive information during prenatal visits about how to support their own mental health and wellbeing, and the monitoring of mental wellbeing through discussion and observation is a routine part of the service. Discussion about family wellbeing can also be encouraged through the use of questionnaires for parents expecting their first child or families with newborn children. Such questionnaires may identify particular risk or protective factors within the family, and are well-suited for use in the extensive health examinations that assess the wellbeing of the whole family. The questions can be answered and discussed at home or at the clinic^{52 53}.

Prenatal clinics also organize preparation classes for parents and group activities, which include information about and support in mental health and wellbeing. According to the Government Decree on prenatal and infant and child healthcare, all families expecting their first child should be offered multidisciplinary family classes, including parent group activities and childbirth counselling. These classes are often organized by prenatal and ICH staff (e.g. public health nurses or midwives) but other professionals (e.g. family workers or psychologists) may also be involved. The format and number of sessions vary by municipality, and topics can include parents' expectations and ideas around child raising, early interaction with infants and the effects of a new baby on family dynamics. Family classes offer peer support, discussions and the modelling of effective parenting practices. They also provide a good venue for identifying and reaching out to parents with social, emotional or substance use difficulties. Family classes in Finland reach almost all women who are expecting their first child, and their partners. These are offered in the two official languages (Finnish and Swedish), and parents' disabilities are also considered. The classes are free of charge but their availability differs from one area to the next.

Family classes are sometimes offered for mothers and fathers separately. Fathers are encouraged to take part in father group activities as well as the extensive health examination. Those with an immigrant status are especially encouraged to attend prenatal visits and preparation classes. Particular attention is also paid to parents who are not employed or studying, as they might need additional support. In the last trimester of the pregnancy, national guidelines recommend conducting a prenatal interview to support the early parent-child interaction ("Supporting Parent-Child

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50. Ministry of Social Affairs and Health. Act on the Status and Rights of Patients 785/1992. Retrieved September 18, 2020, from https://www.finlex.fi/fi/laki/kaannokset/1992/en19920785_20120690.pdf, Tietosuojalaki 1050/2018. [Ministry of Justice, Finlex service. Data Protection Act]. Retrieved September 18, 2020, from <https://www.finlex.fi/fi/laki/ajantasa/2018/20181050>
 51. See e.g. Laki sosiaali- ja terveydenhuollon asiakastietojen sähköisestä käsittelystä 159/2007. [Ministry of Justice, Finlex service. Act on the Electronic Processing of Client Data in Healthcare and Social Welfare 159/2007]. Retrieved September 18, 2020, from www.finlex.fi/fi/laki/ajantasa/2007/20070159
 52. Finnish Institute for Health and Welfare. A questionnaire for identifying the factors that strengthen and burden parents expecting their first child. Retrieved September 18, 2020, from https://www.kauniainen.fi/files/13087/voimavaralomake_1_en.pdf
 53. See also Finnish Institute for Health and Welfare. A questionnaire for identifying the factors that strengthen and burden families with a newborn baby. Retrieved September 18, 2020, from <https://www.keski-uudenmaansote.fi/globalassets/ku-sote/palvelut/lasten-nuorten-ja-perheiden-palvelut/neuvola2/voimavaramittari-vauvaperhe-englanti.pdf>

Interaction"; VaVu), and this is repeated 4–8 weeks after the child is born^{54 55}. To further prepare them for parenthood, all parents are given a maternity package (or baby box)⁵⁶ and a parent handbook ("Meille tulee vauva"/"We're having a baby"⁵⁷), available in six languages and online. The maternity package contains a great variety of items including baby clothes and care products but families can also choose to receive money instead of the package. In addition, a temporary programme was recently initiated ("Lukulahja lapselle" or "Reading gift for child"), which offers a bag of books to all children born between 2019 and 2021 as a part of prenatal and child healthcare services⁵⁸.

Risk factors in pregnancy

According to national guidelines, psychosocial risk factors should be screened and regularly monitored during prenatal visits, such as smoking, alcohol use, mental health, violence and socioeconomic status. These risk factors are assessed through various standardized questions and screening tools in addition to general discussions in prenatal care. The extensive health examination at weeks 13–18 includes an inventory of the pregnant woman's mental health and social support resources, which can be used to identify issues that either increase or decrease the family's resiliency.

If psychosocial problems are identified during pregnancy, defined procedures guide prenatal staff on how to proceed through further examination and care pathways. There is a strong emphasis on making all healthcare and social services uniform throughout Finland so that the same service is provided to everybody, no matter where they live. Strengthening cross-sectoral collaboration has also been a major focus in Finland in recent years. All institutions are required to have joint agreements with other agencies on how their services will be organized and linked together. There is also close collaboration between prenatal and ICH services, which are organized to function as one system in a smooth continuum throughout pregnancy and childhood. However, a weaker link exists between primary care, including prenatal and ICH services, and certain other sectors, such as mental health services. Services for different problems also differ significantly depending on the particular risk factors in question. For example, an extensive, high quality service is available when it comes to alcohol and substance use throughout the continuum from prevention and early intervention to secondary and tertiary care. For mental health, resources are less continuous, less accessible and less focused on prevention and early intervention than on clinical treatment. However, perinatal psychiatric outpatient clinics are currently being established in association with hospitals, and these will serve to strengthen prevention, identification, treatment and follow-up for

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54. Mäki, P., et al. (2017). *Terveystarkastukset lastenneuvolassa ja kouluterveydenhuollossa: Menetelmäkäsikirja*. Terveyden ja hyvinvoinnin laitos. Helsinki. [Health check practices in child health clinics and in school health care – Handbook. Finnish Institute for Health and Welfare]. Retrieved September 18, 2020, from http://www.julkari.fi/bitstream/handle/10024/135858/URN_ISBN_978-952-302-964-4.pdf
 55. Terveyden ja hyvinvoinnin laitos. Raskaudenaikaista varhaista vuorovaikutusta tukeva haastattelu, VaVu. [Finnish Institute for Health and Welfare. VaVu-Interview]. Retrieved September 18, 2020, from https://thl.fi/documents/732587/741077/VAVU_raskauden_aikainen_haastattelu_1.pdf
 56. The Social Insurance Institution of Finland (Kela). Information about maternity package. Retrieved September 18, 2020, from <https://www.kela.fi/web/en/maternitypackage>
 57. Hakulinen, T., et al. (2017) *We're having a baby: A guidebook for expecting and looking after a baby*. Finnish Institute for Health and Welfare. Helsinki, <https://www.julkari.fi/handle/10024/132228>
 58. Suomen Kulttuurirahasto. Lukulahja lapselle [The Finnish Cultural Foundation. Reading gift for a child]. Retrieved September 18, 2020, from <https://skr.fi/hankkeet/lukulahja-lapselle>

mental health difficulties in prenatal and infant and child healthcare.

Mental health difficulties

According to the Government Decree on maternity and child health clinic services, all families must be provided with information about the prevention and symptoms of postpartum depression. The extensive health examination in week 13–18 includes universal screening for depression with the Edinburgh Postnatal Depression Scale (EPDS) and sometimes also screening for anxiety via the Beck Anxiety Inventory (BAI). Depression is screened again near the end of pregnancy, in gestation week 35–36, mainly via the EPDS or the Beck Depression Inventory (BDI). If mental health difficulties are identified, support may be provided at the prenatal clinic, mental health clinic or a family counselling centre, depending on the type and severity of the problem. Usually, the first step is for the expectant mother or other parent to be referred to a GP, with consultation from psychiatric specialized care if necessary. According to national guidelines, prenatal and ICH services must collaborate with a psychiatric nurse, psychologist or family worker in such situations. Psychologists and psychiatric nurses are part of general primary care and available on referral. Family workers can be accessed through collaboration with social services. Although psychotherapy is the recommended treatment for depression and anxiety during pregnancy, psychological treatment is not always available and sometimes only through private practice for a fee.

If mental health issues are minor, the focus is on providing added psychosocial support in prenatal care (e.g. additional visits with a public health nurse) and home support if necessary, such as help with housework and so on. Mild to moderate mental health problems can be treated in primary care, for example through targeted psychoeducation groups led by psychiatric nurses. For moderate problems, a psychiatric nurse or psychologist from secondary care would be engaged in the care team. In such cases, treatment would take place at a hospital outpatient clinic since no specialized mental health services are provided in primary care. Severe mental illness would be treated in specialized units in tertiary care. In Finland, there is also a strong tradition of NGOs providing various services related to health and social support, including mental health resources. Thus, NGOs may offer counselling, group or individual treatment, as well as peer support groups.

Municipalities in Finland are obliged to offer a mental health service as part of their general provision of healthcare and social support. However, the obligation does not specify what kind of support should be given, when or by whom. According to a recent study, there is a lack of psychosocial support in primary services, including prenatal and ICH services. While there is a strong emphasis on evidence-based practices in general prenatal care, mental health resources are limited and the quality of psychosocial support provided by other sectors and systems varies^{59 60}. Thus, there is concern that there might not be a strong enough focus on evidence-based early intervention for mental health during pregnancy or after childbirth.

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59. Klemetti, R., et al. (2018). *Mitä vauvaperheille kuuluu? LTH-tutkimuksen 3–4-kuukautisten vauvojen ja heidän perheidensä pilottitutkimuksen perusraportti*. Terveystieteiden tutkimuskeskus, Helsinki. [How are families with babies doing? Basic report of a pilot study on 3–4-month old babies and their families participating in the LTH survey. Finnish Institute for Health and Welfare]. Retrieved September 18, 2020, from https://www.julkari.fi/bitstream/handle/10024/136799/TYÖ2018_18_Mitä%20vauvaperheille%20kuuluu_9.10.2018_web.pdf
60. See also Holopainen, A. & Hakulinen, T. (2019). *New parent's experiences of postpartum depression*. JBI Database of Systematic Reviews and Implementation Reports (17): 9, 1731-1769. Retrieved September 18, 2020, from https://journals.lww.com/jbisrir/Fulltext/2019/09000/New_parents_experiences_of_postpartum_depression_3.aspx

There are also significant regional differences in the availability of mental health services across Finland.

Services provided by municipalities and outpatient mental health services are free of charge but specialized medical care is subject to a small fee. There is an annual maximum limit for healthcare costs in Finland so that the cost for the individual does not become overwhelming, but certain services, such as psychotherapy, remain less accessible due to financial cost. Municipalities are responsible for the continuity of care and smooth transition between services. The previously mentioned implementation plans include an agreement on the specifics of care pathways and service provision by different service providers in the municipality and region, such as hospitals and NGOs.

Social difficulties

Enquiring about the family's social and economic status is standard practice in prenatal care. The family's financial situation, as well as other social issues, should be assessed early in pregnancy and, if necessary, the family guided towards support such as social services or financial assistance from Kela, Finland's Social Insurance Institution. Expectant parents can also apply for preventive social assistance in the form of counselling, peer support groups, debt counselling, home visits and home support, which is provided as a general family service when there is lowered functional ability or special circumstances in the family. Families can also be guided towards other services and individualized, needs-based assistance from family workers. Many of these services, such as counselling and peer support groups, are also provided by NGOs. The services are free of charge but their availability differs between regions.

Family counselling or family work and support for milder problems can be offered in prenatal care, for example, when there are no co-existing problems regarding mental health or substance use. In more complex or severe cases, expectant parents will receive support from social services and/or child protection services in addition to the services provided in prenatal care. There is a strong focus on organizing services so that they operate as one system and transitions between services are smooth. Municipalities, joint municipal authorities and healthcare districts are responsible for organizing the services and making them equally available for everyone in the area. At the regional level, six Regional State Administrative Agencies (AVI)⁶¹ across Finland guide and monitor the social services provided by both municipalities and the private sector to ensure equality and the rights of the client.

Relationship difficulties

The importance of the intimate relationship, including healthy communication and sex life, is discussed with all parents during pregnancy and after childbirth. It is one of the themes discussed in the extensive health examination as well as during regular visits. According to national guidelines, discussions on growing into parenthood and the effects the birth of a child has on family life should begin early in prenatal care and continue in parent groups and later in child healthcare. There is

61. Regional State Administrative Agencies. Retrieved September 18, 2020, from <https://avi.fi/en/frontpage>

increasing awareness of the impact that the quality of the parental relationship has on parenthood and family life⁶² and supporting the relationship is one of the tasks of the prenatal and ICH services. However, this issue is one of the areas in prenatal and ICH care that needs further strengthening. For example, there is insufficient availability of preventive or early intervention services for relationship difficulties although assistance can be sought outside the prenatal clinic. Municipal family clinics provide counselling for family life that can also include couples difficulties but their services may sometimes be limited⁶³. Some NGOs offer relationship courses or couples counselling (e.g. the Family Federation of Finland⁶⁴) as well as church family counselling centres and therapists in private practice. However, waiting lists for these services are often long and there are large geographical differences in availability. Some services may also be subject to a charge (e.g. private therapists) but others are free (e.g. those offered by the church). If either parent has been diagnosed with a mental disorder, financial assistance for private couples therapy can be sought from Kela with a medical statement through social services. However, the cost is not fully covered so financial status may remain an obstacle.

Alcohol and substance abuse

Discussions about substance use, early intervention and referral to treatment are included in general prenatal care, home visits and preparation courses for parenthood. Screening for alcohol and substance use is included for both parents in the extensive health examination, via the Alcohol Use Disorders Identification Test (AUDIT) and a substance abuse questionnaire. If problems are identified, the need for added support is assessed and a goal-oriented plan is prepared with the family, with close monitoring of its implementation. Parents may also be guided to online resources, such as "Thinking of you: damages caused by intoxicants during pregnancy"⁶⁵ developed by the Federation of Mother and Child Homes and Shelters. According to national guidelines, treatment for substance abuse and other support services should be provided in the form of multidisciplinary collaboration during pregnancy and after delivery. In general, there are very good, specialized, evidence-based services for parents with alcohol and substance use problems in pregnancy, both within healthcare and social services. By law, pregnant women have the right to social services to support a substance-free life without delay. Municipalities are responsible for providing these services in collaboration with regional hospitals. Many municipalities in Finland have also combined their services for mental health and alcohol or substance use.

Treatment for pregnant women with substance use issues can be organized in collaboration with specialized medical care and "A Clinics"⁶⁶, which offer alcohol and substance use treatment for the general population, or specialized prenatal clinics

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62. See e.g. Hakulinen T. et. al (2019). *Vanhemmuuden ja parisuhteen tuen vahvistaminen. Teoriasta käytäntöön*. Terveyden ja hyvinvoinnin laitos. Helsinki. [Supporting parenthood and parent's couple relationship. From theory to practice. Finnish Institute for Health and Welfare]. Retrieved September 18, 2020, from https://www.julkari.fi/bitstream/handle/10024/138389/URN_ISBN_978-952-343-357-1.pdf
63. Bildjuschkin, K. eds. (2018). *Kasvatus- ja perheneuvonta – työnsisältöjen, työtehtävien, tavoitteiden ja työmenetelmien määrittely*. Terveyden ja hyvinvoinnin laitos. Helsinki. Työpaperi 20/2018. [Child guidance and family counselling. The definition of the content, tasks, objectives and the working methods. Finnish Institute for Health and Welfare]. Retrieved September 18, 2020, from http://www.julkari.fi/bitstream/handle/10024/136496/URN_ISBN_978-952-343-126-3.pdf
64. Family Federation of Finland. Retrieved September 18, 2020, from https://www.vaestoliitto.fi/in_english/
65. Federation of mother and child homes and shelters. Thinking of you. Federation of mother and child homes and shelters. E-publications. Retrieved September 18, 2020, from http://www.e-julkaisu.fi/ensi_ja_turvakotien_liitto/thinking_of_you/
66. A-Clinics Ltd., <https://www.a-klinikka.fi/en>

for substance abuse. So-called HAL outpatient clinics (narcotics, alcohol and drugs⁶⁷) at university hospitals, and HAL receptions at central hospitals, also provide extensive services to pregnant women with substance abuse issues. Health counselling, drug replacement therapy, substance abuse rehabilitation and peer support are examples of available resources for expectant parents but there are regional differences in availability. Finnish municipalities are required to provide services according to the population's need, and thus, drug replacement therapy and other services for severe problems might only be available in densely populated, urban areas. There is also variability in the quality of services⁶⁸.

NGOs also offer various services for expectant and new parents with substance use problems, from special homes for pregnant and new mothers to group activities and social networking. However, these services are not available nationwide. The mother and child homes and shelters are organized for mother and baby before and after birth in close collaboration with child protection and prenatal or ICH services. Public health nurses from prenatal and ICH services are a part of the care team and offer home visits and participate in the home's parent groups. If there are justified grounds to suspect that the newborn will require child protection measures after birth, midwives submit a preventive child protection notification during pregnancy⁶⁹. After the child is born, a proper child protection notification is made to arrange support services. The growth and development of children living in families exposed to substance abuse are followed up closely by child welfare services, primary care and specialized medical care. A contact person in charge of coordinating services from different sectors is appointed to ensure follow-up.

Violence and trauma

National guidelines call for regular and systematic assessment of violence and trauma in prenatal care and ICH in Finland. However, the identification of and support for violence and trauma may not be as systematic throughout the country as for some other risk factors, and it needs further development. In prenatal care, both parents are screened for intimate partner violence without the presence of the other parent⁷⁰. Some municipalities also use a risk assessment tool called the Multi-Agency Risk Assessment Conference (MARAC)⁷¹ for intimate partner violence, and offer subsequent support through multidisciplinary teams. All expectant parents are also informed in prenatal visits and family preparation classes about the impact that violence has on children and themselves. If violence or trauma is identified in prenatal care, pregnant women are referred to emergency medical services, and social services and police are contacted when needed. Further support is usually provided by professionals and NGOs outside of the prenatal clinic. The required care

67. Helsinki University Hospital. HAL clinics. Retrieved September 18, 2020, from <https://www.hus.fi/en/medical-care/medical-services/maternity-services/babyjourney/hospital-visits-during-pregnancy/maternity-outpatient-clinics/hal-clinic/Pages/default.aspx>

68. Arponen, A. (2019). *Päihteitä käyttävien raskaana olevien naisten ja perheiden palvelut vuonna 2018. Nykytila ja kehittämisehdotukset*. Terveiden ja hyvinvoinnin laitos, Helsinki. [Services for substance abusing pregnant women and families with infants in 2018. Current situation and development proposals. Finnish Institute for Health and Welfare]. Retrieved September 18, 2020, from http://www.julkari.fi/bitstream/handle/10024/138942/URN_ISBN_978-952-343-411-0.pdf

69. Terveiden ja hyvinvoinnin laitos. Lastensuojelun käsikirja. Ennakollinen lastensuojeluilmoitus. [Finnish Institute of Health and Welfare. Helsinki. Manual for child protection. Preventive child protection notification]. Retrieved September 18, 2020, from <https://thl.fi/web/lastensuojelun-kasikirja/tyoprosessi/lastensuojeluilmoitus-ja-lastensuojeluasian-vireilletulo/ennakollinen-lastensuojeluilmoitus>

70. Finnish Institute for Health and Welfare. Domestic violence enquiry and assessment form. Retrieved September 18, 2020, from <https://thl.fi/documents/605877/1663634/Domestic+violence+enquiry+and+assessment+form.pdf>

71. The National Council for Crime Prevention. A Multi-Agency Risk Assessment Conference. Retrieved September 18, 2020, from <https://rikoksentorjunta.fi/en/marac>

pathways are developed independently for each municipality in the previously mentioned implementation plans for healthcare and cross-sectoral collaboration.

Municipalities are required to have an action plan for preventing and responding to violence, including low-threshold services and emergency medical and social services. Resources can include telephone hotlines, shelter services, crisis support, preventive interventions and long-term support and treatment for trauma from violence and abuse⁷². Support can also be offered to the perpetrator^{73 74}. Specialized crisis centres for sexual violence, such as "Seri" centres and "Tukinainen", provide support, advice and guidance in relation to sexual assault and abuse. Municipalities and healthcare districts are responsible for organizing and monitoring services and making them equally available to all citizens, but they can be provided by either municipalities or NGOs. The services are mostly free of charge but, as with other services, there are differences in accessibility and quality throughout the country. At present, the collaboration between prenatal services and services providing support for violence is not strong enough in Finland but there is an increasing focus on improving this area. The general aim is to have regular assessment and follow-up meetings with different service providers caring for pregnant women exposed to violence and making the route to support as smooth as possible. This corresponds to the general aim in Finnish healthcare and social services for them to function as one system, no matter what kind of support a person needs.

Infant and child healthcare

As mentioned previously, municipal infant and child healthcare (ICH) follows on directly from prenatal care, either as a separate or combined service. Usually, prenatal and ICH services are located in the same building as general primary care, albeit in separate clinics. These services will have joint agreements on how they provide care for children and families, what information and resources they offer, how they respond to risk factors, and so on. Both services are also subject to several of the same national acts, government decrees and national recommendations, such as the Health Care Act, the Government Decree on maternity and child health clinics the Child Welfare Act and the Social Welfare Act. The key recommendations that guide services in ICH include the Child Health Clinic Guide⁷⁵, the Prenatal Clinic Manual and Guidance on Extensive Health Examinations for Maternity and Child Health Clinics⁷⁶. There is also a regularly updated, electronic Child Health Manual available online⁷⁷. The Finnish national ICH guidelines were developed based on

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72. E.g. Terveyden ja hyvinvoinnin laitos. Seri-support centers for victims of sexual violence. Retrieved September 18, 2020, from https://thl.fi/fi/web/lapset-nuoret-ja-perheet/tyon_tueksi/vakivallan-ehkaisy/seksuaalivakivalta/seri-seksuaalivakivallan-uhrin-tukikeskukset, Nollalinja helpline. Retrieved September 18, 2020, from <https://thl.fi/fi/palvelut-ja-asiointi/valtion-sosiaali-ja-terveydenhuollon-erityispalvelut/nollalinja-auttava-puhelin>, see also Rape Crisis Centre Tukinainen. Retrieved September 18, 2020, from <https://tukinainen.fi/en/>
 73. Ensi-ja turvakotien liitto. Tietoa Jussi-työstä [Federation of Mother and Child homes and shelters. Information about Jussi-work]. Retrieved September 18, 2020, from <https://issuu.com/ensi-jaturvakotienliitto/docs/jussi-ty>
 74. Lyömätön linja Espoossa [Non-violent helpline], <https://www.lyomatonlinja.fi/fi/> Maria-Akatemia. Naisen väkivalta. [Maria Academy, information and support for women acting violently]. Retrieved September 18, 2020, from <https://www.naisenvakivalta.fi/>
 75. Sosiaali-ja terveysministeriö (2004). Lastenneuvola lapsiperheiden tukena. Opas työntekijöille. Sosiaali-ja terveysministeriö. Helsinki. [Ministry of Social and Health. Child Health Clinics as a support for families with children. Guide for professionals]. Retrieved September 18, 2020, from <http://julkaisut.valtioneuvosto.fi/bitstream/handle/10024/74223/Opp200414.pdf>
 76. See also Terveyden ja hyvinvoinnin laitos. Suositukset neuvolatyöhön. [Recommendations for maternity and child health care. Finnish Institute of Health and Welfare]. Retrieved September 18, 2020, from https://thl.fi/fi/web/lapset-nuoret-ja-perheet/peruspalvelut/aitiys-ja-lastenneuvola/suosituksenet_neuvolatyohon
 77. Terveyden ja hyvinvoinnin laitos. Lastenneuvolakäsikirja. [Finnish Institution for Health and Welfare. Child Health Clinic Manual]. Retrieved September 18, 2020, from <https://thl.fi/fi/web/lastenneuvolakasikirja>

research evidence, health policy alignments, guidelines from other countries (e.g. the NICE guidelines and guidelines from other Nordic countries) and clinical recommendations from national experts in the field.

Municipalities and joint municipal authorities are responsible for implementing national guidelines. There is a strong infrastructure within the Finnish healthcare system to support the implementation of legislation, guidelines and recommendations into everyday practice. First, as mentioned above, ICH services are guided by extensive, detailed recommendations on evidence-based practices provided by health authorities. Second, administrators for ICH operations within each municipality have a clear role and responsibility to maintain quality and implement national recommendations. Third, the Finnish Institute for Health and Welfare closely monitors the implementation of guidelines and the quality of child health clinic operations.

After a child is born, two visits are offered as an extended service by the maternity clinics, one of which is a postnatal examination performed by a doctor or public health nurse. Additional visits are arranged when needed. Subsequently, there are 11 visits in ICH during the child's first two years. The first takes place within four weeks after the child is born and is either be a home visit or at the ICH clinic. The next visit takes place when the child is 4–6 weeks old, then at two, three, four, five, six, eight, 12, 18 and 24 months. ICH visits include regular check-ups with the public health nurse, two medical examinations by a GP and two extensive health examinations for both parents like the one previously described in prenatal care (when the child is aged four months and 18 months). Public health nurses are the primary professionals in ICH, although GPs are also involved, and families usually see the same nurse throughout the infant and toddler period. Child health clinics and family service networks also have family workers who are trained in social services as partners for public health nurses. Each ICH clinic cooperates with a multidisciplinary team that includes, for instance, social workers and ECEC professionals, but families can also receive service from other sectors if necessary. ICH services are free of charge and families have the right to receive the services in other languages, including with the help of an interpreter.

The first visit should be a home visit from a public health nurse, and this usually takes place within the first week after the child is born. If parents have any concerns or worries, they can also contact the services themselves and ask for an appointment. Breastfeeding guidance is offered systematically through collaboration between primary care, specialized medical care and NGOs, such as the Action Programme for Promoting Breastfeeding⁷⁸. It is recommended that both parents be offered breastfeeding guidance and support during regular ICH visits. Some hospitals also have breastfeeding outpatient clinics where support is available. All relevant services, such as prenatal care, ICH and hospitals, also aim to identify mothers in need of special breastfeeding support, for example teenage mothers, single mothers, immigrant families, those who smoke and those who have had previous problems with breastfeeding. Identifying these groups helps to allocate support to those who need it the most.

Attending ICH is optional but if families miss routine health examinations, public

78. Hakulinen, T. et. al. (2017). Kansallinen imetyksen edistämisen toimintaohjelma vuosille 2018-2020. Terveysten ja hyvinvoinnin laitos. Helsinki. [National program for promoting breastfeeding 2018-2020. Finnish Institute for Health and Welfare]. Retrieved September 18, 2020, from <http://www.julkari.fi/bitstream/handle/10024/135535/Ohjaus%20242017%20netti%202020.3.pdf>

health nurses and GPs are required to investigate the need for support. The need for support can be investigated by contacting the family or arranging a home visit, in collaboration with other parties if necessary (e.g. family work in child welfare, ECEC, etc.). Overall, there are few difficulties with attendance in ICH in Finland as national statistics show that participation is over 99%. The Finnish Institute for Health and Welfare (THL) and Statistics Finland gather information on births and newborns, and health professionals assisting in the birth of a child, whether at home or in hospital, file a report directly to the magistrate. There are no recorded problems with lack of registration or infants who are "lost to the system" in Finland.

Registration of standard information in ICH is nationally coordinated. Health professionals are obliged to record predefined information and measurements for organizing, planning and implementing care and securing follow-up in electronic medical records. From these records, anonymous data can be extracted by THL to compile coordinated statistics on prenatal and ICH visits in the country. The processing of health data and medical records is subject to a number of acts and decrees, and only healthcare professionals involved in caring for the family have access to ICH records. An employee with access to ICH records may only use them for their original purpose and only to the extent required by their responsibilities. Data disclosure to other services requires patient consent, although there are certain exceptions, such as the obligation to submit a notice pursuant to the Child Welfare Act.

Children's emotional wellbeing

During ICH visits, parents receive regular information about healthy social and emotional development in young children and how to promote it. This is one of the issues that ICH professionals are required to address and record in the national electronic ICH registry. Children's social and emotional development, behaviour and interaction with parents is monitored at different ages and the electronic registry system specifies what issues should be addressed at each ICH visit. There is a strong focus on the importance of early attachment for children's healthy development, and ICH staff are well-trained in supporting it, for example through the VaVu approach ("Supporting Parent-Child Interaction"), which aims at supporting early parent-child interaction and addressing risk factors. The VaVu approach is applied at age 4–8 weeks, four months and six months, and includes an interview, discussions, observations and practical training to support positive parent-child interaction. The themes discussed in the interview help to identify any concerns relating to the baby and assess the need for support. The quality of the parent-infant interaction is assessed by observing, for example, the behaviour of both parent and baby, emotions expressed in the interaction and whether they share a mutual understanding. In this way, the development of an emotional attachment between mother and child is systematically monitored. The VaVu approach has been widely implemented across Finland, most public health nurses in ICH are trained in its use and instructions on conducting the VaVu interview are contained in the ICH manual. However, training for the approach is not regular or systematically updated.

Parents' emotional wellbeing

Parents receive emotional support and opportunities to discuss their feelings during the regular ICH visits. The mother's emotional resources to care for her baby are assessed and she is given information about factors that support or threaten parents' mental health when they have a new baby. Parents are encouraged to support their own mental wellbeing and overall health by taking care of their sleep, eating and activity routines. Defined procedures in ICH guidelines dictate how to support parental mental wellbeing and public health nurses are trained to look out for signs of emotional distress among new mothers. According to recommendations, all parents should be given information about the symptoms and prevention of prenatal and postpartum depression. Questions related to mood and emotional wellbeing are a theme in family classes, which, among other things, seek to prevent mental distress. Family classes may consist of parental support groups, which are usually local, and sometimes also online resources, such as digital interventions.

Family wellbeing

As previously described, Finland is systematically moving all primary services in healthcare, social support, early education and care, and services offered by the third sector (NGOs), under one roof in the form of family centres. Thus, family centres will align the services provided by regions, municipalities and NGOs (including the church) in a low-threshold, early intervention, needs-based model of family service. They will include a wide array of services, such as prenatal and ICH services, family planning clinics, speech therapists, occupational therapists, physiotherapists, nutritionists, psychologists, social workers, home support services, child welfare officers, family counselling clinics and open daycare. ICH services are an essential part of the family centre model and its key tasks include monitoring and promoting health and wellbeing among children and families, supporting parenthood and relationships, and considering the special needs of multicultural families. The ICH takes part in the family centre's work on the prevention of domestic violence, supporting amicable divorces and running "open meeting points" for parents to forge social links. Family centres can also link to specialized (secondary or tertiary) services if needed, according to previously described agreements or municipal implementation plans on how cross-sectoral services and collaboration are to be organized. In this way, collaboration can be formed with adult primary or specialized social and health services, such as substance abuse and mental health services. Family centres have been established in all Finnish regions but gradual, ongoing work continues in the drive to change the format of all services to the family centre model.

Parenting skills

Parents receive information about positive and evidence-based upbringing practices through individual support and guidance in ICH. Staff are trained in providing this guidance, both in their vocational training and the continuing education (CE) offered by the Finnish Institute for Health and Welfare (THL). The focus is on providing the child with emotional support, supervising its actions and setting limits that create a

sense of order and safety. An emphasis is placed on offering this counselling to both parents. Parents are informed about the importance of the child's self-esteem, the congenital nature of differences in temperament and understanding the child's uniqueness as a person. Whether parents have received this information is monitored through the regular quality assurance system in ICH. The guidance is also supplemented by the previously mentioned family classes, which start during prenatal care and continue in ICH after the child is born. As previously mentioned, a questionnaire for identifying factors that strengthen and burden parents with a newborn baby can also be used during the extensive health examinations as a tool for discussing daily life and assessing the wellbeing of the family.

ICH and family services also offer other courses for parents, at both universal and indicated levels. These include "supportive interaction" (International Child Development Programme (ICDP); Kannustava vuorovaikutus⁷⁹), which is an attachment-based approach designed to be used after family classes. Another example is the "Vahvuutta vanhemmuuteen" programme⁸⁰ for parents with 3–4-month-old infants. This was originally developed as the "parent first programme" at Yale University for parents with substance abuse problems but has since been tailored to fit all parents as a follow-up to family classes in Finland. The aim is to promote positive parent-infant interaction, strengthen the parents' mentalization ability, support the parents' intimate relationship and offer peer support. A third programme is "Hoivaa ja leiki"⁸¹ ("Nurture and play"), which is a Finnish mentalization-based group intervention from pregnancy through the baby's first year. The aim is to support mothers' mentalization ability and emotional availability in relation to their baby (e.g. through experience-based tasks and playfulness) as well as teaching cognitive-behavioural techniques for managing symptoms of depression. NGOs also offer many different parenthood courses, such as the previously mentioned "Vahvuutta vanhemmuuteen" based on the "Parents first" programme and "Ihmeelliset vuodet" ("Incredible Years") for children aged 2–6 years old⁸². Some courses are also available online. Courses for parents with children under the age of 2 years are diverse, with specified target groups; some are for everyone and some are for risk groups only. Most parent or family classes are free of charge but there are regional differences in quality and availability.

The Finnish Institute for Health and Welfare (THL) offers recommendations on evidence-based programmes but it is still up to individual municipalities to decide what programmes to offer parents. Thus, there are wide regional differences in both the availability and quality of programmes. One of the aims of the new reforms in Finnish social and healthcare is to reduce this variability so that good quality services are provided in a more consistent and coordinated manner, at both regional and national level. In order to promote the use of evidence-based interventions in early childhood services, a free open-access information portal, "Early Intervention – Brokering Knowledge for Support of Children" (kasvuntuki.fi^{83 84}), has also been

79. Kasvun tuki. Kannustava vuorovaikutus. [Kasvun tuki. ICDP-International child development programme]. Retrieved September 18, 2020, from <https://kasvuntuki.fi/tyomenetelmat/kannustava-vuorovaikutus-ohjelma-icdp-international-child-development-programme/>

80. Kasvun tuki. Vahvuutta vanhemmuuteen. [Kasvun tuki. Parents First]. Retrieved September 18, 2020, from <https://kasvuntuki.fi/tyomenetelmat/vahvuutta-vanhemmuuteen/>

81. Kasvun tuki. Hoivaa ja leiki. [Kasvun tuki. Nurture and play]. Retrieved September 18, 2020, from <https://kasvuntuki.fi/tyomenetelmat/hoivaa-ja-leiki/>

82. Kasvun tuki. Ihmeelliset vuodet. Vanhemmuusryhmät. [Kasvun tuki. Incredible Years. Parental Groups]. Retrieved September 18, 2020, from <https://kasvuntuki.fi/tyomenetelmat/ihmeelliset-vuodet-vanhemmuusryhmat/>

83. Kasvun tuki. Early Intervention, Brokering Knowledge for Support of Children. Retrieved September 18, 2020, from [Kasvuntuki.fi/en](https://kasvuntuki.fi/en)

84. Kalland, M. & Salo, S. (2020.) *Vanhemmuuden tukeminen vauva- ja lapsiperheissä*. [Parenting support in infancy and childhood] Duodecim 136, (8): 891-7. Retrieved September 18, 2020, from <https://www.duodecimlehti.fi/duo15527>

established as a resource for professionals, administrators and policy-makers. The portal compiles reliable, extensive, up-to-date and practical information about evidence-based practices that can be used in early intervention for children and families. It recommends programmes and interventions that have achieved moderate to strong effects and can offer support in implementing them in collaboration with competence centres.

Risk factors in the early years

ICH services strive to identify parents and families who need additional support (e.g. single parents, immigrant families, young parents), and practitioners receive regular training in assessing risk factors. In addition to universal screening for depression, alcohol and substance abuse (via EPDS and AUDIT), there are standardized questions about lifestyle habits, smoking, financial difficulties, relationship issues, child illness, violence, neglect and other kinds of child maltreatment. Psychosocial risk factors are assessed during regular visits and in the extensive health examinations when the child is aged four months and 18 months. Both parents, as well as the child's siblings, are invited to the extensive health examinations, where attention is paid to the whole family's health and wellbeing. Public health nurses at the ICH can offer additional home visits according to any identified need for special support or if the family has missed examinations. Such circumstances may include the mother's fatigue, difficult child temperament or disability, perinatal and postnatal depression, insecurity among single or very young parents, and immigrant status. The Kiikku working method is another example of an approach that is suitable for vulnerable families⁸⁵. It is preventive in nature and involves home visits until the child reaches one year of age, in order to support the parent-child interaction and development of an attachment relationship, in a multidisciplinary manner.

As previously stated, ICH services must have predefined routes and collaborative agreements with other services, across systems and sectors, according to implementation plans. Thus, there are mutual collaboration agreements between prenatal care and ICH, primary health centres, specialized medical care (hospitals) and mental health units regarding screening methods, case managers/contact persons, division of responsibilities, care pathways and additional staff training. The emphasis is on identifying any need for special support and offering individual support as soon as possible. However, the provision, quality and coordination of services can vary depending on region and type of service. For example, more extensive services are usually available in larger urban areas than in smaller municipalities, and early intervention, including cross-sectoral collaboration with prenatal care and ICH, is often more developed in the area of substance abuse than mental health.

Nevertheless, each ICH clinic has access to a multidisciplinary team that functions as a link to related services, such as social service and ECEC. The multidisciplinary team provides consultation and discusses how best to organize the monitoring of the child and the family situation. Families are offered support and issues are identified in

85. Kasvun tuki. Kiikku vauvaperhetyö. [Kasvun tuki. Kiikku family work]. Retrieved September 18, 2020, from <https://kasvuntuki.fi/tyomenetelmat/kiikku-vauvaperhetyo/>

meetings with families to arrange further support and child examinations if needed. Cooperation within a local network of experts is necessary to plan the most appropriate early intervention and specialized care for families. This systematic teamwork allows families and children to benefit from the expertise of different professions. Key parties in the network are the public health nurses and GPs at the ICH clinic, and participation from other professionals depends on availability of local resources. All municipalities in Finland have these multidisciplinary teams but the organization and operation of each team may differ from one location to the next according to the size of the population and type of clinic.

According to Finnish legislation, service providers are obliged to consider children's needs for support when adults who are responsible for their care receive social or health services, such as substance use or mental health treatment. The Mental Health Act and the Act on Welfare for Substance Abusers also oblige service providers to pay attention to children and their need for support⁸⁶. Many municipalities and hospital districts have implemented formal practices to respond to children's needs in such situations, such as the Let's Talk about Children approach⁸⁷, which was developed by THL and widely implemented across the country. Currently, municipalities can receive support for this approach from the NGO Mieli⁸⁸. According to the Health Care Act, family matters should as a rule be considered in a holistic way; that is, when providing care to a child, the situation of the entire family should be considered, and vice versa. However, this is not always the case and, to date, there is no systematic monitoring or follow-up regarding this part of adult services.

Mental health difficulties

Attention is paid to mental health in ICH because it is recognized that a parent's depression, anxiety and other mental health difficulties can have a negative impact on their interaction with the child, the formation of attachment and the child's overall development and wellbeing. The mother's mood is assessed in the first week after birth, and postpartum depression is screened via EPDS in week 5–12 after birth. If symptoms of depression are mild or moderate they can be treated at the ICH clinic, where the focus is on preventing the further development of depression through psychosocial support and, if necessary, home support. In the case of moderate depression, GPs and other specialized professionals at the health centre, such as a psychiatric nurse and sometimes a psychologist, are invited to join the care team. Severe depression is treated in specialized medical care. Perinatal mental health outpatient clinics specially designed for pregnant women or mothers with young infants are also in development. As previously stated, if a parent is receiving treatment, the children's situation is also assessed (e.g. via the "Let's Talk about Children" ("Lapset puheeksi") approach) and necessary support is arranged for the family. In such cases, ongoing collaboration with the ICH is established. A guidebook for parents with mental health problems is also offered in ICH.

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86. Ministry of Social Affairs and Health. The Mental Health Act 1116/1990. Retrieved September 18, 2020, from https://www.finlex.fi/fi/laki/kaannokset/1990/en19901116_20101338.pdf, Päihdehuoltolaki 1986/41. [Finlex. The Act on Welfare and Substance Abusers]. Retrieved September 18, 2020, from <https://www.finlex.fi/fi/laki/ajantasa/1986/19860041>, see also Finnish Institute for Health and Welfare, substance abuse services in Finland. Retrieved September 18, 2020, from <https://thl.fi/en/web/alcohol-tobacco-and-addictions/substance-abuse-treatment>
87. Mieli ry. Tietoa Lapset puheeksi menetelmästä. [Mental Health Finland, Let's talk about children-method]. Retrieved September 18, 2020, from <https://mieli.fi/fi/kehittämistoiminta/lapset-ja-nuoret/toimiva-lapsi-perhe-työ/lapset-puheeksi-lp-menetelmä>
88. Mental Health Finland. Retrieved September 18, 2020, from <https://mieli.fi/en>

Several municipalities in Finland have combined their mental health and substance abuse services. Thus, social and health services often collaborate in the prevention and treatment of mental illness and substance abuse. Mental health services can either be free or subject to a fee, depending on the type of service. Access to psychological treatment is more difficult than for substance abuse treatment, and the transition from one system to the next is less smooth. The Finnish Social Insurance Institution (Kela) can offer financial support for psychotherapy but this is usually only given if there are social problems as well. Again, there are regional differences in the availability of services and access to care.

Social difficulties

If it is identified that parents with a new baby have social problems, the ICH services can offer them psychosocial support, information about services (such as financial counselling), peer support groups and other help. Some services are provided in separate systems; for example, financial counselling is offered through social services. In the case of psychosocial difficulties, families can be referred to family counselling clinics for extra support. In such instances, there is collaboration with the ICH through the previously established collaboration between health and social services. Parents may also be offered home support where there is lowered functional capacity or where there are special circumstances in the family. In addition, there is support and guidance available online. The housing and financial aid systems offer necessary assistance with short waiting lists, although there may be regional differences in the availability of more extensive services. All social services, whether they are provided by the public system or NGOs, are free of charge. Municipalities, as well as joint municipal authorities, are responsible for realizing the aims of the service and evaluating its effectiveness.

Relationship difficulties

If relationship difficulties are identified, extra visits to the ICH are arranged and parents may be offered counselling from family workers at the ICH or family centre. The focus is on providing support for intimate relationships and preventing the escalation of problems. If additional support is required, parents can be guided to other services. All municipalities must have family counselling clinics offering additional support in the form of couples therapy and family counselling. The same services can often also be provided by NGOs and churches. Couples therapy can also be sought from private psychotherapists and online courses (e.g. on the Family Federation of Finland website). Couples therapy offered by municipalities and churches is usually free of charge but waiting lists are often long and there are regional differences in the availability and quality of services. Support for the costs of private therapy can be sought from Kela but, as with mental health services, this is usually only given when there are more substantial social problems. In general, support for the parental relationship is an area that needs further strengthening.

Alcohol and substance abuse

Parents receive information about the dangers of alcohol consumption and substance use as a routine part of ICH. They may also be offered online resources, such as those available from the Federation of Mother and Child Homes and Shelters. If mild problems with alcohol or substance use are identified, a brief intervention might be offered by the public health nurse at the ICH. For more severe problems or addictions, treatment is offered through cross-sectoral collaboration agreements, with the ICH monitoring the impact of the addiction on the health and wellbeing of the child. There are clearly defined care pathways for substance abuse in Finland and it is the responsibility of municipalities to coordinate public, NGO-based and private substance abuse services as a functional whole. The services may be in the form of peer support, drug replacement therapy, substance abuse rehabilitation and/or health counselling. Help is also available for parents to reorganize their lives after substance abuse treatment, including support with housing and financial matters. As with other services, there are regional differences in availability and access to care, and some services are free while others are subject to a charge.

According to national guidelines, substance abuse treatment should be provided in a multidisciplinary collaboration with prenatal and ICH clinics. Preventive child protection notifications are submitted for parents with substance abuse problems during pregnancy and after the child is born, a child protection notification is made in order to assess the need for child protection and arrange support services. The growth and development of a child living in a family exposed to substance abuse should be followed up closely by child welfare services, primary care and specialized medical care. Children who have been exposed to substance use in pregnancy should also be followed up in multidisciplinary service settings at social paediatric outpatient clinics or regional hospitals⁸⁹. However, it has been noted that there is insufficient follow-up of children growing up with substance abuse in the home, and this needs to be improved⁹⁰.

Violence and trauma

There are national guidelines and recommendations in ICH for preventing, detecting and responding to intimate relationship and domestic violence. Municipalities, joint municipal authorities and hospital districts develop shared practices for the detection of violence, screening methods and the facilitation of early intervention. In ICH, all women are asked about violence, at the child's six-month examination at the latest, and after that in annual examinations or whenever needed. A screening form that includes psychological violence and violence against the child is recommended as a screening tool for intimate relationship violence. All parents are reminded that violence is forbidden in Finland and informed of the importance of a secure, stable upbringing environment and the harm caused to children by toxic stress, such as in the case of domestic violence. In the extensive health examinations, ICH staff also administer previously described questionnaires about family resources that can

89. Nordic Welfare Centre. Retrieved September 18, 2020, from, <https://nordicwelfare.org/en/publikationer/fasd/>
90. CRC /C/FIN/CO/4, 31. and 32, 2011. Comments 31. and 32. to Finland by the UN Committee on the Rights of the Child, 2011

serve to facilitate discussions on this issue. Parents can receive support and resources from ICH and family counselling clinics (family clinics) for current and previous violent or traumatic experiences. Extensive treatment is not provided in primary care, however, but through referral to other services, such as specialist health services and social services.

In ICH in recent years, more emphasis has been placed on violence prevention, and violence must now be screened in both social services and healthcare^{91 92 93 94}. Professional resources have also been increased and ICH staff receive more training on issues relating to violence. As with other services in Finland, municipalities specify the division of responsibilities between sectors and identify the individuals in charge. All municipalities must have an action plan for preventing and responding to violence, which includes preventive activities, low-threshold services, acute services (e.g. shelters and crisis assistance) and long-term support and treatment for people traumatized by violence^{95 96 97}. For example, shelter services and the Nollalinja hotline are specific social and healthcare services for families experiencing violence. Nollalinja is a national free-of-charge helpline for anyone exposed to violence or threats of violence in close relationships. The helpline is also available for relatives of those who have been subjected to violence and for professionals seeking advice in their work with clients. For acute violence, operational models have been created to ensure that the collaboration and flow of information between the authorities and different service providers are smooth.

Specialized long-term support in the form of individual or group-based therapy for victims of violence must be available in all municipalities or the more extensive region. Those suffering from chronic symptoms caused by sexual violence must also have access to psychiatric consultation and therapy. Support and treatment can be provided in both health services and special violence prevention services organized by the third sector. Examples of such resources are the sexual violence crisis centre Seri, which is being established in connection to hospitals, and Tukinainen, which offers support, counselling and guidance relating to sexual assault and abuse, including legal advice. The Federation of Mother and Child Homes and Shelters is a nationwide child welfare organization that focuses on preventing violence and helping children and families in insecure circumstances. It provides shelter services in the form of free 24-hour crisis units to which individuals or families can turn of their own accord or be referred if they have been subjected to, or are at risk of, intimate relationship violence. Services are provided anonymously if necessary.

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91. Korpilahti, U., et al. eds. (2019) *Väkivallaton lapsuus. Toimenpidesuunnitelma lapsiin kohdistuvan väkivallan ehkäisystä 2020-2025*. Sosiaali- ja terveysministeriö 2019: 27. Helsinki. [Ministry of Social Affairs and Health. Non-violent childhood – Actionplan for the prevention of violence against children 2020-2025]. Retrieved September 18, 2020, from http://julkaisut.valtioneuvosto.fi/bitstream/handle/10024/161899/STM_2019_27_J.pdf
 92. Hoitotyön tutkimussäätiö (2015). *Lasten kaltoinkohtelun tunnistamisen tehokkaat menetelmät sosiaali- ja terveydenhuollossa*. [Effective method for identifying child abuse in social and health care, Nursing Research Foundation]. Retrieved September 18, 2020, from <https://www.hotus.fi/wp-content/uploads/2019/03/kaltoinkohtelu-hs.pdf>
 93. Terveyden ja hyvinvoinnin laitos. Vauvan ravistelun ehkäisy. Tiedä ja toimi. [Finnish Institute for Health and Welfare. Preventing of the shaking of the baby. Info card for professionals]. Retrieved September 18, 2020, from http://www.julkari.fi/bitstream/handle/10024/137002/TT_vauvojen_ravistelu_15102018_verkko.pdf
 94. Sosiaali- ja terveysministeriö (2008). *Tunnista, turvaa ja toimi. Lähisuhde- ja perheväkivallan ehkäisyn suositukset*. [Ministry of Social Affairs and Health. Recommendations for the prevention of interpersonal and domestic violence. Recognise, protect and act. How to guide and lead local and regional activities in social and health care services]. Retrieved September 18, 2020, from http://julkaisut.valtioneuvosto.fi/bitstream/handle/10024/74213/Julkk_2008_9_perhevakivaltatyon_suosituks_verkko.pdf
 95. See also Finnish Institute for Health and Welfare. Barnahus project. Retrieved September 18, 2020, from <https://thl.fi/en/web/thlfi-en/research-and-expertwork/projects-and-programmes/barnahus-project>
 96. See e.g. Finnish Institute for Health and Welfare. Shelters for victims of domestic violence. Retrieved September 18, 2020, from http://www.julkari.fi/bitstream/handle/10024/127166/THL_TT_kortti_A4_Turvakodit_091115_verkko.pdf
 97. The Federation of Mother and Child Homes and Shelters. Retrieved September 18, 2020, from <https://ensijaturvakotienliitto.fi/en/>

Parental leave

In Finland, mothers have an exclusive right to 17.5 weeks of maternity leave, which starts between five and eight weeks before the baby's due date and ends when the child is about 3 months old. This leave is not transferable to the other parent. The mother receives benefits amounting to 90% of her usual income for the first nine weeks and approximately 70% of her income after that. A flat-rate minimum benefit is paid to those with no previous income. The other parent has a right to paternity leave for nine weeks, and receives around 70% of their previous income until the child is two years old. They can take a maximum of three weeks while the mother is on maternity (or shared parental) leave. In addition to the exclusive leave for each parent, either of them can take 26 weeks of shared parental leave until the child is about nine months old, and they receive income-related benefits of around 70%. Thus, in total, parents receive about a year of full-time parental leave after childbirth. However, if both parents simultaneously reduce their working hours to 40–60%, they can use their parental leave on a part-time basis. At the end of formal parental leave, either parent can also take childcare leave and receive a flat-rate allowance until the child is three years old, or they can work part-time and receive a flexible home care allowance. However, this home care allowance is rather low^{98 99}.

Early childhood education and care

Children in Finland have the right to early childhood education and care (ECEC) from the end of parental leave, in the form of either family daycare or early education centres. Children also have the right to attend so-called "open ECEC activities", where parents accompany their children to play and interact with other children in family centres or other facilities. Almost all children under one year old are still at home with their parents, with less than 1% in ECEC outside the home. After the first year, about a third (35%) of children are enrolled in some form of ECEC and at two years of age, the ratio is about 66%. Thus, many parents continue to use a home care allowance to stay at home with their children during the child's first two years. More than half of children in outside ECEC are there for 5–7.5 hours a day and a little under half of them are in ECEC for 8–9.5 hours a day¹⁰⁰. Parents make their own arrangements with ECEC providers regarding the adjustment process and children are slowly introduced to the ECEC environment in the presence of their parents. Usually, the adjustment period is 1–2 weeks but it depends on the age and needs of the child.

The ECEC system in Finland is organized as a whole, irrespective of whether it takes place in family daycare or early education centres, and follows the same national core curriculum issued by the Finnish National Agency for Education. In both settings, there are requirements for working in a systematic and pedagogical manner on the children's upbringing, education and care. Municipalities are responsible for ensuring that ECEC is available according to the needs of the

98. Terveystieteiden tutkimuskeskus. Tutkimusta perhevapaista. [Finnish Institute for Health and Welfare. Research on parental leave in Finland]. Retrieved September 18, 2020, from <https://thl.fi/fi/tutkimus-ja-kehittaminen/tutkimukset-ja-hankkeet/perhevapaatutkimus/julkaisu-ja-perhevapaista>

99. The Social Insurance Institution of Finland (Kela). Parental allowances in Finland, <https://www.kela.fi/web/en/parental-allowances>

100. Hietamäki, J. et al. (2017). *Varhaiskasvatus- ja lastenhoitoratkaisut yksivuotiaiden perheissä: CHILDCARE-kyselytutkimuksen 2016 perustulokset*. Terveystieteiden tutkimuskeskus. Helsinki. [Solutions on early childhood education and care in families with one-year-old children. Finnish Institute for Health and Welfare]. Retrieved September 18, 2020, from https://www.julkari.fi/bitstream/handle/10024/132438/URN_ISBN_978-952-302-869-2.pdf

population. The same regulations apply for private ECEC and parents can also apply for a private daycare allowance from Kela.

Family daycare

Family daycare is part of the education sector and can be managed either by municipalities or private providers. Childminders in family daycare are employed by the municipality although they work in their own homes. They can have a maximum of four children full-time and one child part-time enrolled at a time. The Act on Early Childhood Education and Care^{101 102 103} specifies the qualifications required of ECEC staff, including childminders, with information about the qualifications needed for different roles as well as the number of employees per unit. Required training for childminders in family daycare includes professional skills in early childhood education and care, and they must perform their work according to the principles of the national core curriculum for early childhood education and care. The law stipulates that all organizers of early childhood education and care must provide some form of skills enhancement to support the expertise of their staff. However, the situation varies between municipalities.

Early education centres

Early education centres in Finland are a part of the education sector. They are managed by municipalities and subject to the requirements of the national core curriculum for ECEC¹⁰⁴. Each municipality also develops its own local curriculum based on the national one and each early education centre can have more detailed plans on how it organizes its work. The organizers of ECEC evaluate the service they provide and participate in external evaluations of their operations. An individual ECEC plan is also developed for each child in the early education centre and family daycare ("A child's early childhood education and care plan"; VASU), which aims to support the child's overall development and learning. The child's plan is drawn up in collaboration with the child and their parents and should be reviewed and updated annually. Also, since 2020, a supervision programme on quality surveillance in ECEC has been arranged jointly by the National Supervisory Authority for Welfare and Health and the regional state administrative agencies.

As previously stated, employees must have particular statutory qualifications before they can be employed in particular jobs in ECEC services. Currently, one in three staff members must have a higher education level degree but the Act on Early Childhood Education and Care (the ECEC Act) stipulates that from 2030, two-thirds of staff should be university trained ECEC teachers or social pedagogues in ECEC. The Act stipulates that the remaining third should hold a vocational upper

101. Varhaiskasvatustaki 540/2018. [The Act on Early Childhood Education and Care]. Retrieved September 18, 2020, from <https://www.finlex.fi/fi/laki/ajantasa/2018/20180540>

102. See also e.g Opetus- ja kulttuuriministeriö. Tietoa varhaiskasvatustalvluista. [Ministry of Education and Culture. Information about ECEC services]. Retrieved September 18, 2020, from <https://minedu.fi/varhaiskasvatustalvluista>, Tilastotietoa varhaiskasvatuksesta. Terveysten ja hyvinvoinnin laitos. Helsinki. [Finnish Institute for Health and Welfare. Statistics about ECEC]. Retrieved September 18, 2020, from http://www.julkari.fi/bitstream/handle/10024/138571/Tr32_19_vuositalasto.pdf?sequence=5&isAllowed=y

103. Opetus- ja kulttuuriministeriö. Varhaiskasvatusta koskeva lainsäädäntö. [Ministry of Education and Culture. National legislation on ECEC]. Retrieved September 18, 2020, from <https://minedu.fi/varhaiskasvatustalvluista>, see also Eurydice, European Commission. Early Childhood Education and Care. National Policies. Finland. Retrieved September 18, 2020, from https://eacea.ec.europa.eu/national-policies/eurydice/content/early-childhood-education-and-care-25_en

104. Finnish national agency for education. National Core Curriculum for Early Childhood Education and Care in a nutshell. Retrieved September 18, 2020, from <https://www.oph.fi/en/education-and-qualifications/national-core-curriculum-ecec-nutshell>

secondary qualification in education and guidance or healthcare and social services. Thus, the new staff structure for centre-based ECEC from 2030 will be: one teacher; one teacher or social pedagogue; and one child carer with upper secondary level training in childminding. There is currently a shortage of qualified ECEC teachers in Finland. Staff turnover is also a problem. In the municipal sector, average wages are around DKK 23,968 (€3,215) but the average monthly wage of an ECEC teacher is approximately DKK 19,853 (€2,663), albeit with regional differences. In the private sector, average salaries for ECEC teachers are even lower. National average wages are around 26,093 DKK (3,500 EUR). ECEC teacher salaries have also not increased at the same pace as other wages in the municipal sector. Thus, ECEC teacher salaries are significantly lower than average wages in Finland¹⁰⁵.

The ECEC Act specifies general requirements in terms of accommodation for early education centres, but there are no specifications for the minimum number of square meters required per child. In general, there have been complaints about the quality of accommodation, especially in older buildings which may be too crowded and the quality of air and acoustics may be low. The ECEC Act also states that there must be a sufficient ratio between the number of children and the number of ECEC staff who have a professional qualification (ECEC teacher, social pedagogue or child carer). According to government decree, there needs to be at least one qualified ECEC staff member for every four children under three years of age; and a maximum of 12 children under three years of age are allowed in a single group.

The objectives of the ECEC Act and the implementation of the national core curriculum have largely been achieved well in Finland. For example, according to staff evaluations, the children's groups in ECEC have a positive atmosphere, children's safety is guaranteed and their right to play-based pedagogy is implemented according to the core curriculum. On the other hand, there are shortcomings in terms of structural factors, such as high staff turnover, lack of pedagogical skills and lack of support in relation to the content of ECEC and the core curriculum. It has also been reported that ECEC staff suffer fatigue due to large group sizes and they consider the ratio of staff to children to be too low^{106 107}.

ECEC staff should receive regular training and continuing education (CE) according to need, for example on healthy child development and learning, children's social and emotional needs, and risk factors (e.g. violence and neglect). As is the case for family daycare, the organizers of ECEC facilities are legally obliged to ensure skills enhancement for their staff. All ECEC providers also have a legal obligation to report to child protection authorities immediately if there are any signs of danger or threat to a child's wellbeing. According to national guidelines, all ECEC centres must have written procedures and collaborative agreements with other services (e.g. social services, child healthcare and child protection authorities) on how to respond to signs of violence or neglect among children. However, there is no coordinated surveillance system to support this practice.

105. Local government employers. Average earnings and working times in municipal sector. Retrieved September 18, 2020, from <https://www.kt.fi/en/municipal-sector-and-personnel/average-earnings-and-working-times>

106. See also Repo, L., et al. (2019). *Varhaiskasvatuksen laatu arjessa – Varhaiskasvatussuunnitelman toteutuminen päiväkodissa ja perhepäivähoidossa*. Kansallinen koulutuksen arviointikeskus, Karvi. [Every-day quality in early childhood education and care – ECEC curriculum implementation at day-care centres and in family day-care. Finnish education evaluation centre, Karvi]. Retrieved September 18, 2020, from <https://karvi.fi/publication/varhaiskasvatuksen-laatu-arjessa-varhaiskasvatussuunnitelmien-toteutuminen-paivakodeissa-ja-perhepaivahoidossa/>

107. Talentia (2018). *Varhaiskasvatuksen jäsenkysely*. [Talentia, Union of Professional Social Workers. Questionnaire for ECEC personnel]. Retrieved September 18, 2020, from https://www.talentia.fi/wp-content/uploads/2019/02/Varhaiskasvatuksen-jasenkysely_Raportti.pdf

Social and emotional development

As previously stated, municipalities must create local ECEC curricula based on the national core curriculum. This obligation also applies to open ECEC activities and ECEC activities purchased by municipalities, private ECEC providers supervised by municipalities and childminders in family daycare. The national core curriculum focuses largely on promoting social and emotional development among young children. It describes five interconnected areas of competence that are all related to the development of social and emotional skills: 1) thinking and learning; 2) cultural skills, interaction and self-expression; 3) self-care and everyday life skills; 4) multi-literacy and information; and 5) communication skills, participation and influence. Skills related to interaction, self-expression and empathy are important for identity formation as well as social skills and wellbeing.

Successful interaction with children from different cultural backgrounds or beliefs requires understanding and respect for your own and other people's beliefs and culture. Thus, children are encouraged to learn more about other people, languages and cultures. ECEC staff act as role models for children on how to meet other people in a multilingual and multicultural environment that includes a variety of beliefs. Cooperative activities also offer opportunities to practice interaction and self-expression in different situations with different people. Social skills training (e.g. putting yourself in somebody else's shoes, seeing things from other perspectives and solving conflicts in a constructive manner) involves skills that are regularly practiced with children in ECEC. The child's plan also includes encouraging messages that describe the child's development and learning in a positive manner.

Desired behaviour and social skills are taught in an age-appropriate manner with all children, and there is an emphasis on ECEC staff modelling the skills that children are expected to learn. However, it is not common to see specific social-emotional learning (SEL) programmes in the Finnish ECEC system, although some early education centres have implemented programmes such as the Incredible Years or Triple P. In such cases, the municipality manages their implementation and provides staff training. Generally, there is a strong emphasis on staff coordination in supporting young children's social and emotional skills and responding to their needs. The national core curriculum on ECEC and local curricula align the set of values for the work.

Collaboration with parents

There is active collaboration with parents in Finnish ECEC through parent associations, collaboration with parents of individual children and informal meetings and gatherings. The previously mentioned child's plan is developed in collaboration with parents, so this method of working calls for continuous parental collaboration. The child's plan also details the number of meetings that will be held with each child's parents, which is usually one or two per year. There are also parent surveys to assess the child's wellbeing, ECEC accommodations, relations with staff, and so on.

Parental collaboration is interactive, with the goal of promoting the child's safe and healthy upbringing, development and education. Thus, establishing trust, equal interaction and mutual respect is important. The focus is on taking family diversity and the child's individual needs into account. There is an emphasis on the child

participating in the collaboration in a meaningful and age-appropriate way. The child's plan describes the structure of the child's day, based on the joint observations of parents and staff, to ensure the child's overall wellbeing. Particular attention is paid to any transition periods, such as when the child first starts ECEC or when he or she changes early education centres. Parents are contacted immediately if concerns arise regarding challenges in the child's development, education or social interaction, or other issues concerning the child's wellbeing.

Collaboration with other services

Multidisciplinary and cross-sectoral collaboration is required of all agents involved in children's health and wellbeing, including ECEC. By law, when arranging ECEC, municipalities must collaborate with other parties in education, physical activities and culture, child welfare, social services, healthcare (including prenatal and child healthcare) and any other necessary parties. Thus, there is close collaboration between early childhood education and care and child healthcare, as well as family counselling centres. These parties have jointly agreed methods of collaboration and information exchange. A regular venue for such collaboration is established so that it is already in place when and if concerns arise about the development and wellbeing of a child. Through this cross-sectoral venue, support for the child is assessed, planned and arranged.

Subject to parental written consent, extensive health examinations in ICH also include the ECEC staff's evaluation of the child's wellbeing and ability to cope in early education. The evaluation is an important part of the assessment of the child's overall development and wellbeing, as well as early identification of any needs for special support. Representatives from early education centres participate in family service networks and, if necessary, the previously mentioned multidisciplinary early intervention teams at ICH. Overall, children in ECEC have good access to support for clinically diagnosed problems (e.g. autism or Down syndrome) but staff can experience difficulties in accessing adequate support to address more general issues, such as emotional or behavioural problems. There are ECEC support services ("ambulatories") that visit early education centres to guide ECEC staff in such situations but their services are often not as accessible or sufficient as needed, especially for milder problems.



Iceland

Prenatal care

Prenatal care as well as infant and child healthcare are provided in primary healthcare centres in Iceland. The healthcare system is managed by the state through seven health regions across the country¹⁰⁸. There are a few primary healthcare centres in the capital area that are privately run but these are funded by the state and offer the same service as publicly run healthcare centres. Midwives are the key professionals in prenatal care, in collaboration with general practitioners (GPs). Most primary healthcare centres also offer psychological services, and pregnant women can be referred to specialists, such as obstetricians, when needed. Women usually see the same professionals throughout pregnancy.

The first prenatal appointment usually takes place around gestation weeks 8–12¹⁰⁹. According to national guidelines, women have ten prenatal appointments when they are expecting their first child and seven during subsequent pregnancies. More frequent appointments are offered for high-risk pregnancies. Women in this category are usually referred to care at the maternity unit of one of the two main hospitals, the National University Hospital in Reykjavik and Akureyri Hospital in the north of Iceland. Apart from regular prenatal appointments, an ultrasound scan is offered 19–20 weeks into the pregnancy and an optional screening for chromosomal abnormalities in weeks 11–14. The latter is the only test that is subject to a fee, otherwise all prenatal care is free of charge. The other parent is encouraged to join women for prenatal appointments and they often attend at least the first appointment as well as the ultrasound. They are not offered individual appointments on their own but can request one. However, midwives prefer to see pregnant women alone at least once, ideally in week 16, to screen for violence.

Icelandic prenatal services adhere to the NICE guidelines, which were translated and adapted to Icelandic settings in 2008, and are currently under revision¹¹⁰. The

108. Lög um heilbrigðisþjónustu, No. 40/2007. Retrieved September 14, 2020, from www.althingi.is/lagas/nuna/2007040.html [Icelandic Healthcare Act no. 40/2007, English translation: www.government.is/media/velferdarraduneyti-media/media/acrobat-enskar_sidur/Health-Service-Act-No-40-2007-as-amended-2016.pdf]

109. Heilsugæsla höfuðborgarsvæðisins (n.d.). *Mæðravernd*. Retrieved September 14, 2020, from www.heilsugaeslan.is/thjonusta-stodvanna/maedravernd/

110. Embætti landlæknis & heilsugæsla höfuðborgarsvæðisins (2008). *Meðgönguvernd heilbrigðra kvenna í eðlilegri*

Development Centre for Primary Health Care in Iceland (DCPHI) is responsible for the implementation of the guidelines and offers regular courses for midwives on applying them in clinical practice. There is a defined procedure for the implementation of the guidelines throughout the country but it is not mandatory to attend courses and some rural municipalities have reported a lack of information and limited access to training courses. The registration of standard information is coordinated throughout the country through an electronic medical record system called Saga. The Saga system is managed by the Directorate of Health and is used in all healthcare facilities nationwide, from primary healthcare centres to hospitals. Health professionals and certain administration staff have access to maternity records but may only access them for good reason. Maternity records were digitised in 2018, and accessing them leaves a digital footprint. As of 2019, all patients can partly access their own health records, including maternity records, through an online health information and service hub, "Heilsuvera" (www.heilsuvera.is), which is jointly managed by the Directorate of Health and the Primary Health Care of the Capital Area.

There are no formal procedures to make sure that all women attend prenatal care but due to the small size of the Icelandic population, information about prenatal services and the healthcare system in general is well disseminated. Information is available on the primary health service's website, on heilsuvera.is and booklets in waiting rooms at primary care facilities. However, the information may not reach marginalized groups as easily. For example, although immigrants receive information about the healthcare system in Iceland, including prenatal services, when they enter the country most of the information on the primary health service and Heilsuvera websites is only available in Icelandic. Nevertheless, it is estimated that nearly all women attend prenatal care during pregnancy, with national statistics showing that only around 0.03% do not attend before childbirth.

Mental wellbeing and preparation for parenthood

National guidelines specify that prenatal staff should be mindful of expectant mothers' mental wellbeing throughout pregnancy. Mental wellbeing should be discussed during the first prenatal appointment and regularly throughout prenatal care, along with general discussions about both parents' lifestyle and life circumstances. However, there are no defined procedures for providing women with information on how to support their own mental wellbeing during pregnancy, and this may be an area in which improvement is needed. Greater emphasis seems to be placed on detecting or preventing signs of mental health problems than on promoting or maintaining positive mental health. The other parent does not receive specific information about their mental health but they receive information regarding the pregnant woman's wellbeing if they attend prenatal appointments.

A variety of information is available online, for example on heilsuvera.is and the Icelandic Midwives Association's website at www.ljosmodir.is, which offers extensive information about pregnancy, birth and parenthood. It has a large Q&A section where anyone can send an anonymous question or search through thousands of

questions that midwives have answered previously. The association also has a large social media presence, including a popular Instagram account run by recently graduated midwives. Parents can also download the "Pregnant" app to help them prepare for parenthood, which includes information on mental wellbeing. This is an Icelandic adaptation of the Danish version of the app, which was developed by midwives in collaboration with the Danish and Icelandic midwives associations. Some private clinics and individuals also offer courses on wellbeing during pregnancy and preparation for parenthood but these are usually only available for a fee in urban areas.

Although national guidelines state that all expectant parents should be offered preparation courses for parenthood in prenatal care, the courses that are currently offered mostly focus on the upcoming birth and breastfeeding, rather than the parenting role per se¹¹¹. The courses are offered for a moderate fee and run by midwives in the more densely populated areas. They are offered in English and Polish as well as Icelandic. The DCPHI also runs a six-week course for pregnant women, run by a midwife and a psychologist¹¹². Although the course consists of a six-week series of trans-diagnostic, cognitive-behavioural therapy (CBT) group therapy sessions for mental distress, it also focuses on mental wellbeing and preparing for motherhood, involving themes such as body image, attachment, mindfulness and relaxation techniques. The course was developed for pregnant women with mild mental health difficulties but a diagnosis is not a prerequisite for attendance. It is free of charge with a short waiting list and can be accessed via referral from a midwife, GP or psychologist. However, it is only available in Icelandic, and only in the capital area and a few other regions. Thus, there are linguistic and geographical restrictions to access although the aim is to deliver the course nationwide.

Risk factors in pregnancy

At the first prenatal appointment, it is recommended that midwives discuss risk factors with pregnant women as well as general health, nutrition and lifestyle. Prospective mothers are asked about their use of tobacco, alcohol, prescription medicine and other substances, and are given information about the harm caused by such substances and the importance of a healthy lifestyle during pregnancy. They are also asked about social factors, such as their relationship status, housing situation and other children in the household. National guidelines emphasize that prenatal care should take place in an environment where pregnant women feel comfortable discussing sensitive matters, such as domestic or sexual violence, mental health difficulties, substance use and social problems. These issues should be continuously monitored throughout pregnancy, through regular contact between midwives and pregnant women. Although access to interpreters is available in prenatal care, including by telephone, language can still be a barrier, especially when discussing sensitive matters. There are defined procedures and clear routes for referral for psychosocial problems but no specific procedures are in place to ensure adherence to them.

111. Heilsugæsla höfuðborgarsvæðisins (n.d.). Retrieved September 14, 2020, from <https://www.heilsugaeslan.is/serthjonusta/namskeid/>

112. Heilsugæsla höfuðborgarsvæðisins (n.d.). Retrieved September 14, 2020, from <https://www.heilsugaeslan.is/serthjonusta/namskeid/andleg-vanlidan-a-medgongu/>

National guidelines for prenatal care include a stepped-care model for women who may need more specialized services, such as very young women, women lacking social support and women with intellectual disabilities. In such cases, a more multidisciplinary approach may be needed than can be provided in regular prenatal care. Other vulnerable groups, such as women with a history of recurrent miscarriage or mental health issues, may also need to be under the supervision of other specialists such as obstetricians or psychologists, but can still receive standard prenatal care in other respects. Women with severe difficulties, such as substance abuse or a history of postpartum psychosis, should receive specialized prenatal care that is organized by an obstetrician-gynaecologist and a midwife in a hospital setting.

Mental health difficulties

According to national guidelines, enquiries about pregnant women's mental health, including previous psychiatric treatment and any family history of mental illness, should take place at the first prenatal appointment. Two Whooley questions about depression and two items on the General Anxiety Disorder scale (GAD-2) for anxiety, should also be administered as a preliminary screening. If answers indicate a problem, the Edinburgh Postnatal Depression Scale (EPDS) and the full General Anxiety Disorder Scale (GAD-7) should be administered. Universal screening for depression and anxiety via the EPDS and the GAD-7 takes place around gestation week 16. A few healthcare centres also report using other screening instruments, such as the Depression Anxiety Stress Scale (DASS), the Patient Health Questionnaire (PHQ-9) and questions from the Adverse Childhood Experiences (ACE) questionnaire. These screening tools are all available in several languages.

The DCPHI has developed standard procedures in prenatal care regarding screening and treatment for depression and anxiety, which have been adopted by most healthcare centres around the country¹¹³. Training courses for midwives on screening methods and mental health support are delivered on a regular basis by the DCPHI but there may be less access to these courses in rural areas, as midwives in some parts of the country have reported a lack of training. In the stepped-care protocol for the treatment of depression and anxiety in prenatal care, when problems are detected the first step is to offer more frequent midwife appointments with guidance and supervision from the healthcare centre's psychologist. The next step would be a referral to the aforementioned CBT group therapy led by a midwife and a psychologist. Pregnant women may also be referred to general CBT group therapy, which is offered at several healthcare centres. The third step involves collaborating with the healthcare centre's GP and/or psychologist for a further evaluation of clinical problems and treatment needs. The number of psychologists in Icelandic primary care has multiplied over the last few years and most (but not all) healthcare centres can offer pregnant women short-term psychological treatment for mild to moderate problems. While emphasis is placed on equal care, resources and services may differ from one area and healthcare centre to the next. The fourth and final step would be to issue a referral to a hospital psychiatric unit for further evaluation

113. Þróunarmiðstöð íslenskrar heilsugæslu (n.d.). *Vinnulag við skimun og meðferð þunglyndisog kvíða í ung- og smábarnavernd*. Retrieved September 14, 2020, from [http://throunarmidstod.is/library/Files/Vinnulag%20vi%C3%B0%20skimun%20og%20me%C3%B0fer%C3%B0%20%C3%BEunglyndis%20og%20kv%C3%AD%C3%B0a%20%C3%AD%20ung-%20og%20sm%C3%A1barnavernd%20-%20Copy%20\(2\).pdf](http://throunarmidstod.is/library/Files/Vinnulag%20vi%C3%B0%20skimun%20og%20me%C3%B0fer%C3%B0%20%C3%BEunglyndis%20og%20kv%C3%AD%C3%B0a%20%C3%AD%20ung-%20og%20sm%C3%A1barnavernd%20-%20Copy%20(2).pdf)

and treatment at one of the two main hospitals, in the capital area and in the north of Iceland. There is usually good collaboration and teamwork between the different professionals in the healthcare centres. The referring professional, usually the midwife, is responsible for the follow-up and continuity of services.

The other parent can also be referred to the healthcare centre's psychologist, where available, if their problems are mild to moderate. However, at present, psychological services in primary care prioritize 0–18-year-old children and expectant or new mothers. The service is free of charge for children and pregnant women but other adults pay a small fee. Psychological treatment usually involves CBT-based interventions but other resources in primary care include appointments with a GP or sometimes a psychiatric nurse. A specialized service is also currently being devised within primary care services for those struggling with emotional difficulties and attachment during pregnancy and the child's first year. This work is in its initial stages and the structure and function of the services are still under development.

Several healthcare centres around the country also offer multidisciplinary mental health services for adults at the secondary care level. These services are intended for more serious mental health problems that require a specialized, community-based approach. They are available through referral from a GP or other primary care professional but are not specially tailored to the needs of expectant parents. In some cases, the service offers flexible opening hours, and sometimes also home visits, but there is local variability in service operations. The service is free of charge but there is usually a waiting list. This is the only secondary level mental health service offered by the public healthcare system. The other option is to visit a professional in private practice, but this can be costly. Sessions with a psychiatrist are partly covered by the national health insurance system but private psychological services are not subsidized and can cost DKK 800–950 per session. Some unions partly subsidize psychological treatment, and social services can cover a few sessions if the individual concerned also has social problems. However, geographical limitations and language issues can be a barrier as well. Access to psychological services, and especially psychiatrists, is limited in rural areas, although recent developments in online treatment have improved this to some extent. Access to psychiatrists remains a problem, however, even in the capital area, as there is a general shortage of professionals in the field. Another issue is that resources in the private sector have no ties to prenatal care and follow-up is therefore limited.

For the past decade, a tertiary-level service called Parents–Pregnancy–Child (Foreldrar–meðganga–barn; FMB) has been available for expectant and new parents who are struggling with serious mental health difficulties when there are concerns about their ability to connect to and care for their child¹¹⁴. The service has been offered in combination with tertiary mental health resources at the National University Hospital and incorporates a multidisciplinary, family-based approach with a focus on parent-child attachment. It was organized collaboratively with specialized prenatal care, social services and child protection services, and each family was appointed a coordinator who was responsible for service coordination. At the moment, however, the service is undergoing re-structuring in collaboration with the primary healthcare services in the capital area.

In addition, several Icelandic NGOs specialize in mental health issues. They are open

114. Landspítali háskólasjúkrahús (n.d.). *Foreldrar meðganga barn - FMB teymið*. Retrieved on September 14, 2020, from www.landspitali.is/sjuklingar-adstandendur/teymi-/foreldrar-medganga-barn-fmb-teymid/

to anyone in the general population and provide self-help groups, peer support and free consultation for people with mental health difficulties and their families. The consultation can be done in person, or via email or telephone, is free of charge, does not require a referral and there are usually no waiting lists.

Social difficulties

Social services in Iceland are managed by the municipalities, which means that the organizational structure is not the same as for the healthcare system. The service is not aligned with prenatal care but midwives can refer pregnant women to municipal social services or contact child protection services if warranted, e.g. if living conditions are unacceptable. Social service resources differ somewhat between municipalities but most offer appointments with a social worker, financial assistance, housing assistance and home support (e.g. help with housework, child raising, etc.), and some offer a personal counsellor to accompany women to prenatal appointments. The services are free of charge but there can be long waiting lists, especially for housing, which can have waiting times of several years. However, vulnerable pregnant women and new mothers are a prioritized group for most resources.

Social services are generally responsible for the follow-up and continuity of services. There is currently a lack of systematic cross-sectoral collaboration in many areas, however, although this has been a major focus in healthcare reform and policy development in recent years. The sharing of information across systems is also limited by legal restrictions and this means that healthcare staff do not receive information regarding the social resources offered to pregnant women or whether child protection measures have taken effect after a notification has been filed. Work is currently underway within the Ministry of Social Affairs to improve this to some extent, for example through legislation that clearly defines the roles and responsibilities of different sectors in children's services according to a tiered model and legal obligations on sectors to work together. Service providers in certain areas have already started to form their own routines for cross-sectoral collaboration, which may be easier in some areas and in smaller municipalities, due to the services' proximity to each other.

Relationship difficulties

Relationship difficulties between expectant parents are not routinely assessed in prenatal care. However, if concerns arise, midwives can offer additional appointments for support or refer the parents to outside resources. Icelandic municipalities are obliged to provide family counselling for various issues, including parenting, but the legislation is rather vague and it is unclear whether it applies to couple's difficulties. For milder problems or disagreements, options vary between areas and may be limited to private therapists at a considerable cost. Some municipalities offer financial assistance for family or couple's therapy but generally there is limited access to such services. Only one healthcare centre in Iceland reports offering family therapy as part of its services. Psychologists in primary care usually do not offer couples or family therapy, and relationship difficulties would not qualify in themselves as a reason for psychologist referral. However, the pregnant woman's

partner might be invited to accompany her to treatment sessions if it is seen to benefit her wellbeing. Other resources include counselling for couples and families at local parishes, which are either free or provided for a moderate fee. The national church in Iceland also runs a family service centre and has offered courses for couples nationwide¹¹⁵. In general, however, there are no links between these services and prenatal care.

Alcohol and substance abuse

At the first appointment, all pregnant women are asked about their alcohol and substance use, and that of their partner, and receive advice on the risks during pregnancy. No screening instruments are available in Icelandic so standardized questions are used. National prenatal guidelines link to national guidelines on the treatment of alcohol dependence in primary care, which are adapted from the Scottish Intercollegiate Guidelines Network's (SIGN) clinical guidelines, "The Management of Harmful Drinking and Alcohol Dependence in Pregnancy"¹¹⁶.

If pregnant women have a history of alcohol dependence and/or substance abuse but have been sober for some time, they can be referred to the healthcare centre's GP or psychologist if they need support. Some municipalities also offer free sessions with a substance abuse counsellor. Additionally, pregnant women can be encouraged to seek consultation at the National Centre of Addiction Medicine (SÁÁ), a large NGO that offers individual and group counselling for those struggling with substance use disorders and their families. The centre also operates a detoxification clinic, inpatient and outpatient rehabilitation centres and halfway houses. It provides a large part of the alcohol and drug abuse treatment services in Iceland and is well linked to the general healthcare system.

If active alcohol and/or substance abuse is identified during pregnancy, women are referred to inpatient or outpatient services at the National University Hospital or the National Centre of Addiction Medicine. Day treatment is also available at the National University Hospital. In such cases, or when there is a recent history (within a year) of alcohol or substance abuse, prenatal care takes place at a high-risk pregnancy unit at the National University Hospital with a multidisciplinary team consisting of specialized midwives, social workers, a psychologist and an obstetrician¹¹⁷. Sometimes, however, especially in rural areas, women might continue to attend their regular prenatal care with support and supervision from the national high-risk unit. The Akureyri hospital in the north of Iceland also offers outpatient treatment for alcohol abuse but services are limited in other parts of the country. There are usually extensive waiting lists for alcohol and substance abuse services in Iceland but pregnant women are prioritized for admission. The services are mostly free of charge. The collaboration between hospital services and prenatal care are good but other services, such as the National Centre of Addiction Medicine, have few ties to prenatal care. In such cases, it is often unclear who has responsibility for the follow-up and continuity of services. Follow-up by systems that are meant to provide

115. Þjóðkirkjan (n.d.). *Fjölskylduþjónusta*. Retrieved September 14, 2020, from <https://kirkjan.is/thjonusta/serthjonusta/fjolskylduthjonusta/>

116. Scottish Intercollegiate Guidelines Network (2003). *The management of harmful drinking and alcohol dependence in primary care: A national clinical guideline*. Retrieved September 14, 2020, from <https://lx.iriss.org.uk/sites/default/files/resources/sign74.pdf>

117. Nissinen, N.M. & Frederiksen, N. (2020). *Identifying use of alcohol and other substances during pregnancy: a Nordic overview*. Stockholm: Nordic Welfare Centre. Retrieved September 14, 2020, from https://nordicwelfare.org/wp-content/uploads/2020/04/FASD-rapporten_FINAL.pdf

a safety net after treatment is sometimes found to be lacking, for example in areas such as housing assistance and general support to get back on track after prolonged alcohol and substance abuse.

If problems concerning maternal alcohol or substance use arise during pregnancy, healthcare staff are obliged by the Child Protection Act to contact child protection services. They work in close collaboration with healthcare facilities and social services. In Reykjavik, which is by far the largest municipality in Iceland, pregnant women with alcohol or substance abuse issues can be offered a residential place at a special home provided by child protection services, for observation and support during and after their pregnancy. However, there are no special procedures or resources if the other parent has problems with alcohol or substance use. They would receive the same care as the general public, which may include GP appointments, encouragement to attend local AA/NA meetings or referrals to the substance abuse unit at the National University Hospital or the National Centre of Addiction Medicine.

Violence and trauma

National guidelines on prenatal care state that prenatal staff should watch out for signs of domestic violence throughout pregnancy and that prenatal care should take place in settings where women feel comfortable discussing sensitive matters. The guidelines also stress the importance of early identification of women who have experienced genital trauma or mutilation. All women should be asked about their current or previous experience of violence, usually around week 16, without the presence of their partner. National guidelines on evaluating and responding to intimate partner violence in primary care were published in 2012, and these offer examples on how to phrase questions and adapt them to each individual. Many midwives have been trained in using the guidelines in clinical practice in order to better evaluate the health consequences of violence and trauma for pregnant women, make it easier for them to open up about their experience and ensure referrals to appropriate treatment and resources. However, there is no monitoring of whether or not enquiries about violence take place in prenatal care and women's answers are not systematically recorded in the electronic patient register so it is not possible to compile national data on the subject.

If concerns about violence or trauma arise, midwives can offer counselling, additional support and information about various resources, and can refer women to outside services, such as social services, child protection services and women's shelters. All health professionals also have a legal obligation to contact child protection services if there is concern about a child's wellbeing (e.g. due to violence in the home), which extends to unborn children. In case of physical harm, GPs and emergency services can provide medical assistance and primary care psychologists can offer therapy for mild to moderate trauma. As there are limitations in the availability of treatment at other service levels, primary care psychologists have also been trained to treat more severe post-traumatic stress disorder (PTSD). A specialized team at the National University Hospital's psychiatric unit offers treatment for severe PTSD via referral but the waiting list is currently more than a year. In addition, treatment can be sought from specialists in private practice, but this can be very expensive although social services sometimes offer financial assistance in this regard. There is also great

geographical variability in the availability of specialist services across the country. Healthcare centre services, including psychological treatment, and hospital treatment are free for pregnant women.

Other resources include a women's shelter (Kvennaathvarfið) for intimate partner violence, sexual assault and human trafficking, where women can stay for free when they are unable to stay in their own home¹¹⁸. The shelter offers self-help groups, emotional support, consultation and information, either in person or via telephone. It is located in Reykjavik but open to anyone regardless of where they live, and social services often pay travel expenses for women who live outside the capital area. Information and awareness-raising material, such as booklets, posters and information stickers for women's bathrooms, have been published in several languages. A counselling centre for survivors of sexual abuse and violence, called Stígamót, offers services for adults of all genders through individual sessions and support groups¹¹⁹. The main centre is located in Reykjavik but some counselling is offered around the country and there are two sister organizations outside the capital area, Sólstafir in the Westfjords and Aflið in Akureyri, the largest town outside the capital area¹²⁰.

Peace within the Home (Heimilisfriður) is a treatment and information centre for intimate partner violence that offers therapy for perpetrators as well as support for partners¹²¹. Drekaslóð is another information and support centre for victims of all kinds of violence and their families¹²². It offers counselling for individuals, couples and families, support groups and various courses, for a small fee. Bjarkarhlíð is a new family justice centre for survivors of violence, including human trafficking, which offers free counselling, support and information¹²³. Its aim is to provide coordinated services for survivors of violence in one place, including legal consultation, counselling, and guidance from social workers and the police. A sister organization, Bjarmahlíð, is located in Akureyri¹²⁴. There are usually no waiting lists for these services but major geographical limitations exist, as stated before. Furthermore, most resources have no links to prenatal care, and which means that follow-up is limited, although the referring midwife or health professional is responsible for following up on the case. If child protection services are involved, they take responsibility for follow-up and continuity of services.

Infant and child healthcare

Infant and child healthcare (ICH) is part of primary healthcare services and is located in general primary healthcare centres. Nurses and general practitioners (GPs) are the main professionals who manage ICH but paediatricians are also sometimes employed at the healthcare centre. Families usually see the same professionals throughout pregnancy and the child's early years, as this is an important part of ensuring continuity and building trust with the family. As previously stated, most healthcare centres also offer psychology services and some

118. Kvennaathvarf (n.d.). Retrieved September 14, 2020, from www.kvennaathvarf.is/?lang=en

119. Stígamót (n.d.). Retrieved September 14, 2020, from www.stigamot.is/

120. Aflið (n.d.). Retrieved September 14, 2020, from <https://afliak.is/>

121. Heimilisfriður (n.d.). Retrieved September 14, 2020, from <http://heimilisfridur.is/>

122. Drekaslóð (n.d.). Retrieved September 14, 2020, from <https://drekaslod.is/>

123. Bjarkarhlíð (n.d.). Retrieved September 14, 2020, from www.bjarkarhlid.is/

124. Bjarmahlíð (n.d.). Retrieved September 14, 2020, from <https://bjarmahlid.is/>

offer access to an occupational therapist, physical therapist, psychiatric nurse or family therapist, although that is rare. Nurses are present at all ICH appointments and a GP attends four of the appointments.

After the child is born, the service is divided between a midwifery service, which includes 5–8 home visits for the first 10 days after the birth¹²⁵, and ICH services, which begin when the child is aged 1–2 weeks¹²⁶. All infants are also examined by a paediatrician five days after birth in outpatient hospital settings. All of the services are free of charge. Midwives offering home visits work as contractors for healthcare centres and adhere to their own guidelines, which were last issued by the Directorate of Health in 2014¹²⁷. The service is not part of actual ICH but it is aligned with it, and often the same midwife caring for the family in prenatal care offers home visits after birth. Midwives determine the number of home visits based on individual need and the length of time the mother and baby stayed in hospital after the child was born. In some parts of the country, where women stay in hospital longer, they do not get this service. Midwives offer breastfeeding support through home visits, and families can get free appointments with a hospital breastfeeding counsellor for the first six weeks.

The first ICH visit is a home visit from a nurse 7–14 days after the child is born. After this, one or two home visits are offered over the next few weeks, and more can be arranged if needed. Although home visits are intended for all women, one healthcare centre reports it only provides this service for at-risk groups. In most cases, extended periods of home visits are offered for those who need it (e.g. due to social, emotional or developmental problems). Nurses evaluate each case and decide how many visits are needed. The first ICH appointment at the healthcare centre takes place when the infant is six weeks old, the next at nine weeks, and then at three, five, six, eight, 10, 12 and 18 months. Two appointments take place after the first two years, one at the age of 2½ years and the last one at four years of age. Thus, there are 12–13 ICH appointments in total, two or three of which are home visits. ICH services are free of charge and accessible for all. The service can be offered in many languages via an interpreter, including by telephone.

Children are automatically registered into the ICH system at birth. Health professionals are required to register them regardless of whether they are born in hospital or at home. It is very rare for children to be born at home with no health professional present at or shortly after the birth, and there are no indications that any infants are not being registered into the system. Parents are not obliged to attend ICH but most of them do, as they tend to trust ICH and want to receive the services they provide. According to national statistics, there is a participation rate of 91–100% at the appointments at three, five, 12 and 18 months, which include a vaccination¹²⁸. There has been an increased emphasis on recruiting families in recent years as there was a slight drop in attendance in 2016–2017. Thus, nurses sometimes call or send text messages to remind families of appointments, and some centres

125. Ljósmodir.is (n.d.). *Heimþjónusta ljósmæðra*. Retrieved September 14, 2020, from www.ljosmodir.is/saengurlega/heimathjonusta-ljosmaedra

126. Heilsugæsla höfuðborgarsvæðisins (n.d.). *Ung- og smábarnavernd*. Retrieved September 14, 2020, from www.heilsugaeslan.is/thjonusta-stodvanna/ung-og-smabarnavernd/

127. Embætti landlæknis (2014). *Faglegar leiðbeiningar fyrir heimþjónustu ljósmæðra*. *Endurskoðuð útgáfa*. Reykjavík: Embætti landlæknis. Retrieved September 14, 2020, from www.landlaeknir.is/servlet/file/store93/item23146/Fagl-leidbein-heima_ljosmaedur_2014_heildarskjal.pdf

128. Embætti landlæknis (2019). *Páttaka í almennum bólusetningum barna á Íslandi 2018*. Reykjavík: Embætti landlæknis. Retrieved September 14, 2020, from www.landlaeknir.is/servlet/file/store93/item37616/%C3%9E%C3%A1ttaka%20%C3%AD%20almennum%20b%C3%B3lusetningum%20barna%20%C3%A1%20%C3%8Dslandi%202018%20-%20loka.pdf

send out an invitation by mail before certain appointments. However, these procedures are not nationally coordinated, and since the service is not obligatory, nurses cannot enforce attendance.

National ICH guidelines were published in 2016 by the Directorate of Health and the Development Centre for Primary Healthcare in Iceland (DCPHI)¹²⁹. The guidelines focus on evidence-based practices and build on previous domestic and international guidelines, such as the NICE guidelines and the Swedish and Norwegian national guidelines. Procedures for implementation are nationally coordinated and professional managers at each healthcare centre are responsible for implementation. The DCPHI leads quality development on a national level in collaboration with the Icelandic Directorate of Health, which also conducts periodic audits of the quality of healthcare centre services. However, these audits are not performed on a consistent basis. The DCPHI also offers a training course for new nurses in ICH twice a year and whenever new elements are added to the guidelines. The course is run by nurses and midwives, in collaboration with other specialists as needed, and provides instructions about the practical application of ICH guidelines, registration of patient data, developmental assessments for young children and so on. It also includes specific topics, such as breastfeeding, attachment, vaccination and screening for anxiety and depression among new parents. While the course is intended to be accessible to all ICH professionals, some healthcare centres in rural areas report that lack of resources hinders nurses from participating in the training. However, increased options for internet-based training are expected to ameliorate this to some extent.

The registration of standard information in ICH is nationally coordinated through Saga, the electronic patient register. All health professionals in the public healthcare system have access to the register but are only allowed to access relevant information about their own patients. Unauthorized access is flagged and leaves a digital footprint. Patients also have the right to get copies of their medical records and the medical records of children under 16 years old in their custody.

Children's emotional wellbeing

Nurses monitor the development of emotional attachment between mother and child at home visits and regular ICH appointments, according to national guidelines. This is done by observing the interaction between mother and child, and the responses of the child, which is a particular focus in ICH for infants up to three months of age. The regular courses provided by DCPHI for new ICH nurses provide training in how to monitor attachment between parents and children and assist parents in reading the child's signals and expressions. Some healthcare centres have also trained all their nurses in motivational interviewing (MI), others emphasize using modelling and feedback with parents, and one centre has adopted the Solihull approach¹³⁰, which focuses on positive parent-child relationships and reflective parenting styles from birth through adolescence with a particular emphasis on including both parents in the training. According to national guidelines, parents

129. Þróunarmiðstöð íslenskrar heilsugæslu. *Ung- og smábarnavernd*. Retrieved September 14, 2020, from www.throunarmidstod.is/svid-thih/ung-og-smabarnavernd/

130. Solihull approach (2015). *Quick guide to the Solihull Approach*. Retrieved September 14, 2020, from <https://solihullapproachparenting.com/quick-guide-to-the-solihull-approach>

should receive regular information throughout ICH on children's emotional needs and healthy socio-emotional development. Whether and how this information is given, however, seems to depend on each healthcare centre. Often it is touched upon more informally through general discussion, but some healthcare centres offer more formal information and training regarding this topic and record it in the patient registry. There is also information about child development, parent-child interactions and mental wellbeing in the early years on the Directorate of Health's website (www.landlaeknir.is) and the information hub Heilsuvera (www.heilsuvera.is).

Children's social and emotional milestones are monitored at specific ages, starting at the first home visit, and continuing throughout ICH. Parents are routinely asked about their children's social and emotional development, with national guidelines stating which developmental milestones in particular to look for during each visit. For example, at the 12-month visit, specific indicators for autism are registered in the electronic patient register. The Parent Evaluation of Developmental Status (PEDS) screening is administered at 12 and 18 months (and again at 2½ years and four years) but can also be applied at other times if needed. This is an evidence-based screening tool that includes a 10-item questionnaire on parental concerns regarding the children's development, health and wellbeing. Some healthcare centres also collaborate with preschools on the collection of information on children's development and even administer some of the developmental monitoring in preschool settings, although this is still quite rare.

Some healthcare centres offer parents information on risk and protective factors for infant and child mental health, but this is not a systematic practice and there are no defined procedures for giving this information in ICH. However, the electronic patient register offers a structure for discussing any concerns that parents might have, as well as guidance for nurses on giving information that encourages healthy development. Parents are not usually informed about severe risk factors, such as the harm caused by toxic stress, unless indicated. The emphasis is on building trust between the nurse and family, and through the nurses' knowledge and understanding of family circumstances, they can better detect the need for information and support for each family. All nurses in ICH are offered a training course on providing relevant information and training to parents by the DCPH, but it is not obligatory.

Parents' emotional wellbeing

The mental wellbeing of the new mother is a particular focus in ICH for the first few weeks after birth, and they receive regular information on mental wellbeing from both the midwives at the home visits and the nurses in ICH. There are defined procedures for giving this information and a checklist for topics to discuss in Saga, the electronic patient register. However, there is local variability in how this is approached and the focus may be more on preventing, detecting or responding to mental health difficulties than promoting positive mental wellbeing. There are no resources on positive mental health in particular but there is a short-term CBT group therapy for new mothers with mild to moderate mental distress, which includes topics such as positive body image, self-care and social relations. No diagnosis is needed but a referral from ICH staff is required.

Family wellbeing

There is generally a lack of family intervention in the Icelandic primary care system, and family counselling is usually not part of the service, although nurses and primary care psychologists can provide some guidance. Families can be referred to social services or child protection services for serious family conflicts, or to private practice, for a substantial fee, for milder cases. Although municipalities are obliged to provide family counselling for issues such as parenting or intention to divorce, this may not apply to mild to moderate couple's or family difficulties. The national church offers family counselling, but the service is not aligned with ICH. There are no family centres in Iceland as in the other Nordic countries but some municipalities have aligned their services to cooperate in a more intersectoral manner across the education, social and healthcare sectors with an emphasis on prevention, early intervention and coordinated services. However, to date, there is no one-stop, low-threshold public family service that is universally available to parents.

Parenting skills

Through regular ICH appointments, nurses can offer parents advice on positive child-raising practices and encourage them to attend a parenting skills training course in primary care called *Parenting That Works: Building Skills that Last a Lifetime*¹³¹. This is a locally developed programme based on behavioural and social learning theories for parents of young children up to six years old as a universal or primary prevention resource. The programme consists of four two-hour sessions at a price of around DKK 420 for one parent and DKK 630 for two. The focus is on promoting positive interactions between parents and children, setting limits and encouraging positive behaviour. The course is run by nurses, psychologists or other professionals who take a special instructor course before delivering it. However, access depends on geographical location. Some municipalities also offer parenting skills courses through social or family services, such as *PMTO* and *SOS! Help for parents*, which are based on behavioural approaches, although these are usually not intended for parents with children under two years of age. In general, there are not many programmes to choose from and there are no national competence centres to guide the development or implementation of interventions in this area.

Risk factors in the early years

According to national guidelines, nurses and midwives should evaluate family circumstances and psychosocial difficulties from the very beginning in home visits and continuously through ICH. They should pay particular attention to vulnerable groups, such as young parents, immigrants and parents with substance abuse problems. Factors such as age, education, self-image, difficult life experiences,

131. Heilsugæsla höfuðborgarsvæðisins (n.d.). *Uppeldi sem virkar*. Retrieved September 14, 2020, from www.heilsugoeslan.is/serthjonusta/namskeid/uppeldi-sem-virkar/

difficulties caring for the baby, difficulties in the parental relationship, distress or difficulties during pregnancy and previous history of mental health problems can also indicate a need for extra help or specialized services. The DCPHI also regularly offers educational courses about certain topics, such as autism and children's language development.

There is routine screening for depression and anxiety in ICH but not for alcohol or substance use although nurses are encouraged to ask about this, as well as tobacco use. There is also no routine screening for violence. Routes for referral and follow-up differ somewhat from one area to the next as resources vary across regions and are often more limited in smaller, rural areas. In general, cross-sectoral collaboration and service continuity in Iceland has been criticized for being fragmented and inconsistent, with numerous reports calling for improvements in this area^{132 133}. Improving cross-sectoral collaboration and continuity of services is one of the top priorities in Iceland's mental health policy and action plan 2016–2020¹³⁴. However, progress has been rather slow at national level, although, as mentioned previously, some communities have already started to form their own routines for intersectoral collaboration and service continuity.

There is also a strong emphasis within the DCPHI on improving collaboration between prenatal and ICH services. The recommended practice is that prenatal care and ICH services should have regular consultation meetings and joint work procedures for families at risk, but this has not been established everywhere. If serious problems, such as mental illness, violence or substance abuse, are identified in prenatal care, ICH should be notified before the child is born but this may not be done consistently. Healthcare centres also collaborate with social services on a needs or referral basis, but this is another area that needs further development in Iceland. However, some healthcare centres do have a formal, permanent venue for collaboration with social services, not only for problems but also for prevention, early intervention and joint organization. In such cases, the healthcare centre and social services (as well as other parties, e.g. child protection services and tertiary mental healthcare for children) meet regularly for consultation and coordination of their work. In some areas, there is also collaboration between ICH and preschools, such as exchanging information about children in need of special support, developmental assessments in preschool where young children may feel more comfortable, or holding regular collaborative meetings to synchronize services. However, this collaboration is not systematic across the country and does not have a legal basis in the same sense that school healthcare has at the compulsory school level. As previously stated, however, current work on legal reforms by the Ministry of Social Affairs aims to make services for children and families more comprehensive and integrated, for example by prescribing the roles and responsibilities of different sectors (e.g. healthcare, education, social services) in relation to each other and the user (i.e. children and families) in a tiered fashion across all levels to tertiary care. It also proposes that all families requiring services across sectors should be assigned a service coordinator, which is currently not the case.

132. Ríkisendurskoðun (2016). *Gedheilbrigðisþjónusta við börn og unglínga: Annað og þriðja þjónustustig*. Reykjavík: Ríkisendurskoðun. Retrieved September 14, 2020, from <https://rikisendurskodun.is/wp-content/uploads/2016/02/SU-Gedheil-born-unglinga.pdf>

133. Embætti landlæknis (2018). *Stöðugreining og framtíðarsýn í gedheilbrigðismálum barna og ungmenna á Íslandi*. Reykjavík: Embætti landlæknis. Retrieved September 14, 2020, from www.landlaeknir.is/servelet/file/store93/item34860/Stodugreining%20og%20framtidasyn%20i%20gedheilbrmalum%20barna%20og%20ungmenna%20a%20Icelandi_Apri1%202018.pdf

134. Þingsályktun um stefnu og aðgerðaáætlun í gedheilbrigðismálum til fjögurra ára no. 28/145. Retrieved September 14, 2020, from www.althingi.is/altext/145/s/1217.html

In 2019, a new law was also passed in Iceland to support children's rights and wellbeing in adult services. The law defines the responsibility of health professionals to investigate whether adults in their care, who are being treated for mental disorders, substance abuse or a serious physical illness, have children under 18 years old in their custody¹³⁵. If so, the rights and circumstances of the child must be discussed with the patient, and the healthcare centre where the child is registered must be notified so they can open a dialogue with the child and/or their carers and offer support. If needed, the law also obliges the health professional, in collaboration with relevant healthcare centres, social services and the child's legal guardians, to contact the child's pre-, primary- or secondary school to ensure that support and counselling is offered. This also applies in the case of a parent's or guardian's death.

Mental health difficulties

The DCPHI has developed standardized procedures for the screening of depression and anxiety in ICH, as well as a stepped-care treatment protocol, which has been adopted by most healthcare centres around the country. Regular training courses are held for midwives and nurses on screening methods and clinical support. At the first ICH home visit from a nurse 1–2 weeks after a child's birth, two Whooley questions about depression and two items from the GAD-7 scale (GAD-2) for anxiety should be used to look briefly for signs that give rise to concern. If answers to these questions indicate a problem, the EPDS and GAD-7 are administered in full. All new mothers are also screened for depression and anxiety via these scales at the nine-week appointment. According to the stepped-care treatment protocol, additional appointments with a nurse should be offered for milder signs of mental distress but if symptoms are more severe, appointments with the GP or primary care psychologist would be offered. However, services may differ from one healthcare centre to the next as local resources vary, as does the professional diversity within the centres. As previously stated, several healthcare centres across the country provide secondary adult services that offer a specialized, multidisciplinary, community-based approach for more serious mental health problems. Some offer flexible opening hours and even home support, although there is local variability in service operations. The service is free of charge but there is usually a waiting list.

In the most clinically severe cases, referrals would be made to outpatient or inpatient services at psychiatric hospital units. If a mother with a young infant has to be admitted to inpatient psychiatric care, she can have her baby with her at the hospital and receive assistance in caring for it. However, secondary or tertiary services are limited in smaller or more rural areas. The same applies to various NGO services, such as counselling and support groups. The cost of mental health service varies considerably, from quite substantial (e.g. private psychological sessions) to limited (e.g. primary psychological services) or even free (e.g. inpatient hospital treatment).

Until recently, new mothers with serious mental health problems could also be referred to a tertiary outpatient service at the National University Hospital (Parents–Pregnancy–Child; Foreldrar–meðganga–barn; FMB) when there were concerns about their ability to care for their baby (up to 1 year of age). The service

135. Lög um breytingu á ýmsum lögum vegna réttar barna sem aðstandenda. Retrieved September 14, 2020, from www.althingi.is/altext/stjt/2019.050.html

offered a multidisciplinary, family-based approach with a particular focus on parent-child attachment. It was organized in collaboration with the family's healthcare centre, social services, child protection services and other relevant agencies, and each family was appointed a coordinator who was responsible for the coordination and continuity of services. However, the service is currently undergoing revision and restructuring, and new resources are being developed for parent and infant mental health and attachment within the primary care services.

Social difficulties

If parents with a new baby are identified as having social difficulties, they are usually referred to local social services, which offer a range of services that differ somewhat from one municipality to the next. Social services are not aligned with ICH but, as previously stated, there is often collaboration between the systems, albeit of varying quality and extent. Social service resources include counselling, financial assistance, housing assistance, home support (e.g. help with housework, etc.), a support family or support person and family-based interventions for issues such as child raising or difficulties in the family. The services are free of charge but are often subject to long waiting lists, especially for housing. However, families with young children, especially single parents, are prioritized. As previously stated, some municipalities have started to unite their services to enhance cross-sectoral collaboration (e.g. between pre- and primary schools, social services and child protection), with a focus on prevention and early intervention. This has resulted in a more comprehensive service and a more holistic, family-oriented approach to difficulties that families may be facing.

A specialized resource for young, single parents has also been developed as an experimental project in Reykjavik over the past decade. It is tailored to vulnerable groups who have received financial assistance from social services and offers diverse, multidisciplinary interventions aimed at increasing self-efficacy, daily activity, family wellbeing, social networking, and education and employment skills, thus breaking the cycle of poverty¹³⁶. To date, this resource has only been available in Reykjavik but preparations are underway for national implementation.

Relationship difficulties

During the first home visit, nurses should enquire about family circumstances and the parental relationship. When indicated, the mapping of family relations and social resources should be drawn up through a "genomap" of the internal family structure and an "ecomap" of relationships between the family and community, to enable social support needs, social network and resources to be estimated, and to assess their current use by the family. If it is identified that the parents have communication or relationship difficulties, and the problems are substantial, ICH staff can refer the case to social services or child protection services. Fewer resources exist for milder problems and in these cases parents may be referred to couples counselling in private practice. One healthcare centre in Iceland reports having a family therapist on their staff, and in this centre residents have good access to family counselling for free. Usually, primary care psychologists do not offer

136. Reykjavíkurborg (2017). *TINNA - Tækifæri til betra lífs*. Retrieved September 14, 2020, from https://reykjavik.is/sites/default/files/svid_skjol/VEL/tinna_vel_juli_2017.pdf

couples counselling and relationship difficulties would not warrant a referral to their services as a reason in itself. However, if relationship conflict was a contributing factor to a new mothers' clinical problems, this might be addressed in combination with other treatment priorities.

Alcohol and substance abuse

There is no formal screening for alcohol and substance abuse in ICH services and parents are usually not asked about their use of alcohol or narcotics unless concerns arise (e.g. during home visits). However, if alcohol or substance abuse has already been identified in prenatal care, ICH staff should be notified. Apart from general supportive counselling and motivational interviewing, there are no specific resources for alcohol or substance-related problems in primary care. Thus, parents of young children, like the general population, would be referred to treatment services at the National University Hospital or the National Centre of Addiction Medicine, both of which offer inpatient and outpatient services. The Akureyri hospital in the north of Iceland also offers outpatient treatment for alcohol abuse but, other than this, service is limited in rural areas.

In general, while treatment services for alcohol and substance abuse are mostly free or subject to limited charge, there are extensive waiting lists for most resources, especially after-treatment facilities. In addition, since there are often long waiting lists for social services as well, further help with restructuring life after treatment, including housing support, financial resolutions and social support, can be limited. This is an area that needs further improvement in Iceland in order to create a more continuous flow of services according to individual need that extends from access to treatment through to long-term follow-up. Alcohol and substance abuse treatment is not aligned with primary care and, thus, ICH services would not be involved in the care team. ICH staff are obliged to notify child protection services when there is reason to believe that a child's wellbeing is at risk, for example due to alcohol or substance abuse. However, as stated before, there is no formal way for these systems to exchange information so health professionals in ICH would not be notified about any measures taken to protect the child unless the initiative came from child protection services.

Violence and trauma

At present, there is no formal screening for or enquiries into violence or trauma in ICH services, although nurses are encouraged to ask about this if they believe there might be a problem. ICH staff should also be notified if a current or any previous history of violence has been detected in prenatal care. A regular course on domestic violence is offered to professionals by a specialized midwife in ICH and primary care. If intimate partner violence is detected, professionals in ICH follow national guidelines on evaluating and responding to it in primary care. Midwives and nurses can offer counselling and support, give information about helpful resources, and refer the case to social services, child protection and women's shelters. All health professionals have a legal obligation to contact child protection services if there are concerns about a child's wellbeing due to violence or neglect. In the most serious cases, children might be immediately removed from their home to ensure their

safety. A new protocol has also been established in recent years where a child protection representative is always called to the scene when the police make an emergency house call for domestic violence if children belong to the household, even if they do not reside there. The protocol also ensures that child protection services follow up on incidents and that the children receive ongoing support.

If new parents have a history of violence or trauma, primary care psychologists can offer treatment for mild to moderate cases; as previously stated, they have also been trained to treat more severe cases because of long waiting lists in tertiary care. Treatment can also be sought from clinicians in private practice, and a specialized PTSD team at the National University Hospital offers treatment for severe PTSD. However, the waiting list for this resource is currently over one year. Most of the available resources for violence and trauma are in the more densely populated areas and thus there are significant geographical limitations to most services. In addition, there are NGOs that can offer individual counselling, legal advice, empowerment and support groups. Most of these resources are in the capital area although some counselling is offered around the country in addition to telephone or internet services. A specialized resource for perpetrators and their families, Peace within the Home (Heimilisfriður), is available in Reykjavik and Akureyri. A new family justice centre for survivors of violence (Bjarkarhlíð), with a sister organization in the north (Bjarmahlíð), was also recently established. These offer a free one-stop service for counselling, peer support, legal consultation and police support, in addition to linking survivors with other services, such as healthcare or social services.

In the case of recurring violence, women can also be helped to contact the national women's shelter (Kvennaathvarfið), where they can stay for free with their children for a short period of time. The shelter offers self-help groups, emotional support, consultation and information via telephone or in person. The shelter is in Reykjavik but social services can help with travel expenses for women outside the capital area. Emergency services for sexual violence offer a specialized crisis unit at the National University Hospital, which includes medical examinations, emotional support, counselling and legal consultation. They can also offer psychological services in collaboration with the hospital's outpatient psychiatric unit. Similar crisis units can be found in a few other locations around the country, although their services may not be as extensive. A specialized resource for childhood sexual abuse, Children's House (Barnahús), is also available although this service is usually not offered to children under two years of age.

As a special resource for birth-related trauma, the Neonatal Intensive Care Unit (NICU) offers parents of premature babies a therapeutic interview to process their experience. This is based on research findings that mothers of premature babies are at increased risk of postpartum depression and attachment difficulties. The interview is offered to both parents when the child's health has stabilized and they are about to be discharged from the NICU. Listen to Me (Ljáðu mér eyra) is another interview intervention, offered at the maternity unit at the National University Hospital, for women who have had a negative birth experience and thus may fear getting pregnant or giving birth again¹³⁷. The intervention involves an interview with a midwife during which women are given the chance to discuss their experience step by step and make a plan for future births. About 50–70 women use this service

137. Emma Swift (2015). *Ljósmaður hjálpa konum að komast yfir erfiða fæðingarreynslu*. Retrieved September 14, 2020, from <https://heilsanokkar.is/ljosmaedur-hjalpa-konum-ad-komast-yfir-erfida-faedingarreynslu/>

annually, or 1–2% of all women giving birth in Iceland, although a large increase in demand was noticed in 2019 and 2020. It is recommended that women wait until a few weeks after giving birth to have the interview but it is also possible to have it years later. It is free of charge and available to all women but there may be a waiting list.

Parental leave

Icelandic parents are entitled to paid leave for 10 months, which is due to be extended to 12 months in 2021. Leave is divided between the parents, each receiving four months and arranging the remaining two months as they see fit. The right to parental leave must be used before the child reaches the age of 24 months and if one parent does not use their four-month leave it cannot be transferred to the other parent. An exception is made if the child is conceived in vitro or if the other parent is deceased, seriously ill or has to be admitted to hospital. Parents need to apply for parental leave and they receive 80% of their mean wages over the previous 12 months. There is a maximum payment of approximately DKK 32,000 and a minimum of approximately DKK 7,000 for parents in part-time employment of less than 50% of a full-time position and approximately DKK 9,600 for parents in part-time employment of 50–100% of a full-time position. There is no other form of paid leave for parents to stay at home with their children after formal parental leave ends, although a few municipalities do offer parents the option of home care allowance, which is usually the same subsidy as municipalities provide for family daycare. All parents also have a right to unpaid leave for up to three months, which expires when the child reaches eight years of age.

Early childhood education and care

There is currently a significant gap between the end of parental leave (when the child is aged 10 months) and admission to preschool (usually around the age of two), especially in the more densely populated areas. Home daycare is available during this period, but there can be long waiting lists for the service. In 2018, only 1% of Icelandic children under the age of 12 months and 49% of one-year-olds were enrolled in preschool. By two years of age, however, 94% of children were enrolled in preschool. Thus, as many as half of Icelandic children may be enrolled in home daycare between the ages of 10–24 months. Most children stay in preschool for eight hours per day. About 60% of preschools offer participatory adjustment, where parents can stay with their child for at least three full days. Others offer different adjustment processes, such as parents staying with their child for part of the day.

Home daycare

The home daycare system is managed by social services within each municipality. They provide licenses for childminders in home daycare and are responsible for the monitoring of the quality and safety of the service. The license allows the

childminder to care for four children in home daycare, or 10 children if two daycare providers work together. The level of monitoring and support of home daycare can differ from one municipality to another. The larger municipalities have supervisors dedicated solely to the support and monitoring of home daycare facilities, while in smaller municipalities this may be just one of the many diverse tasks managed by social services and thus may receive less focus.

Municipalities are responsible for offering a preparation course for new childminders in home daycare as well as regular training courses or meetings for those who are already practising. There are no specific conditions for the education or qualifications of childminders in home daycare other than a clear criminal record, a certificate of good general health and the completion of the preparation course held by the municipalities. Housing and general health and safety issues also apply (e.g. fire and accident prevention) and smoking or any use of intoxicants is forbidden. The preparation course covers bringing up and caring for children, children's needs and development, childhood illnesses, first-aid, fire and accident prevention, and child safety. There are no specific requirements for educational or social-emotional content in home daycare but regulations stipulate the childminder's overall responsibility to support children's healthy development and wellbeing, such as via food choices, games, toys, physical activity, time outdoors and social and emotional development¹³⁸. Each municipality can also set its own standards, consistent with regulations, about the content and quality of home daycare. For example, the city of Reykjavik has developed quality standards that, among other things, describe childminders' responsibility to participate in play with the children, foster autonomy by allowing them to try things for themselves, and promote language development through singing, reading and conversations.

Preschool

The Icelandic preschool system is managed by the education department in each municipality. However, the Ministry of Education and Cultural Affairs lays the legal foundation for the system, develops national policies and issues the national curriculum. In addition to the national curriculum, each municipality develops its own education policy and each preschool creates its own local school curriculum for how the national curriculum and the municipality's education policy will be implemented. The supervision of preschool quality is divided between the preschool administration, the municipalities and the Directorate of Education. Each preschool is required to perform an annual analysis of the quality of the work (e.g. by collecting data from staff, children and parents). The preschool should then present the results and an improvement plan to the education department at the local municipality. The municipalities and the Directorate of Education are also responsible for performing external evaluations based on results of the internal evaluation, field visits, interviews, and so on. However, external evaluations are done much less frequently.

Under Icelandic law, two-thirds of preschool staff must be university trained preschool teachers, but the current reality is that less than a third (28%) of staff are preschool teachers¹³⁹. Around 20% hold another university degree related to

138. Reglugerð um daggæslu barna í heimahúsum no. 907/2005. Retrieved September 14, 2020, from www.reglugerd.is/reglugerdir/allar/nr/907-2005

139. Mennta- og menningarmálaráðuneytið (2019). *Aðgerðir í menntamálum: Nýliðun kennara*. Reykjavík: Mennta- og

education or care, while other staff are not professionally trained. The 2018 TALIS report also showed that, compared to other participating countries, a relatively low percentage of Icelandic ECEC staff have received practical training (71%) and training specifically to work with children (64%)¹⁴⁰. In 2009, the university education required for preschool and compulsory school teachers increased from three years to five years. Since then, a difficult situation has developed in which the number of new students enrolled in preschool and compulsory school teacher education has decreased by 40%¹⁴¹. Based on the current graduation rate for new preschool teachers, it will take Icelanders a century to fulfil the legal obligation of two-thirds of preschool staff holding a university degree in preschool teaching. However, current government action aims at ameliorating this situation, for example through scholarships, paid internship in the final year of university and increased guidance and supervision for new teachers.

Currently, there are no legal requirements for the ratio of staff to children or a minimum number of square meters per child in preschool housing. It is up to each preschool administrator to decide the number of children per staff member. It is stated that the design and organization of the preschool should be based on the number of children, their needs and the length of stay, and that children and staff should be provided with a safe and healthy working environment, but this is not defined in depth. Numerous audits and reports in recent years have revealed significant problems related to housing and staffing in Icelandic preschools, such as unsatisfactory spaces for teaching and play, shortages of staff and frequent staff turnover¹⁴². In a new national report, around half of Icelandic preschools reported staff shortages and frequent turnover as a severe problem that threatened the quality of preschool work. However, according to the 2018 TALIS study, overall job satisfaction is quite high among Icelandic preschool staff – but only 9% are satisfied with their wages compared to 29% in other OECD countries in the study¹⁴³. In 2018, the average monthly salary for Icelandic preschool teachers was approximately DKK 29,350 (ISK 543,000) or about 75% of the national mean wage (DKK 39,000 or ISK 721,000)¹⁴⁴. For untrained staff, who comprise more than half of the overall workforce in Icelandic preschools, average wages were around DKK 20,270 (ISK 375,000) which is 52% of the national average. According to the TALIS report, the most significant stressors for Icelandic preschool staff are related to large group sizes and lack of preparation time. For preschool administrators, the biggest stressor is the extra work that results from ongoing staff shortages.

menningarmálaráðuneytið. Retrieved September 14, 2020, from www.stjornarradid.is/lisalib/getfile.aspx?itemid=2d8cee62-3f5b-11e9-9436-005056bc530c

140. OECD (2018). *Iceland – Country Note – TALIS Starting Strong 2018 Results*. Retrieved September 14, 2020, from www.oecd.org/education/school/Country_Note_Iceland.pdf

141. Mennta- og menningarmálaráðuneytið (2019). *Aðgerðir í menntamálum: Nýliðun kennara*. Reykjavík: Mennta- og menningarmálaráðuneytið. Retrieved September 14, 2020, from www.stjornarradid.is/lisalib/getfile.aspx?itemid=2d8cee62-3f5b-11e9-9436-005056bc530c

142. Embætti landlæknis (2019). *Geðrækt, forvarnir og stuðningur við börn og ungmenni í skólum á Íslandi: Niðurstöður landskönnunar*. Reykjavík: Embætti landlæknis. Retrieved September 14, 2020, from www.landlaeknir.is/servlet/file/store93/item38083/Landsk%C3%B6nnun%20%C3%A1%20ge%C3%B0r%C3%A6kt%20%C3%AD%20sk%C3%B3lum_okt%C3%B3ber%202019_LOK.pdf

143. Menntamálastofnun (2019). *Talis 2018 – leikskólastig starfshættir og viðhorf starfsfólks leikskóla*. Kópavogur: Menntamálastofnun. Retrieved September 14, 2020, from https://mms.is/sites/mms.is/files/talis_leikskolaskyrsla_okt_2019.pdf

144. Hagstofa Íslands (2019). *Algengustu heildarlaunin á bilinu 550 til 600 þúsund krónur á mánuði*. Retrieved September 14, 2020, from <https://hagstofa.is/utgafur/frettasafn/laun-og-tekjur/laun-2018/>

Social and emotional development

The Icelandic National Curriculum for Preschools outlines the overall focus and content of preschool education¹⁴⁵. It defines the six pillars of education, which are literacy, creativity, equality, sustainability, democracy and human rights, and health and wellbeing. There is a strong emphasis on children's social and emotional development in both the National Curriculum for Preschools and the Icelandic Preschool Act. Support for children's healthy development is interwoven in all activities and is considered a core element of preschool activities. According to a recent national study¹⁴⁶, Icelandic preschools place a strong emphasis on fostering a warm and welcoming environment for young children, developing close bonds between children and staff, and treating children with empathy and respect.

The same study showed that half of all preschools had developed a comprehensive strategy for social-emotional learning (SEL) with specific learning standards in the school curricula. Most said that children were consistently taught SEL skills in daily preschool activities, such as friendship skills, emotional literacy, problem-solving and coping, and some had implemented specific SEL programmes, such as Free from Bullying (Fri for mobberi), Aggression Replacement Training (ART) and Second Step. However, it is unknown to what extent these programmes are used with children under two years old. Staff usually receive initial training in applying SEL programmes but ongoing training may be less common.

There is an emphasis in most preschools that staff should model the behavioural and social-emotional skills that children are expected to learn, although only 60% of preschools report coordinated staff practices in supporting children's behaviour. The vast majority of preschools offer regular educational sessions for staff on child wellbeing, and two out of three preschools emphasize enhancing staff skills regarding children's social-emotional development in their continuing education plans. However, actual staff training is much less common. For example, only 38% of preschools provide regular staff training in evidence-based practices for supporting positive behaviour. While all preschool staff are legally obliged to report to child protection services if they notice signs of neglect or violence among children, only 40% of preschools report having registered procedures of which all staff are aware¹⁴⁷.

Collaboration with parents

Under Icelandic law¹⁴⁸, each preschool must have a parent council whose role is to

145. Mennta- og menningarmálaráðuneytið (2011). *Aðalnámskrá leikskóla*. Retrieved September 14, 2020, from www.stjornarradid.is/media/menntamalaraduneyti-media/media/forsidumyndir/lokadrog-leiksk_vefur.pdf [The Icelandic National Curriculum for Preschools, in English: www.government.is/lisalib/getfile.aspx?itemid=3e4939f4-cb84-11e7-9421-005056bc530c]

146. Embætti landlæknis (2019). *Geðrækt, forvarnir og stuðningur við börn og ungmenni í skólum á Íslandi: Niðurstöður landskönnunar*. Reykjavík: Embætti landlæknis. Retrieved September 14, 2020, from www.landlaeknir.is/servlet/file/store93/item38083/Landsk%C3%B6nnun%20%C3%A1%20ge%C3%B0r%C3%A6kt%20%C3%AD%20sk%C3%B3lum_0kt%C3%B3ber%2019_LOK.pdf

147. Embætti landlæknis (2019). *Geðrækt, forvarnir og stuðningur við börn og ungmenni í skólum á Íslandi: Niðurstöður landskönnunar*. Reykjavík: Embætti landlæknis. Retrieved September 14, 2020, from www.landlaeknir.is/servlet/file/store93/item38083/Landsk%C3%B6nnun%20%C3%A1%20ge%C3%B0r%C3%A6kt%20%C3%AD%20sk%C3%B3lum_0kt%C3%B3ber%2019_LOK.pdf

148. Lög um leikskóla nr. 2008/90. Retrieved September 14, 2020, from www.althingi.is/lagas/nuna/2008090.html [Icelandic Preschool Act no. 2008/90, in English: www.government.is/media/menntamalaraduneyti-media/media/]

review the school's curriculum and other strategies on preschool activities, monitor the implementation of national school curricula and other programmes within the preschool, and ensure that parents are kept informed of preschool activities. The parent council has a right to comment on all major changes in preschool activities, but it is less common that they take an active part in developing policy and activities within the preschools. Nevertheless, parents are regarded as important collaborators and there are regular parent-teacher meetings in all preschools. Parents are contacted immediately if concerns arise about a child's wellbeing, and staff report that they welcome suggestions from parents on how to improve the work they do. However, only about half of preschools send out annual parent surveys on children's wellbeing, accommodations, relationship with staff, and so on¹⁴⁹.

Collaboration with other services

The vast majority of preschools report active collaboration with other services in the community, such as school psychological services or other specialist services for children and families. Still, a large proportion of staff feel that they do not receive enough support to manage children's behaviour, social and emotional difficulties or signs of trauma or violence¹⁵⁰. In most areas of the country, there is no consistent collaboration between preschools and child health services, although some healthcare centres and municipalities have established such collaboration, as previously stated. There is no systematic collaboration between ICH and preschools on a national level but some healthcare centres contact preschools for information on children's development or even conduct routine developmental assessments in preschool settings. Collaboration with social services and child protection is usually on an indicative rather than a preventive level, except in a few municipalities where explicit action has been taken to improve cross-sectoral collaboration, prevention and early intervention.

frettatengt2016/Preschool-Act-No-90-2008.pdf

149. Embætti landlæknis (2019). *Geðrækt, forvarnir og stuðningur við börn og ungmenni í skólum á Íslandi: Niðurstöður landskönnunar*. Reykjavík: Embætti landlæknis. Retrieved September 14, 2020, from www.landlaeknir.is/servlet/file/store93/item38083/Landsk%C3%B6nnun%20%C3%A1%20ge%C3%B0r%C3%A6kt%20%C3%AD%20sk%C3%B3lum_akt%C3%B3ber%202019_LOK.pdf
150. Embætti landlæknis (2019). *Geðrækt, forvarnir og stuðningur við börn og ungmenni í skólum á Íslandi: Niðurstöður landskönnunar*. Reykjavík: Embætti landlæknis. Retrieved September 14, 2020, from www.landlaeknir.is/servlet/file/store93/item38083/Landsk%C3%B6nnun%20%C3%A1%20ge%C3%B0r%C3%A6kt%20%C3%AD%20sk%C3%B3lum_akt%C3%B3ber%202019_LOK.pdf



Norway

Prenatal care

The Norwegian healthcare system is structured in three levels: national level, which is managed by government institutions, such as the Ministry of Health and the Directorate of Health; regional level, which is managed by regional health authorities (e.g. specialist healthcare); and municipal level, which includes primary healthcare and social services. Prenatal services are mainly a part of primary care, managed by municipalities, with some specialist service available according to individual needs. Both primary and specialist prenatal healthcare are guided by relevant laws and regulations and are subject to the same national guidelines, which were last issued by the Norwegian Directorate of Health in 2018¹⁵¹. The national guidelines are based on evidence-based practice, international guidelines, such as the NICE guidelines, and local professional expertise. The Directorate of Health is also developing a tool that can help municipalities estimate the human resources needed to fulfil national guidelines for prenatal care. Norwegian municipalities have considerable independence in the way they structure and manage their primary services, including prenatal care, as long as they adhere to legal requirements regarding the service. Thus, municipalities are not bound by national guidelines per se, but as the guidelines are official recommendations for quality service and evidence-based care, they are essential as an official standard of care in health service supervision. Hence, if municipalities do not comply with the guidelines, they will need to provide documentation that they ensure equal access to services of the same quality and standard. The county governors at regional level and Norwegian Board of Health Supervision at national level are supervisory authorities. All statutory services are subject to supervision, irrespective of whether they are provided by municipalities, private providers, public-owned hospitals and residential childcare institutions, or healthcare personnel who run their own practices. County governors provide proactive supervision through guidance, implementation of national guidelines and review of services. In addition, several county governors have conducted local surveys

151. Helsedirektoratet (2018). *Svangerskapsomsorgen, Nasjonal faglig retningslinje*. Retrieved September 10, 2020, from <https://www.helsedirektoratet.no/retningslinjer/svangerskapsomsorgen>

of services. However, no nationwide surveys have been conducted on how municipalities meet the authorities' requirements for prenatal care. Municipalities are responsible to county governors and, ultimately, the Norwegian Ministry of Health.

Prenatal care in Norway is free of charge except for birth preparation courses, which are often conducted in the evenings. Prenatal services usually take place at local primary health centres where they are combined with infant and child healthcare (ICH). Most women also see a GP at a private office during pregnancy, in which case, the GP and midwife will collaborate on providing prenatal care. Although all women are entitled to midwifery services, access has been found to be lacking in some areas. In some municipalities, there might be only one primary health centre with a midwifery service, in which case pregnant women would have to attend that particular centre for appointments with a midwife but could continue to see their GP for doctor's appointments. Women in Norway can also choose only to see their GP or midwife for prenatal care, although the choice may be restricted by availability and capacity of services in certain areas. Women usually see the same doctor and midwife throughout pregnancy. There are no national statistics on how many women only see a GP or a midwife during pregnancy, but current work on a new national electronic registry will facilitate the compilation of such data. Regardless of where and how prenatal care is provided, it is regulated by the same laws and guidelines.

The first prenatal visit usually takes place between gestation weeks 6 and 12. It should be offered as early in the pregnancy as possible and should be one week at the latest after the woman first contacts her GP or midwife. As a standard, there are seven prenatal visits as well as an ultrasound at a hospital outpatient clinic in week 17–19. When necessary, additional visits are offered. The other parent is invited to accompany the pregnant woman to prenatal visits, but ultimately it is the woman's choice whether she wants the other parent with her or not. There are no national statistics on the other parents' attendance, and they are not offered private appointments, but the new national electronic registry will facilitate the compilation of such data. There is discussion at the moment about exploring ways to involve fathers or the other parent more in the pregnancy process.

Information about the progress of the pregnancy, examinations performed and so on is recorded on a personal health card for each woman. This is a paper-based universal information record for all parties across institutions and services (i.e. the pregnant woman, her doctor, midwives and hospital). Everyone has access to the same information about the progress of the pregnancy and any special needs¹⁵². Detailed instructions specify, in accordance with national guidelines, what should be addressed and what information should be recorded on the health card during each prenatal visit. However, there are weaknesses in this system, in terms of incomplete data registration and the administration of the health card. Pregnant women have to bring their health card to prenatal visits, receive copies of any test results and take the card to their birthing centre. A further limitation is that pregnant women can decide what information they want to be registered in the card.

There are no national procedures in place to ensure that all pregnant women attend prenatal care. However, information about their rights and recommended services

152. Helsedirektoratet (2018). *Helsekort for gravide*. Retrieved September 10, 2020, from <https://www.helsedirektoratet.no/tema/svangenskap-fodsel-og-barsel/helsekort-for-gravide>

are readily available online through public information¹⁵³ for which the Directorate of Health and the Directorate of E-health are responsible. The Directorate of Health has also published a booklet about pregnancy, birth and the postnatal period¹⁵⁴ and the Norwegian Board of Health has produced a video about rights in pre- and postnatal services¹⁵⁵. In addition, Norway holds a licence to the website, *Zanzu; My Body in Words and Pictures*, which includes information on sexual and reproductive health and rights, provided in seven languages, as well as information on prenatal services¹⁵⁶. There is currently no available data on how many women give birth without having attended prenatal care, but a study from 2000 showed that this was around 0.2%. A municipal registry for user and patient data is being developed, and this should make it possible to produce these statistics more readily.

Mental wellbeing and preparation for parenthood

National guidelines emphasize the importance of pregnant women being able to discuss their feelings and thoughts openly in prenatal care but do not specifically address how they can maintain their mental health and wellbeing during pregnancy. It is recommended that providers of prenatal care (e.g. midwives and GPs) ask women about their current and previous mental health, and offer assessment and referral when necessary, although procedures regarding this are not described in detail. The other parent does not usually receive specific information about mental wellbeing, apart from the information offered to women during regular visits and in parenting preparation courses. However, not all municipalities offer such courses in prenatal care. Some only offer courses about birth and breastfeeding, and practices differ between municipalities. Targeted courses for vulnerable parents are also available through family protection offices. Finally, expectant parents can access *Mamma-Mia*, a free self-help web-based programme about the psychological preparations for parenthood¹⁵⁷. The programme is customized for each user and intended to run from mid-pregnancy until the baby is six months old. It targets risk and protective factors for postpartum depression, such as prepartum and postpartum attachment, couple satisfaction, social support and subjective wellbeing. Currently, the aim is to implement the programme in all prenatal services. Another resource for expectant and new parents is the National Association for 1001 days, which is a user organization focusing on mental health in pregnancy and the early years¹⁵⁸.

Risk factors in pregnancy

There is no nationally coordinated screening for psychosocial risk factors in prenatal

153. Helsenorge.no. (n.d.). *Gravid*. Retrieved September 10, 2020, from <https://helsenorge.no/gravid>

154. Holan, S. (2013). *Er du gravid? Venter dere barn? Graviditet, fødsel og barseltid i Norge*. Helsedirektoratet. Retrieved September 10, 2020, from <https://www.helsedirektoratet.no/brosjyrer/er-du-gravid-venter-dere-barn-graviditet-fodsel-og-barseltid-i-norge>

155. Statens helsetilsyn (2018). *Retten til svangerskaps- og barselomsorgstjeneste*. Retrieved September 10, 2020, from <https://www.helsetilsynet.no/publikasjoner/videoer/?pid=134083&vid=38564>

156. Helsedirektoratet (n.d.). *Zanzu, Min kropp i ord og bilder*. Retrieved September 11, 2020, from <https://zanzu.no/no/>

157. Norske kvinners sanitetsforening (n.d.). *Mamma Mia*. Retrieved September 11, 2020, from <https://sanitetskvinnene.no/mamma-mia>

158. Landsforeningen 1001 dager (n.d.). *Mental helse under graviditet & etter fødsel*. Retrieved September 11, 2020, from <https://www.landsforeningen1001dager.no/>

care in Norway, although prenatal guidelines stress the importance of enquiring about psychosocial difficulties and actively identifying pregnant women at risk. National guidelines recommend a structured conversation about lifestyle during the first prenatal visit, and additional follow-up if needed, with motivational interviewing as the recommended approach. Indicators such as marital status, use of tobacco, alcohol, illegal substances and prescription medications, as well as mental and physical health status, should be identified and recorded on the health card for each pregnant woman. Different risk factors are identified in various ways. Where valid and reliable screening instruments are available, these are recommended (e.g. TWEAK or AUDIT for alcohol and substance use), but when they are not available, standardized questions are usually recommended, such as when enquiring about violence. It is recommended that all pregnant women are asked about violence, past or present, without the presence of the other parent. Also, to protect them from further violence, this information is only recorded in the woman's journal and not on the health card she carries with her between visits. Other issues, such as relationship difficulties or adverse childhood experiences, are not routinely assessed but can be raised in conversations about general life circumstances. It varies between municipalities what (or whether) screening instruments are used in prenatal care. Several municipalities use the Edinburgh Postnatal Depression Scale (EPDS) to screen for depression, either universally or indicated, but screening for depression is not a national recommendation in prenatal care. However, there has been recent debate about whether systematic screening of depression for all pregnant and postpartum women should be implemented.

Almost half of all municipalities in Norway have implemented an educational training programme in pre- and postnatal care called *Early In* (Tidlig Inn). The aim is to ensure early, interdisciplinary intervention for all pregnant women and families with young children where there are signs of substance and alcohol abuse, mental health problems and violence¹⁵⁹. Training for the programme is free, and participants (i.e. municipal staff, their leaders and general practitioners who provide services to pregnant women and young children) undergo training in the use of specific assessment tools (e.g. EPDS, AUDIT, TWEAK) and counselling methods. Routes for referrals when difficulties are identified in prenatal care vary across municipalities, problem areas and severity of problems. The Health Supervision Act states that those who provide health and welfare services should establish an internal management system that ensures that services are organized, provided and maintained in accordance with rules and regulations. This is ensured and supervised by county governors.

There are several national "centres for excellence" in the area of mental health and substance abuse, such as The National Competency Centre for Mental Health Work in the Municipalities (NAPHA)¹⁶⁰, The National Competency Service for Comorbid Substance Abuse and Mental Illness (ROP),¹⁶¹ The Drug and Alcohol Competence Centres (KoRus) and the Regional Centres for Child and Adolescent Mental Health (RKBU/RBUP)¹⁶². The aim of these centres is to enhance competencies and the

159. Helsedirektoratet, Barne-, ungdoms- og familiedirektoratet, Regionsenter for barn og unges psykiske helse, helseregion øst og sør, Regionale kunskapsenter for barn og unge, Regionale ressursentre, Barne-, ungdoms- og familieetaten, De regionale kompetansesentrene på rusefeltet (n.d.). *Opplæringsprogrammet tidlig inn*. Retrieved September 11, 2020, from <http://tidliginn.sats.forebygging.no/Nyheter/Opplæringsprogrammet-Tidlig-Inn/>

160. *Nasjonalt kompetansesenter for psykisk helsearbeid* (n.d.). Retrieved September 11, 2020, from <https://www.napha.no/>

161. *Nasjonalt kompetansetjeneste for samtidig rusmisbruk og psykisk lidelse* (n.d.). Retrieved September 11, 2020, from <https://rop.no/>

162. *Regionsenter for barn og unges psykiske helse (RBUP)* (n.d.). Retrieved September 11, 2020, from <https://ehealthresearch.no/en/knowledge-organisations/regionsenter-for-barn-og-unges-psykiske-helse-rbup>

quality of services in their respective areas, for example by disseminating evidence-based knowledge and practice, offering training and supervision, and issuing information for the public. The Family Network is a national learning network for employees in family outpatient clinics ("family ambulatories" and similar services that target pregnant women, and parents of infants and toddlers, who suffer from mental health or substance use problems¹⁶³ .

In recent years, a great deal of focus has been placed on improving collaboration between different systems and levels of service in Norway. Anyone in need of long-term, coordinated services has the right to a coordinator or case manager, and an individual care plan from the municipal health and welfare services. All agencies in specialist services that assess and treat patients in interdisciplinary, specialized mental health and substance abuse treatment (TSB) must appoint a coordinator for the course of assessment and treatment. When problems call for medical management, the coordinator will be a doctor, but otherwise it can be anyone within the interdisciplinary team – usually the person with the most contact with the person or family (e.g. a psychologist or social worker). The patient's wishes must also be considered and they are allowed to choose who the coordinator will be for their care¹⁶⁴ . According to the Municipal Health and Care Services Act¹⁶⁵ , all municipalities must have a coordinating unit with the administrative role of managing individual care plans and appointing coordinators for long-term, coordinated services. All available services for substance abuse or mental health problems are usually integrated within these coordinating units. Thus, municipalities are required to facilitate coordinated, interdisciplinary care by instigating cooperation with regional healthcare services. However, according to a recent report, less than half of the municipalities in Norway state that collaborative agreements with specialist services within different areas of mental health and substance abuse are working well. There also seems to be little collaboration between services for adults and services for children¹⁶⁶ .

Mental health difficulties

If a pregnant woman is found to be at risk for, or already suffering from, mental health difficulties, an initial assessment is made by her GP and subsequent support is offered by the municipality's mental health services (e.g. a psychiatric nurse or psychologist). In prenatal care, GPs, midwives, psychologists or psychiatric nurses can offer pregnant women additional visits according to individual needs. If problems are mild, additional midwife visits are usually offered as a start, with the concurrent involvement of mental health professionals as needed. The other parent would not be offered special services for mental health in prenatal care, but they can bring up concerns with their GP and be referred to appropriate mental health services. As of 2020, all municipalities in Norway must provide psychological services

163. Oslo Universitetssykehus (n.d.). *Familienettverket*. Retrieved September 11, 2020, from <https://oslo-universitetssykehus.no/fag-og-forskning/nasjonale-og-regionale-tjenester/tsb/nasjonal-kompetansetjeneste-tsb/vare-prosjekter/familienettverket>

164. HelseDirektoratet (2017). *Oppfølging av personer med store og sammensatte behov, nasjonal veileder*. Retrieved September 11, 2020, from <https://www.helseDirektoratet.no/veiledere/oppfolging-av-personer-med-store-og-sammensatte-behov>

165. *Lov om kommunale helse- og omsorgstjenester m.m. (helse- og omsorgstjenesteloven)*, LOV-2011-06-24-30 Retrieved September 11, 2020, from https://lovdata.no/dokument/NL/lov/2011-06-24-30/KAPITTEL_7#%C2%A77-3

166. Ose, O.S., Kaspersen, S.L., Ådnanes, M., Lassemo, E. and Kalseth, J. (2018). *Kommunalt psykisk helse- og rusarbeid 2018: Årsverk, kompetanse og innhold i tjenestene*. SINTEF Digital. Retrieved September 11, 2020, from https://www.sintef.no/globalassets/sintef-teknologi-og-samfunn/avdelinger/helse/endelig_kommunalt-psykisk-helse-rusarbeid-2018.pdf/

in primary care, but their services can be limited. Some pregnant women and their families may not have access to psychologists or only to a few sessions. However, primary care psychologists often offer group therapy, such as CBT, as well as training and supervision for midwives and other prenatal staff. If problems indicate a more long-term, specialized or multi-disciplinary approach, a referral would be made to the local district psychiatric services (DPS) centre although mild to moderate issues might also call for collaboration with, or referral to, specialist services¹⁶⁷. Some child and adolescent psychiatry centres have also established infant teams who can start consultation during pregnancy.

DPS centres are professionally independent institutions responsible for general mental health services. They offer various types of service, both inpatient and outpatient, and are sometimes connected to hospitals. Each Norwegian citizen is assigned to a local DPS centre but, as with other health services in Norway, citizens are free to choose their own centre provided there is sufficient capacity. In addition, there are nine family outpatient clinics for pregnant women in Norway. Access to these services, and their content, varies depending on how they are organized and their access to professionally trained staff. Some include the other parent in the service and offer both parents support in caring for their child, which continues after the child is born. Others only provide service to the pregnant woman. Family outpatient clinics are organized under specialist health services but may be managed by different parties, including NGOs. For example, the largest clinic in Norway is run by the Blue Cross. Regardless of management, family outpatient clinics are always a part of the larger universal network of health and social services. These services are all free of charge.

The Norwegian Directorate of Health has developed various "patient pathways" or "care packages" in the field of mental health and substance abuse, and these also apply to pregnant women¹⁶⁸. They describe the course of treatment for different clinical problems with the aim of offering patients and their families a comprehensive overview of the treatment process, reducing unnecessary delays and giving patients more influence over their own treatment. A standard care package begins with a GP referral to the local DPS centre, which conducts a clinical assessment and, if applicable, offers treatment within 10 working days. It is the municipality's responsibility to ensure follow-up, if it is needed, during the time between referral and the start of DPS treatment. The Norwegian government has awarded special grants to municipalities to support the implementation of patient pathways, but a recent report on mental health and substance abuse showed that the grants have not always been used as intended to improve municipal services. For example, only about half of municipalities have established a coordinated unit to implement the patient pathways¹⁶⁹. There are also wide geographical differences in mental health services in Norway, partly because municipalities are highly independent in their choice of programmes and interventions, and partly because resources inevitably vary depending on the size of the municipality. Smaller

167. Malt, U. (n.d.). *Distriktpsikiatrisk senter*. Store Norske leksikon, Store medisinske leksikon. Retrieved September 11, 2020, from https://sml.sn.no/distriktpsikiatrisk_senter

168. Helsedirektoratet (2018). *Psykiske lidelser – voksne*, Pakkeforløp. Retrieved September 11, 2020, from <https://www.helsedirektoratet.no/pakkeforlop/psykiske-lidelser-voksne>

169. Ose, O.S., Kaspersen, S.L., Ådnanes, M., Lassemo, E. and Kalseth, J. (2019). *Kommunalt psykisk helse- og rusarbeid 2019: Årsverk, kompetanse og innhold i tjenestene*. SINTEF Digital. Retrieved September 11, 2020, from https://www.helsedirektoratet.no/rapporter/kommunalt-psykisk-helse-og-rusarbeid-2019/Kommunalt%20psykisk%20helse%20og%20rusarbeid%202019.pdf/_/attachment/inline/59d6f697-9aba-4e0d-8447-62c6b5bb08a6:3826c145e7348817deb326a0694b809a101cef36/Kommunalt%20psykisk%20helse%20og%20rusarbeid%202019.pdf

municipalities (i.e. population below 50,000) have fewer interventions for mental health and substance use than the larger ones.

Social difficulties

One of the aims of the first prenatal visit is to assess the need for social support. If indicators of social problems are identified, pregnant women are encouraged to contact the local office of the Norwegian Labour and Welfare Administration (NAV) for information, guidance and counselling. They can book an appointment themselves or allow their service coordinator to book the appointment for them and engage other services. When assistance is needed from other public agencies, the municipality and NAV office should collaborate and establish the necessary contacts. If needed, NAV can collaborate with follow-up services, child welfare services, BUP for children and young people and DPS for adults. NAV services are free of charge, but there may be geographical differences in terms of waiting lists and available resources. However, priority is given to pregnant women in accordance with their economic and social situation. An example of the sort of resources available specifically for expectant mothers is the pregnancy allowance, which can be awarded to women who cannot continue to work as usual because to do so would carry a risk for the baby. Subsidies for housing and home loans are also administered by municipalities and citizens can apply for municipal housing due to social or health-related conditions. By law, Norwegian municipalities must help those in need to find secure housing, but they do not have to provide it themselves; short-term housing services run by charitable NGOs can also be offered in some cases.

Many municipalities in Norway have established interdisciplinary teams, competency teams or collaboration groups for handling social problems. These teams can receive enquiries from parents and others when there is a need to deliberate on a concern for an unborn child before the concern is reported to child welfare services. If the parents consent to the team deliberating on the case, it must be discussed anonymously. Some municipalities also employ a comprehensive model for interdisciplinary work in services for pregnant women, children, young people and parents about whom concern has been raised¹⁷⁰. One model that has been widely implemented is *Better Interdisciplinary Efforts* (Bedre Tverrfaglig Innsats (BTI)), which facilitates early intervention, collaboration and patient involvement with the aim of ensuring comprehensive and coordinated services and follow-up. The model gives an overview of the progression of the service and promotes effective collaboration between services at local, regional and state levels.

Relationship difficulties

If relationship difficulties are identified during pregnancy, midwives, GPs or municipal psychologists in primary care can offer individual counselling, couples counselling and/or parent training. For milder problems, prenatal staff can also recommend the *We* app, which was developed by psychologists in cooperation with the Ministry for Children and Families and launched in 2019¹⁷¹. The app is free of charge and includes

170. Helsedirektoratet (2020). *BTI – Bedre Tverrfaglig Innsats*. Retrieved September 11, 2020, from <http://tidliginnsats.forebygging.no/Aktuelle-innsater/BTI/>

171. Thuen, F., Sagen, C. and Foreningen Famileskolen (n.d.). *VI-APPEN*. Retrieved September 11, 2020, from; <https://www.vi-appen.no/>

videos that offer professional advice and inspiration for conversations between couples. There are also some independent resources that can be recommended. For example, the foundation *Alternative to Violence*, which has eleven offices across Norway, offers courses for staff in health and social services in working with couples' difficulties¹⁷².

Prenatal staff can also refer expectant parents to family protection services for courses and couples or family counselling for moderate to severe problems, conflict or crisis¹⁷³. There are 49 family protection service offices across Norway that offer both counselling and mandatory mediation in case of serious conflict or intention to divorce. The service is provided by public agencies and the churches, both of which are free of charge, as family protection services are fully financed by the state. The staff consists of psychologists, pedagogues and social workers who specialize in family therapy. However, services may differ between offices across the country because of different focus areas or resources. The service can be accessed without a referral, and families can choose what family protection service for which they want to apply. However, since there is high demand for this service, there is usually a waiting list of a few weeks. In 2018, the aim of offering the first appointment within four weeks was achieved in 89% of cases but expectant couples, or those with young children, are prioritized.

The Norwegian Directorate for Children, Youth and Family Affairs (Bufdir) has professional and administrative responsibility for the service, which is organized in five regions covering all 354 municipalities in Norway. The directorate is responsible for quality assurance and that the service meets the demands of the population. This is regulated by the Family Counselling Service Act¹⁷⁴. A recent trial project emphasized the importance of improving systematic collaboration between family counselling services and health centres. The trial was a part of the national action plan, "A Good Childhood Lasts a Lifetime", and showed that when parents involved in mild conflicts received help in an earlier phase, it prevented the conflict and the potential for violence from escalating. The trial also pointed out the added value of cooperation on all levels. The subsequent aim is to implement lessons learned from this project, such as altering services that have worked well in local contexts for use on a larger, national scale in the coming years. The professional competence centre on prevention and parental support will be responsible for its implementation¹⁷⁵.

Alcohol and substance abuse

Midwives and GPs should discuss and assess the use of alcohol, illegal substances and addictive prescription medication during the initial prenatal visits and regularly throughout prenatal care. Resources in prenatal and primary care include additional support from midwives, GPs, municipal psychologists, social workers or substance abuse counsellors. Individual and couples counselling, as well as various courses, may be offered in primary care in addition to courses, counselling and other family

172. Alternativ til vold (n.d.). Retrieved September 11, 2020, from <https://atv-stiftelsen.no/>

173. Barne-, ungdoms- og familiedirektoratet (n.d.). *Familievernet hjelper deg å finne løsninger*. Retrieved September 11, 2020, from https://bufdir.no/Familie/Familievernet/Familievernet_hjelper_deg_med_a_finne_losninger/

174. Lov om familievernkontorer, LOV-1997-06-19-62. Retrieved September 11, 2020, from <https://lovdata.no/dokument/NL/lov/1997-06-19-62>

175. Brodtkorb, E., Businaro, N., Fårstad, G.R., Glavin, K., Herland, M.D. og Voldner, N. (2018). *Styrket og tidligere tilbud til småbarnsforeldre. Systematisk samarbeid mellom helsestasjon og familievernkontor. Evaluering af Tiltak 26 i «En god barndom varer livet ut».* Tiltaksplan for å bekjempe vold og seksuelle overgrep mot barn og ungdom (2014-2017). VID rapport 2018/2 Oslo. Retrieved September 11, 2020, from https://bufdir.no/globalassets/global/Styrket_og_tidligere_tilbud_til_smobarnsforeldre.pdf

interventions offered by family counselling services or municipal child welfare services. Health professionals who identify substance use in pregnancy are legally bound to report this to social services; however, it is not possible to open a child protection case for an unborn child as the Child Welfare Act does not become active until the child is born. Child Welfare Services can offer pregnant women different forms of voluntary intervention, but they cannot open an investigation or intervene without the pregnant woman's consent. Thus, ideally, interventions should commence voluntarily in collaboration with the pregnant woman. Specialized substance abuse services (TSB), however, are allowed to initiate forced interventions if voluntary measures prove insufficient.

According to Norwegian law, pregnant women with severe alcohol or substance use problems may be detained, against their will if needed, for the benefit of the unborn child. However, the application of such measures are extremely rare as most pregnant women are willing to collaborate for the wellbeing of their unborn child, even if they do not plan to raise the child themselves. They receive excellent services, which are provided free in the aforementioned family outpatient clinics. While these clinics, as the name implies, are mostly an outpatient service, pregnant women with alcohol or substance use problems can also receive full-time residential care there. In addition, some family outpatient clinics offer a service after the birth of the child, who will receive extensive follow-ups until they reach school age, to assess and treat any developmental, neurological or psychosocial difficulties resulting from intoxication during the mother's pregnancy. If the other parent has substance abuse issues, this is raised with the GP, who can refer them to specialist services or instigate patient pathways for drug addiction¹⁷⁶. The Directorate of Health recently published special patient pathways for pregnant women with a current or previous history of substance abuse, as well as new national guidelines for women receiving treatment for opioid addiction^{177 178}. In general, there is good access to treatment for alcohol and substance abuse, but as with all other services in Norway, there are differences based on location and size of the municipality.

Seven regional competency centres for substance abuse (KoRUS) operate in Norway. These centres are responsible for implementing national and professional guidelines relating to drugs and alcohol and supporting municipalities and specialist services with their professional development¹⁷⁹. The aim is to enhance competencies and the quality of preventative measures and addiction-related services. According to standard treatment packages for pregnant women who have substance abuse issues, follow-up and treatment is provided in collaboration by the municipality and specialist care services. Pregnant women are eligible to have a coordinator for their course of treatment, both in the municipality and specialist services, and they should be offered an individual plan that includes their partner or relatives and contact with user organizations. When there is a need for an individual plan and a coordinator, healthcare providers must alert the municipalities' coordinating unit as soon as possible so they can initiate the process of appointing a coordinator in collaboration with the patient. Norway also has the first competence centre in the Nordic countries that is specifically focused on prenatal exposure to alcohol or drugs. The

176. Helsedirektoratet (2018). *Rusbehandling (TSB)*. Pakkeforløp. Retrieved September 11, 2020, from <https://www.helsedirektoratet.no/pakkeforlop/rusbehandling-tsb>

177. Helsedirektoratet (2019). *Gravide og rusmidler*. Pakkeforløp. Retrieved September 11, 2020, from <https://www.helsedirektoratet.no/pakkeforlop/gravide-og-rusmidler>

178. Helsedirektoratet (2019). *Gravide i legemiddelasistert rehabilitering (LAR)*. Nasjonal faglig retningslinje. Retrieved September 11, 2020, from <https://www.helsedirektoratet.no/retningslinjer/gravide-i-lar>

179. *Kompetensesenter-Rus* (n.d.). Retrieved September 11, 2020, from <http://kompetansesenterrus.no/>

Regional Health Authority Resource Centre for Children with Prenatal Alcohol/Drug Exposure conducts research, supports the quality enhancement of services and provides information and training to professionals regarding the identification, diagnosis and treatment of children with prenatal exposure to alcohol or narcotics.

Violence and trauma

In Norway, municipalities and their services are obliged to prevent, identify and respond to violence and instances of sexual abuse, female genital mutilation and neglect. In addition, individual professionals in health and welfare services have an ethical, professional and legal obligation to prevent their clients from being exposed to violence. National guidelines for prenatal care recommend assessing both past and present exposure to violence and any need for immediate physical and mental health care. As previously stated, enquiries about, and identification of, violence should be documented in the pregnant woman's journal and not her health card as that might put her at risk of further harm. The National Competency Centre on Violence and Traumatic Stress has developed special guidelines for health and welfare services on domestic violence that specify responsibility and routines for referral^{180 181}. The national centre develops and disseminates knowledge through five regional resource centres, which provide guidance to municipalities through teaching, consultation and networking across sectors, bureaux and levels of government. Unfortunately, while identifying violence and potential harm to mother and baby is a priority concern in prenatal care, a national study showed that one in ten midwives do not fulfil the recommendation to enquire about violence or abuse, and that there are barriers to doing so in practice¹⁸².

If exposure to violence is detected, individual or couples counselling can be offered by municipal psychologists or family therapists. Midwives and GPs can also offer additional follow-up and support. Municipal child welfare services offer various interventions, and all municipalities should ensure that those in need of immediate help are offered in-patient care within health and welfare services. Family counselling services also offer courses, group counselling, individual and couples counselling and anger management training¹⁸³. District Psychiatric Centres (DPSs) can offer treatment for trauma resulting from violence as well as treatment for perpetrators through referrals from GPs. This is free of charge, but there may be waiting lists. In general, the resources that are available vary from one municipality to the next.

Every municipality must ensure victims of abuse or violence have access to a crisis centre, or shelter, which is often managed by NGOs in close collaboration with municipal services. Crisis centres are the only services that have highly specialized competence on immediate protection, safety, advice and counselling for those exposed to domestic violence¹⁸⁴. In Norway, there are 47 crisis centres spread across the country. Some healthcare institutions and municipalities have also established

180. Nasjonalt kunnskapssenter om vold og traumatisk stress (n.d.). Retrieved September 11, 2020, from <https://www.nkvts.no/>

181. Nasjonalt kunnskapssenter om vold og traumatisk stress (n.d.). *Veileder for helse- og omsorgstjenestens arbeid med vold i nære relasjoner*. Retrieved September 11, 2020, from <https://voldsveileder.nkvts.no/>

182. *Få jordemødre spør om vold* (2016, December 5th). Sykepleien. Retrieved September 11, 2020, from <https://sykepleien.no/2016/12/fa-jordmodre-spor-om-vold>

183. Barne-, ungdoms- og familiedirektoratet/ Barne-, ungdoms- og familieetaten (n.d.). *Sinnemestring*. Retrieved September 11, 2020, from https://bufdir.no/Familie/Hjelp_til_parforholdet_og_familien/Sinnemestring/

184. Barne-, ungdoms- og familiedirektoratet (2015). *Krisesentre*. Retrieved September 11, 2020, from https://bufdir.no/vold/Krisesentre_incestsentre_og_botilbud_for_utsatt_ungdom/Krisesentre/

their own centres for medical care and counselling for victims of sexual abuse and domestic violence. Emergency abuse services offer medical care, support and advice without referral. This consists of counselling, medical examinations, help with contacting the police, help for those who have previously suffered abuse, help with contacting a specialized lawyer and information on follow-up services, crisis centres and other services. Crisis centres are free of charge and can be accessed without referral. There are no waiting lists, but reports have indicated shortcomings in crisis centre services for victims of violence who have a history of substance abuse or mental health issues and for people with disabilities.

Other resources are also available. For example, the *Office for the State Compensation to Victims of Violence and Abuse* processes claims for damages from victims of violence and offers advice and counselling¹⁸⁵. There is also a national emergency hotline for victims of incest and sexual abuse¹⁸⁶. The previously mentioned *Alternative to Violence* is an NGO that offers individual counselling, group interventions and support to all members of the family, both perpetrators and victims, adults and children. The Stine Sofie Foundation is the world's first educational and rehabilitation centre for child victims of domestic violence¹⁸⁷. They have developed an educational programme for prospective and new parents that aims to give parents and children a safe start in life by, among other things, teaching parents how to cope with demanding family situations. The programme builds on national guidelines for prenatal and infant and child healthcare and contains various themes, such as brain development, attachment, and awareness of the impact of one's own childhood on the parenting role. The programme also aims to help healthcare professionals raise sensitive issues with prospective and new parents. Last but not least, the National Association for Public Health Nurses recently developed *In Safe Hands* (2018), an animated cartoon and booklet that can be used by primary care staff to prevent, identify and respond to violence¹⁸⁸. It can be offered to parents or used to guide conversations with them.

Infant and child healthcare

Infant and child healthcare (ICH) is part of the primary care provided at health centres, which include multidisciplinary services with GPs, public health nurses, physiotherapists and midwives. Many also offer psychological services but, as stated before, the service may be limited. Municipalities can also choose to organize their healthcare in combination with other services, such as social services, either under the same roof or under the same overall administrative management. The service is free of charge. It should be offered to the entire population on an equal basis and adapted to individual need; for example, linguistic and cultural differences must be taken into account when working with the Sami and other indigenous populations, as well as immigrant groups. The service must also take into account socioeconomic differences and be adapted to any physical or mental disabilities. Children and parents with special needs must receive the follow-up they need, and the service

185. *Kontoret for voldsoffererstatning* (n.d.) Retrieved September 11, 2020, from <https://www.voldsoffererstatning.no/>

186. *Hjelpetelefonen for seksuelt misbrukte* (n.d.). Retrieved September 11, 2020, from <https://hfsm.no/>

187. Stine Sofies Stiftelse (n.d.). *Stine Sofie Foreldrepakke*. Retrieved September 11, 2020, from <https://www.stinesofiesstiftelse.no/aktuelt/lanserer-nytt-nasjonalt-foreldreprogram>

188. Landsgruppen af helseyskepleiere (2018). *I trygge hender*. Kompetansebroen. Retrieved September 11, 2020, from <https://www.kompetansebroen.no/article/i-trygge-hender/#>

must be accessible.

Children are registered in the infant and child healthcare system at birth by health professionals. It is not mandatory to attend regular health check-ups, but healthcare providers will alert child welfare services if families are unreachable. According to national guidelines, ICH centres are required to have defined routines regarding follow-up for parents who repeatedly fail to show up for appointments and/or repeatedly cancel or change scheduled health examinations as, by law, parents cannot deny their children necessary healthcare. Parents may, however, choose to receive the service from the child's GP. No nationwide surveys have been conducted on whether ICH reaches all children in Norway, but it is believed to be virtually universal and acceptable. For example, national statistics show that ICH examinations are completed for 98.8% of infants in Norway by eight weeks of age.

The standard ICH service consists of 13 visits in the child's first two years. After age two, there is one more visit when the child is four. Some of the consultations also include health checks from a doctor and/or a physical therapist. According to the guidelines, health centres should offer both group sessions and individual consultations, as networking is considered important. Group sessions should be offered when the child is aged four weeks, four months and 17–18 months if possible. Health centres may also choose to offer group sessions at five months and either eight or 10 months instead of individual consultations. However, if parents decline invitations to group sessions, they should be offered individual consultations instead. Health centres may also facilitate the formation of social networking groups, such as special mother's groups, father's groups, and so on. Some social networking groups are also organized by NGOs.

Public health nurses are key professionals in ICH and they have the most contact with the family. The service is coordinated with prenatal care, and an emphasis is placed on the same healthcare provider following the family throughout the infant and toddler period. However, individual approaches to guidelines in primary care, as well as a lack of resources, may result in there being different practices from one health centre to the next. According to national guidelines, the first contact after birth should be a home visit from a midwife within the first three days after discharge from the hospital. However, only around 35% of Norwegian municipalities achieved this in 2018. The first scheduled ICH visit is a home visit from a public health nurse, 7–10 days after birth. It is recommended that health centres offer extra home visits to families in need, but this is not always the case. Some health centres refer to a lack of financial or human resources as a reason why added home visits are not achievable.

After the initial home visit, visits continue at the health centre when the child is aged four and six weeks, three, four, five, six, eight, 10, 12, 15 and 17–18 months, and at two and four years. However, experience shows that not all health centres prioritize this or have enough resources to facilitate all of the recommended visits. Thus, some visits are skipped or merged. In addition to regular visits, many health centres offer "open hours" that allow parents to visit the centre without a prior appointment for guidance or consultation. Open hours are not meant to replace standard ICH visits, as examinations or vaccination are not offered, but to provide additional opportunities for the family to monitor growth (e.g. weighing the baby) and seek further consultations according to the family's needs. Breastfeeding counselling is offered in home visits and all ICH appointments until the child is 12 months old. To

support this work, the Norwegian National Advisory Unit on Breastfeeding collaborated with the Norwegian Association of Public Health Nurses (NSF) to develop directions for health centres called "Six Steps for Breastfeeding Counselling at Health Centres". They are based on the Mother-Child-Friendly initiative and the *10 Steps for Successful Breastfeeding* issued by WHO and UNICEF, adapted to the structure of Norwegian health centres.

ICH services in Norway are guided by two main national guidelines issued by the Norwegian Directorate of Health: the National Guideline for Postnatal Care (2014) and the National Guidelines for Health Promotion and Preventive Work in the Child and Youth Health Centres and School Health Service (2017). As with the prenatal guidelines, they are based on international guidelines, research findings, clinical practice and user experience. County governors are responsible for implementing national guidelines, and when new guidelines are issued, the Directorate of Health organizes national launch conferences and implementation workshops for municipal staff in cooperation with county governors.

There is no national monitoring of adherence to the national guidelines and, as previously stated for prenatal care, municipalities are not required to follow them per se. However, they do need to document an acceptable reason for not providing a service as per national guidelines. Municipalities are required to perform annual "internal control" assessments regarding the quality and effectiveness of their services. County governors periodically conduct surveys of the quality of the municipal service in certain areas. If signs of inadequate practices are identified, whether it be after periodic investigations or user complaints, municipalities are required to submit an improvement plan to the county governor, who is responsible for the follow-up and implementation of any changes. Thus, county governors act as a joint control and coordinating body in relation to municipalities and regional state authorities. The last nationwide survey on ICH was conducted in 2013.

All healthcare services in Norway are obliged to keep a patient journal or medical record, in which every contact with the patient is registered. However, it is not specified what information must be registered at each visit in ICH. Thus, registration of ICH information is not nationally coordinated, but most health centres use the Electronic Patient Journal as a standard system. Relevant healthcare staff have access to patient records, so long as it is justified by the need for care and compliant with confidentiality legislation, and health centres can interact with other relevant services with a corresponding system.

Children's emotional wellbeing

Children's development and their attachment to their parents is monitored systematically in ICH by means of regular visits. National guidelines recommend that municipalities offer ICH staff regular training and continuing education on this subject but the extent to which this is done is unknown. Age-related social and emotional milestones are monitored, and parents are given information on secure attachment, healthy social and emotional development and supportive interaction with their child. The parent-child interaction should be routinely addressed at each ICH consultation, and parents should be given counselling to encourage attachment so that their child feels understood, and the parents are able to modulate its

emotions. The ICH staff should, through counselling and observation, attempt to identify interactions between parents and children that may present a risk for unsafe attachment, associative disorders and/or neglect. In some health centres in Norway, the New-born Behavioural Observation (NBO) approach is used as a flexible relationship-building tool to promote tailored supervision to parents with 0–3-month-old infants. The aim is to increase parental sensitivity to the infant's signals, transform them into a communication language and counsel parents on supporting and responding to their child's needs. Public health nurses model good interaction with the baby during regular examinations and act as role models for parents. Many health centres also use the booklet "Parents and Children Together" published by the Norwegian Directorate for Children, Youth and Family Affairs (Bufdir). The booklet, which can be found on Bufdir's "Everyday Parents" website¹⁸⁹, gives an overview of age-adjusted development during the child's first four years. There are also several other websites and competence centres that supply online information on these topics.

Parents' emotional wellbeing

There is a strong focus on parental mental health and wellbeing in ICH. According to national guidelines, this topic should be discussed at every ICH visit, and at the home visit 7–10 days postpartum. Public health nurses especially focus on detecting early symptoms of postnatal depression at the 7–10-day home visit and at the four-week- and six-week check-ups. Although municipalities have chosen to organize some ICH visits as group sessions, the Norwegian Directorate of Health recommends individual or personalized support rather than group-based consultation, because intensive and accommodating support (e.g. home visits) is likely to reduce the occurrence of postnatal depression. Several initiatives are also organized in health centres to support mental and physical health, foster good social conditions and prevent illness and injury, although specific activities vary from one centre to another. User organizations also provide services; for example, "Mental Helse" offers a support line with information and support on maintaining mental wellbeing and preventing mental health difficulties with a new baby. It also has a low-threshold phone and online service for parents who need to talk.

Family wellbeing

Family wellbeing is an important part of the service provided in health centres and ICH services. At the consultation when the child is six weeks old, it is recommended that public health nurses ask parents about wellbeing, mental health and their relationship. The primary care system is seen as the first step for families to get support related to family life and child-raising, as it is a low threshold service that is free and available to all. All ICH staff are trained to provide support for family relationships. Families can get advice and counselling from public health nurses, and many health centres offer counselling from psychologists and, if needed, family

189. Barne-, ungdoms- og familiedirektoratet (n.d.). *Foreldrehverdag*. Retrieved September 12, 2020, from <https://bufdir.no/en/Foreldrehverdag/>

therapists as well. In addition, there are various groups and parent training programmes available at health centres.

As previously noted, some municipalities combine their health and social services under one roof, such as a "family house", or work collaboratively in other ways (e.g. according to the BTI model). About a third of Norwegian municipalities, mostly the larger ones, have established "family houses", which are similar to the family centres found in other Nordic countries. In family houses, health centre services (including prenatal care and ICH) are provided along with a child welfare service, open daycare and educational and psychological preventive services. Some municipalities also include a family protection office in family houses in addition to other services, depending on community need, municipal priorities and available resources. The aim is for families to encounter a comprehensive and united chain of actions in all municipal services. According to the family house model, services should be preventive in nature, focused on early intervention, adapted to family needs and influenced by user experience and views. In several municipalities, family houses offer parental guidance, including parenting skills programmes, and universal counselling.

Parenting skills

One of the main purposes of ICH is to help parents master their new role and develop good interaction with their child. Parents receive regular information about positive and evidence-based child-raising practices through the 14 consultations in ICH and, if necessary, additional consultations and home visits are offered that focus on optimal care for infants and toddlers. National ICH guidelines provide defined procedures for giving advice to parents on raising their child, with a specified list of topics for each consultation. In addition, several Norwegian municipalities offer parenting skills training and counselling in primary care. However, universal, primary-preventive parenting programmes are classified as a weak recommendation in the national guidelines. The only programme proposed by government agencies is the International Child Development Programme (ICDP). The ICDP is a primary prevention programme with an adapted daycare version that is theoretically based on developmental psychology, attachment theory and the biopsychosocial model. It has been implemented in nearly 200 municipalities in Norway through the Directorate for Children, Youth and Family Affairs (Bufdir).

Despite not being recommended in national guidelines, there is still a wide variety of parental programmes available to health centres, and municipalities are free to choose which ones they use. Some examples in addition to the ICDP are New Families (only in Oslo), the Nurse Family Partnership (NFP), the COS-Circle of Security, The Incredible Years (DUÅ) and PMTO. According to a 2017 report, the majority of health centres offer programmes on both a universal and selective basis and the ICDP, the COS-Circle of Security and COS-P are the most commonly offered programmes. Whatever programme or courses the municipalities offer, they are required to have skills enhancement plans for the staff running the programmes and to fund the courses so that they are free for the families.

In 2018, the first government strategy for parental support, "Safe Parents – Safe Kids", was launched in Norway, and this runs until 2021. One of its central aims is to strengthen parenting skills, both through universal measures for all parents and

through targeted measures for parents with special needs (e.g. parents with a different cultural background, parents who have children with disabilities, etc.). In relation to this, the Directorate for Children, Youth and Family Affairs is developing an informative website about all available parenting programmes that will offer municipalities digital support for their parental support measures. The aim is for the website to be completed before the end of the strategy period (2021).

Risk factors in the early years

Various vulnerable groups are addressed in the national ICH guidelines, such as young parents, parents with alcohol or substance use problems, those with mental health issues, victims of violence, those of low socioeconomic status, asylum seekers, and so on. In general, children born with special challenges or disabilities, as well as children whose parents are ill, injured or have significant social problems, are considered to be at risk. All vulnerable groups are offered individual follow-up in ICH in addition to the universal service. However, specific national guidelines on how to ensure specialized follow-ups are only available for some groups, such as mothers with substance use problems, eating disorders or premature babies. For other groups, local or regional guidelines and standards with recommendations are available. In all ICH services, an emphasis is placed on identifying physical, mental and developmental disorders as early as possible and preventing, averting and uncovering violence, abuse and neglect. Although screening for risk factors is not coordinated at national level, ICH guidelines provide instructions on the early identification of risk among children and families. An emphasis is placed on health centres being aware of factors that could indicate violence, abuse or neglect by observing the child and family. Public health nurses and doctors are supposed to use medical histories and clinical examination to identify risk factors that may lead to negative outcomes in physical and mental health and child development. A 2014 survey showed that screening for problems in ICH did not occur to the extent that it should, but this is likely to have improved since then as the importance of early detection of problems has been emphasized heavily in recent years. In the years since the survey, national guidelines for health promotion and preventive work in child and youth health centres and the school health service up to the age of 20 have been implemented, which also helps to draw attention to this topic.

Enquiring about lifestyle habits and tobacco, alcohol and substance use is recommended at the initial ICH consultation, and enquiries about violence and mental health should be made repeatedly. In general, the screening tools used by municipalities vary. National guidelines recommend some tools, such as TWEAK or AUDIT, as well as offering practical suggestions for standardized questions. There are also several widely implemented programmes for the early identification of risks among parents and children, such as the previously mentioned *Better Interdisciplinary Efforts* (BTI) and the *Early In* (Tidlig Inn) training programme. Also worth noting is a new national guideline that was developed to strengthen the early detection of risk among children and improve competence across all sections in a collaborative effort between the Directorate of Health, the Directorate for Education and Training, the Directorate for Children, Youth and Family Affairs, the National Police Directorate and the Norwegian Labour and Welfare Administration (NAV).

As previously stated, cross-sectoral collaboration is statutory in Norway. There are laws and regulations to ensure this, but some work is still needed before relevant sectors find a way to share responsibility for it. Guidelines for child and youth health centres state the duty to engage in systematic cooperation with child welfare service and cooperate with the Norwegian Labour and Welfare Administration (NAV), but experience shows that this is often lacking. It is also established by law that health centre services must facilitate and have defined routines for the requisite cooperation with relevant municipal services, county council services and governmental service. Yet, some municipalities have not established such structures and systems. The appointment of service coordinators, individual care plans and a coordinating unit is meant to specify and ensure the responsibility of different service providers towards people in need of long-term, coordinated services but this does not always happen. There is also a wide variation in the accessibility of different services and their organization, as municipalities have different resources, initiatives and priorities that affect services for parents, families and young children.

At present, grand strategic investments are being made to improve cross-sectoral collaboration in relation to the *Nordic-0-24-Collaboration* project¹⁹⁰, which aims to strengthen support for vulnerable children and young people. One of the main goals of this project is to develop more comprehensive and coordinated health and welfare services in which three measures are central: 1) collaborative agreements between municipalities and other service providers; 2) the development of good models for continuous courses of care that are informed by patient experience, and 3) increased use of information channels between agencies. Currently, there are developments to implement lessons from this initiative on a wider, national scale to strengthen collaboration between the different parts of the health service and related systems.

In 2010, changes were made to regulations in Norway to ensure that children whose parents have mental health or substance use problems are better taken care of within adult health and social services. As a result, all healthcare providers in specialist services must ask clients whether they have children and, if so, who takes care of them. All adult specialist services are required to appoint a children's representative who is responsible for securing support and follow-up for children whose parents have physical or mental illnesses or other problems that might affect their wellbeing. Municipalities are similarly obliged to have systems in place that ensure follow-up for these children, which can be organized in various ways. For example, the responsibility of a children's representative may be placed within a family centre or similar service. Children's representatives function as coordinators of care and are responsible for ensuring that children's needs are assessed and protected. The children's representatives have a responsibility to be aware of all relevant services, both in-house services and those offered by other systems, and protect the child's best interests, including filing reports of concern or prompting necessary action when needed. Despite this, recent reports have shown that collaboration between services for adults and services for children is lacking and that less than half of the municipalities in Norway state that collaborative agreements with specialist services within different areas of mental health and substance abuse are working well¹⁹¹.

190. *Nordic 0-24 collaboration* (n.d.). Retrieved September 11, 2020, from <https://0-24-samarbeidet.no/nordic-0-24-collaboration/>

191. Ose, O.S., Kaspersen, S.L., Ådnanes, M., Lassemo, E. and Kalseth, J. (2018). *Kommunalt psykisk helse- og rusarbeid 2018: Årsverk, kompetanse og innhold i tjenestene*. SINTEF Digital. Retrieved September 11, 2020, from https://www.sintef.no/globalassets/sintef-teknologi-og-samfunn/avdelinger/helse/endelig_kommunalt-psykisk-helse-

Mental health difficulties

The Edinburgh Postnatal Depression Scale (EPDS) is not recommended for universal screening in Norway, but it may be employed as one method of detecting antenatal and postnatal depression, combined with supportive counselling. It is used at around 6–8 weeks postpartum. If mild to moderate postnatal depression or other mental health problems are detected, a first step would be for public health nurses to offer personalized support, additional consultation and guidance. In cases of severe or long-lasting depressive symptoms, women should immediately be referred to specialist care. Intensive and flexible support should be offered, preferably through home visits, where three or more home visits are recommended for vulnerable families. If needed, public health nurses should also establish interdisciplinary collaboration (e.g. with GPs, midwives or psychologists) and encourage parents to contact relevant professionals for further assessment and treatment. Statistics about the degree to which the other parent's mental health needs are assessed and met in ICH are sparse, and it is not known whether there are any particular programmes or support for fathers. However, there are NGO resources for men, such as "Reform", which is a non-political organization working with gender equality from a male perspective. They offer some low-threshold services for difficult life situations.

Psychological services are free of charge through health centres, although the service is limited to only a few sessions. In the case of more sustained or complex mental health problems, referrals are made to local DPS services. As previously noted, municipalities are obliged to cooperate with other services and sectors when necessary, and specialist services have a corresponding legal duty to cooperate. DPS services may carry some of the costs, but the amount is usually minimal. Family counselling services are available free of charge, and they are accessible to everyone. As stated before, different "patient pathways" have been developed in Norway for mental health and substance use problems, and these can be initiated by both primary and specialist services (DPS). Some family clinics also offer services for mothers or families with young children who struggle with mental illness or substance abuse, which are organized in specialist services.

Other services include the healthy lifestyle centres, which can offer counselling for sleep problems, stress and mental wellbeing, and "rapid mental health care", which is a low-threshold, short-term service for mild to moderate anxiety, depression, sleep disorders and early-stage substance abuse. No referral is needed, but GPs and public health nurses can be important collaborative partners. However, these services are not available in all municipalities, and cost, availability and waiting times can vary. Other interventions for new parents with mental health difficulties are available in only very limited areas. One example is the *Nurse-Family Partnership* (NFP), which starts in early pregnancy and offers first-time parents in need of extra support regular home visits from a nurse throughout pregnancy and the first two years after birth¹⁹². Another home visiting programme is New Families, which is offered only in selected boroughs in Oslo Municipality. This is a lighter version of NFP, but so far

rusarbeid-2018.pdf/

192. Regionsenter for barn og unges psykiske helse, Helseregion øst og Sør (n.d.). *Familie for første gang (Nurse family partnership)*. Retrieved September 11, 2020, from <https://www.r-bup.no/no/vi-tilbyr/skreddersydd-opplaering/nurse-family-partnership-programmet-nfp#>

there is a lack of research evidence documenting its effectiveness¹⁹³.

Social difficulties

Social services may be organized independently or as part of the family house model, where families receive coordinated health and welfare services. Municipalities hold the main responsibilities for financial assistance, housing and so on, but charities and NGOs remain important collaborators. Service users, their social support system, and interest group organizations also contribute to the organization of social services. Those who need help from NAV must contact their local office or give their service coordinator permission to make contact for them. If there is a need for collaboration between different service providers, NAV can collaborate with health and welfare services, child protection services, child and adolescent psychiatry (BUP) and the district psychiatric centre (DPS). National recommendations for coordinating units have been developed that function as guidelines for how municipalities can fulfil the requirements of the Municipal Health and Care Services Act. Around 66% of municipalities have established collaboration between NAV and health and welfare services regarding the rehabilitation of people with mental health issues or a history of substance abuse.

Home support services can also be offered to parents with social difficulties, which can include counselling and practical assistance at home. This can be offered for any sort of problem, including mental health, substance use or disability. The idea is to build on the parents' strengths and resources, so they are better able to care for their child. Advice and guidance can be offered not only by family welfare services or the family protection office but also by other professional services such as DPS. Additional support services for vulnerable families with infants and toddlers include a prioritized place in daycare, a support home or support person, home inspection, financial subsidies and social networking. There are also 18 "Parent and Child Centres" spread across Norway that offer a live-in service for vulnerable pregnant women. Access to the service varies, as does the content, depending on the way the centres are organized and their access to professionally trained personnel. Some include the other parent in the service and offer support to new parents with particular issues (e.g. very young parents, parents with learning difficulties or parents with substance use problems) to care for their child. Others only provide services to pregnant women. Admission to the centres mainly goes through the Child, Youth and Family Administration (Bufetat), which is responsible for state child and family protection in five different regions in Norway. Municipalities co-fund places in them.

Relationship difficulties

There is no systematic identification of relationship difficulties in Norwegian ICH, but if challenges arise, a number of interventions may be considered. Several health centres offer a marital discord prevention programme for first-time parents called *Good Cohabitation* (Godt samliv) in collaboration with family counselling services. The programme aims at strengthening the couple's relationship and offering support

193. *Storstilt prosjekt med VID-professor i spissen*. 2018, 26th of March. VID vitenskapelige høgskole. Retrieved September 11, 2020, from: <https://www.vid.no/nyheter/storstilt-prosjekt-med-vid-professor-i-spissen/>

and inspiration in the period of changes and challenges when a new baby arrives. Other relationship programmes include PREP, which is a universal course for all couples to support positive interactions, and the *Buffer Course* (Bufferkurs), which gives information about the characteristics of a good relationship and teaches ways to manage negative emotions, conflicts and personality differences. The previously mentioned "We-App" is an online resource for parents that centres on the couple's relationship. The *Alternative to Violence* foundation also offers courses for couple's problems at several locations across Norway.

As previously stated, family counselling is offered through 49 family protection offices that are regionally organized and cover all municipalities in Norway. They can also offer new parents help with relationship difficulties. The service is free of charge although there may be waiting lists. Parents can make contact themselves, or GPs, psychologists or other professionals can refer them. Parents with young children are prioritized. According to The Marriage Act and The Children Act, parents who are considering divorce must first attend statutory mediation with the family protection service. The average waiting time before the initial appointment is 24 days for clinical cases (the maximum allowed is four weeks) and 19 days in mediation cases (the maximum allowed is three weeks). Family protection services must, among other tasks, collaborate with municipal services (e.g. health centres), the courts, regional competence and resource centres, and private services like *Alternative to Violence*. Family protection services also cooperate closely with local child welfare services. This applies to cases where both services are involved with the same family and involves both services providing guidance and competencies and following up on parents who have lost custody of their children.

Alcohol and substance abuse

Under the national guidelines, indicators of substance abuse should be discussed at the first consultation in ICH, and then regularly as needed. If challenges are uncovered, the child's needs must be considered, and the family should be referred to their GP. Follow-up should then be offered in specialist care (DPS) or treatment institutions, depending on the severity of the issue, and there should be extended follow-up in municipal healthcare services if this has not already been scheduled. Health centres may also offer individual counselling courses for patients and their social network. GPs should always be involved in referrals to DPS as they have an important medical coordinating role and must cooperate with other relevant services to provide their patients with the best of care. All public agencies, as well as a number of practitioners with a duty of confidentiality, are obligated to report to child welfare services when there is reason to believe that a child is exposed to substance abuse. To facilitate reports about concerns for children's wellbeing, the Children, Youth and Family Directorate launched a digital portal in 2020 where both individuals and public employees can report any concerns they have about children's wellbeing directly to child welfare services in electronic form.

Some municipalities have "fortified health centres" with more specialized services and follow-up for vulnerable groups. In these centres, municipal psychologists and various other professionals have established a more focused interdisciplinary collaboration and enhanced their competencies in caring for parents with substance abuse or mental health problems. However, this is not a universal service, and it is

only available in larger municipalities. Several municipalities also offer special NGO services to families in vulnerable circumstances due to substance abuse or mental health problems who have children up to 8 years old. In severe cases, support services can be offered outside the home, such as voluntary placement in foster care or child protection institutions, with the agreement and consent of parents. Some treatment institutions also have specialized units for expecting and new parents where they can get help coming off drugs and alcohol, learn how to live drug-free and focus on positive parenting. Family protection services also offer various services to parents with substance abuse problems, such as individual counselling, couple counselling and group support programmes.

In general, resources for parents of young children with alcohol and substance abuse problems vary substantially between municipalities. In some areas, the service is very good, and parents receive the necessary treatment for free on a sliding scale appropriate to the severity of the problem, including after-care and social support to build up their lives after treatment. In other areas, however, there may be significant limitations, from insufficient efforts to detect problems early on to the incomplete implementation of effective treatment measures. Municipalities have different resources and priorities, and they are free to organize their services as they see fit, as long as they provide a legally mandated service. Thus, the availability of quality services varies. It has also been revealed that services are not as well coordinated as government regulations intend them to be.

Violence and trauma

An increasing emphasis is being placed on the prevention, identification and response to violence in ICH services. Numerous improvement plans have been implemented in recent years so that there is now a stronger focus on this topic, although there are still weaknesses, mostly due to lack of cross-sectoral collaboration and differences in municipal services. National guidelines recommend universal screening for violence in ICH, but this is not always done. If domestic violence, sexual violence or other forms of abuse are identified, ICH staff must report to child welfare services and the police. The reporting of concerns to local child welfare services also applies to violence against partners. The Norwegian Centre for Violence and Traumatic Stress Studies (NKVTS) has developed recommendations on domestic violence for health and welfare services, and these specify responsibilities and routines for referral. They are linked to the national guidelines for both prenatal and ICH care.

In accordance with regulations on the municipalities' health promotion and preventive work in health centres, all health centres must have a plan for preventing and detecting violence, neglect or abuse. All public authorities, as well as a number of practitioners with a duty of confidentiality, are obligated to report to child welfare services when there is reason to believe that a child is exposed to abuse or neglect, or when a child has persistent and severe behavioural difficulties. It is the responsibility of child welfare services to decide how the report should be followed up. This should be done in collaboration with ICH, but the quality of the collaboration may vary. To improve the ability to detect and work with violence in ICH, the national action plan against domestic violence suggests that e-learning courses, which have been developed by the National Competence Centre for Acute Medicine (NKLM),

should be offered to all GPs. When support services are instigated by child welfare services, a plan must be drafted in collaboration with the parents, with goals and a timeline. In conflict-ridden cases, the collaboration must be preserved with the child's needs as a guiding principle. Child welfare services have an obligation to collaborate with other services to ensure holistic and coordinated care and, as always, service users who need long-term, coordinated services have the right to a coordinator and an individual plan.

National ICH guidelines recommend counselling parents regularly on the importance of predictability, establishing good routines in the home and sensitive communication with infants and young children. However, there are no defined procedures for how this should be done or implemented, and there is no systematic monitoring of whether it is done. The online self-help resource for violence prevention, *In Safe Hands*, which was developed by the National Group of Public Health Nurses, has been implemented in around 67% of health centres in Norway. It teaches parents that constant fighting and yelling can cause harm and stress to the baby, about how to cope with extended crying without losing one's temper, and so on. Another resource that has been widely implemented is *Stine Sofie's Parenting Package* for future and new parents. The programme offers parents good strategies for dealing with stressful or demanding family situations and is based on existing guidelines for prenatal care, postnatal care and newborn intensive care, as well as the child healthcare programme in health centres. It is intended to be informative for both parents and ICH staff on how to address challenging issues. The *Stine Sofie Parenting Package* is developed as an app, which can be used by parents and professionals alike.

Other resources include the webpage and app, "Littsint", which helps parents with anger management in relation to their children. The previously mentioned NGO, *Alternative to Violence*, offers individual and group counselling for victims of violence. Some centres also offer support to all members of the family, both adults and children, and both perpetrators and victims of violence. The organization also provides online resources and telephone support services. In several municipalities, anger management training according to the "Brødset Model" is also offered by child welfare services or family counselling offices. The Regional Resource Centre for Violence, Traumatic Stress and Suicide Prevention (RVTS) provides training for professionals in using this approach. Families can also be offered individual counselling or cohabitation training programmes by child welfare or municipal mental health services. However, this can only be offered in agreement with the family after a comprehensive assessment. Finally, the programme, "Talk to Children" ("Snakke med barn") was developed by RVTS on behalf of the Directorate for Children, Youth and Family Affairs as part of the government's action plan, "A Good Childhood Lasts a Lifetime" (2014–2017). The aim is to increase professional knowledge and competence among everyone who works with children.

As previously stated, all municipalities are obliged to offer crisis centre services (shelters) for those exposed to domestic violence. In line with the law, this service must include housing, day services, phone services and follow-up tailored to individual needs and integrated with other services. Children should be treated as separate service users at crisis centres, meaning that they are entitled to services according to their own needs, irrespective of the needs of their parents, and be protected in a manner that fulfils those needs. Some hospitals have also established

specialized assault units or "assault centres" that offer comprehensive emergency, legal and social support for adult victims of violence. Outpatient clinics for mental health services for children and adolescents (BUP) and district psychiatric centres (DPS) can also offer trauma treatment for both victims and perpetrators of violence via GP referral. The Norwegian Directorate for Children, Youth and Family Affairs (Bufdir) has developed instructions and tools for how municipalities can achieve comprehensive and integrated work against domestic violence, which also includes information on different support services and integration of follow-up services.

Until recently, there has been a lack of evidence-based trauma treatment suitable for children under the age of six in Norway. Existing services have usually targeted either the parents or the child, despite the fact that integrated efforts are known to be necessary for the successful treatment of trauma (e.g. due to violence) and severe psychological distress. Child-Parent Psychotherapy (CPP) is an interactive, trauma theory-informed treatment for infants and preschool children who show symptoms of trauma, psychological distress, severe relational or mental health problems, or are at risk of developing mental illness due to exposure to traumatic events. The implementation of CPP in Norway is now in its initial phase and is operated by the Regional Competence Centre for Child and Adolescent Mental Health (RBUP). At the state level, the Children's House is a service provided for children and young people who may have been exposed to, or witnessed, violence or sexual abuse when a police report has been filed. The Children's House offers children a safe medical examination and a place to discuss their experience with professionals who are specially trained in talking to children about violence. This ensures they only need to tell their story once, instead of repeating it to the police, social workers, therapists, and so on. Since some verbal ability is required it is not known whether this service is offered to children under the age of two. However, medical examinations can be conducted in the Children's House.

Parental leave

Parental leave is offered to parents who have been working or are enrolled in approved full-time education for at least six of the ten months before the benefit period. Parental benefit is based on the average income for the three months preceding the beginning of the leave. The Norwegian Labour and Welfare Administration (NAV) does not pay parental benefit for a yearly income that is six times in excess of the National Insurance basic amount, which is around DKK 379,000. Some employers cover the excess amount for those earning more than this, but that is not mandatory.

The total parental benefit period is 49 weeks, with 100% coverage or 59 weeks, with 80% coverage. The corresponding period for adoptive parents is 46 weeks (100% coverage) or 56 weeks (80% coverage). Additional time is offered for twin births (or more) or multiple adoptions. Mothers can start their parental leave up to 12 weeks prior to the expected delivery date at the expense of fewer weeks in the shared period. The leave must commence no later than three weeks prior to the due date, however. Parental leave in Norway is split into a maternal quota of 15 weeks, of which six must be taken immediately after birth, a paternal or partner quota of 15 weeks, and a shared period of 16 weeks, which the parents can divide between them

as they see fit. If 80% coverage is chosen, the period consists of a maternal quota of 19 weeks, a partner quota of 19 weeks and a shared period of 18 weeks (total of 59 weeks). The maternal and partner quotas cannot be transferred between parents unless circumstances prevent the other parent from caring for the child. If only the father or partner is entitled to parental leave, they will receive full parental benefits except for the nine weeks reserved for the mother before and after giving birth. Parental leave can also be deferred or taken as a partial leave (i.e. flexible leave). However, parental benefits cannot be offered more than three years after childbirth or adoption.

Early childhood education and care

Under the Norwegian Kindergarten Act, every child who turns one year old by the end of August has the right to a place in kindergarten in their municipality from 1 August that year. Children who turn one in September, October or November also have the right to a place in kindergarten by the end of the month of their birthday. Most children start kindergarten immediately after parental leave, but there may be a short waiting list (of one to two months). During this time, parents can choose to enrol their children in family daycare, but that is uncommon. Parents can also seek the service of individual childminders (described below), or they can receive financial child support for children aged 1–2 who are not enrolled in kindergarten. The parents of children with part-time places in kindergarten may receive 20%, 40%, 60% or 80% of financial child support as appropriate. Currently, 100% financial child support is approximately DKK 5,300 (NOK 7,500) per child per month. It is very rare for children to attend kindergarten before their first birthday as most parents are still on parental leave at that time. Statistics from 2018 show that approximately 4% in this age group are enrolled in kindergarten, whereas the figure for 1–2-year-olds is 83%. After that, almost all children are enrolled in kindergarten (97% of 3–5-year-olds).

Family daycare

In family daycare, children receive an educational service in private homes. Similar to the Danish system, family daycare staff receive guidance from kindergarten teachers and adhere to the Kindergarten Act in addition to Family Day Care Regulations. However, family daycare is very rarely used in Norway, and less than 2% of children are enrolled in them. Most children go directly from parental leave to kindergarten but sometimes a short period (e.g. 2–3 months) needs to be covered between parental leave and the start of kindergarten. In such cases, parents can seek the service of individual childminders (“dagmamas”), who provide care in their homes but are not licensed family daycare providers. Individual childminders must have their homes approved by the municipality as a suitable venue for children but other than that no requirements are made for their competency or the content of their work. Home daycare provided by individual childminders is not part of the early childhood education and care (ECEC) sector in Norway and the rules for this system are rather minimal. For example, there is no routine scrutiny of the home daycare,

and childminders are not required to have clean criminal records. However, if parents report unhealthy or dangerous conditions or other signs of inadequate care, municipalities can investigate and, if warranted, close down the facility.

Kindergarten

The Norwegian Ministry of Education and Research, the Norwegian Directorate for Education and Training, county governors, municipalities and kindergarten owners share responsibility for the early childhood education and care (ECEC) sector in Norway. The Norwegian Directorate for Education and Training is responsible for quality assurance and competency enhancement in ECEC. It also administers subsidies, laws and regulations, supervision and guidance. County governors are responsible for disseminating national policies at the regional level and influence the ECEC system in their county through the administration of state subsidies, supervision and guidance to municipalities and kindergarten owners and other tasks under the Norwegian Kindergarten Act. This includes initiation of work related to the development of competency and coordination in the municipalities and kindergartens in the county. County governors conduct formal inspections of kindergartens under special circumstances, such as in the case of complaints or indications from official reports that the service is lacking in some way. Municipalities have a double role as local ECEC authority and kindergarten owner. As a local authority, they are responsible for approving and inspecting kindergartens and family daycare in their municipality, both public and private. Municipalities also own and run about 50% of Norwegian kindergartens, while the rest are privately owned. Regardless of ownership, all kindergartens receive public funding from the municipalities, which must also provide guidance, ensure that they operate according to regulations and ensure that their work conforms to the National Framework for Kindergartens and the Norwegian Kindergarten Act.

Along with head teachers, kindergarten owners are responsible for hiring sufficient numbers of competent staff. In 2018, new pedagogical standards were established, stating that there must be at least one member of ECEC staff for every three children under the age of three and at least one pedagogical leader for every seven children in the same age group. Since these requirements are rather new, they have not yet been met in all kindergartens. However, all kindergartens are required to have a plan on how they will work towards fulfilling the requirements in the coming years. Pedagogical leaders are responsible for the content of ECEC work in the group of children they supervise or the areas with which they are tasked. They must be qualified kindergarten teachers or have a three-year university degree in pedagogy with an additional specialization in ECEC. However, municipalities may grant dispensations from these requirements under certain circumstances, such as when kindergartens do not receive a sufficient number of qualified applications for advertised positions. Currently, about 40% of kindergartens meet the requirements for both the number of staff and the number of pedagogical leaders. At the moment, the approximate breakdown of ECEC staff nationally is: 40% kindergarten teachers; 10% with other higher education or skilled-worker training; 20% certified child and youth workers; and 30% with unspecified training or education.

ECEC in Norway is not free of charge but subsidized by municipalities so that parental cost does not exceed a maximum of approximately DKK 2,150 per month.

This applies to all types of kindergarten, both public and private, and all are obliged to offer lower rates to parents with a lower income to ensure that it is available to all children regardless of financial status. Almost all children attending kindergarten in Norway (97%) have a full-time placement, which equals scheduled care for at least 41 hours per week. However, there are some minor differences in terms of how many hours constitute a full-time place, depending on the age group. There are no national regulations on group size in Norwegian kindergartens but the average number of children in a toddler group (nine months to three years) is 8–9 children. There are no general norms for the adjustment period when a child starts daycare, but an emphasis is placed on a smooth transition and a sense of safety and comfort for the child. Parents participate in the process, and some (at least those parents who work for the state or municipality) can get three days of paid leave to be with their child during the adjustment period. However, the overall duration and process of the adjustment depend on individual needs.

In 2013, a new national strategy for ECEC staff competence and recruitment was put in place with the aim of ensuring that all children receive high-quality early childhood education and care. One of the focus points is to ensure that all ECEC staff have opportunities for professional development and that kindergartens develop their educational practices through kindergarten-based competence development. According to the 2018 TALIS Starting Strong report, Norway has very high rates of staff participating in professional development activities (94%)¹⁹⁴, but it is up to each kindergarten owner and kindergartens to plan how they will improve and maintain staff competencies. However, all municipalities are obligated to develop action plans to address violence and neglect, and these should include measures on increasing staff knowledge on the issue, including ECEC staff. There is no national system in place to ensure that all ECEC staff receive this type of training.

According to the aforementioned TALIS Starting Strong report, Norway had the highest percentage of ECEC staff (97%) reporting satisfaction with their jobs among the nine participating countries. The proportion of staff satisfied with their salary, however, was much lower (30%). According to Statistics Norway, average monthly wages in Norway are about DKK 29,474, but the average salary for kindergarten teachers is approximately DKK 25,370. The average salary for untrained ECEC staff is DKK 21,241. Thus, kindergarten teachers' salaries are 86% of the average in Norway, and untrained ECEC staff wages are 72% of the average. In the 2018 TALIS Starting Strong report, staff absences, staff shortages, and inadequate budgets and resources were considered key barriers to effectiveness in Norwegian ECEC and reducing group sizes by recruiting more staff was considered the top spending priority.

Social and emotional development

The ECEC sector is part of the education system in Norway, and kindergartens adhere to a common national Framework Plan for Kindergartens that is aligned with the National Curriculum for Schools (ages 6 to 18). The Framework Plan outlines, among other things, children's need for care and play, the promotion of learning and

194. OECD (2018). *Norway – Country Note – TALIS Starting Strong 2018 Results*. Retrieved September 11, 2020, from www.oecd.org/education/school/Country_Note_Norway.pdf

formative experience, and the importance of attending to individual circumstances and needs. According to the National Framework Plan, all kindergartens must develop an annual plan on how they will work towards meeting their goals and content requirements. If necessary, plans are developed for shorter or longer periods, as well as for specific groups of children. The annual plans describe how the kindergarten approaches care, play, formative assessment and learning. In the annual plans, kindergartens also lay out their activities for promoting wellbeing and all-round development, but they are independent in choosing their own ways of achieving the Framework Plan's purpose.

It is up to kindergarten owners and kindergartens to choose their approaches to social and emotional learning (SEL), and some have implemented programmes to strengthen social-emotional skills among the youngest children. One example is *Being Together*, a programme focusing on early intervention, authoritative child-raising practices, increasing social skills and managing challenging behaviour. *START* is an adapted version of the "Step by Step" programme for children between 1 and 3 years old. The focus is on improving social and emotional skills, fostering cooperation and reducing aggressive behaviour among young children. *The Incredible Years* is a primary prevention programme that is used both in schools and daycare and focuses on improving social skills and reducing behaviour problems. As previously mentioned, the International Child Development Programme (ICDP) is also used in adapted form as a primary prevention programme in daycare. COS International Parenting (COS-P) is a primary prevention programme for parents, which may also be used in ECEC. Similar to the parental version, the ECEC version aims to enhance staff competencies in attending to children's emotional needs, interpreting their behaviour and expressions, and helping children regulate their emotions.

The National Framework Plan for Kindergartens underscores the kindergarten's responsibility to meet children's need for care and play and develop caring relationships between children and staff through openness, warmth and genuine interest. ECEC staff are expected to create an inclusive environment where all children can participate and experience the joy of play. Pedagogical leaders are responsible for providing staff in their group with sufficient guidance to ensure that their practices are in line with the requirements of the National Framework Plan. However, it is not known to what degree this is carried out. In addition, a new national guideline from the Directorate of Health on the early identification of vulnerable children and adolescents dictates that the municipality must ensure that all employees working with children and young people have general knowledge about protective and risk factors among children so they can recognize signs of normal development and causes for concern. This is especially relevant for the youngest children in kindergarten.

Collaboration with parents

The National Framework Plan for Kindergartens has a specific chapter on collaboration between parents and kindergarten. This is also enshrined in the National Kindergarten Act. The kindergarten and the home should collaborate for the benefit of the child, and the kindergarten is responsible for facilitating parental collaboration. This is intended to be practised both at group level, for example through parents' councils and collaboration committees, and at individual level,

through regular consultation and meetings with parents of individual children. Annual plans should detail how the collaboration with parents and children will be organized throughout the year, including how they will be involved in the process of developing the kindergarten's plans and internal evaluations of the pedagogical work. In addition, there is a national committee for parents of children in ECEC. Almost all kindergartens choose to conduct parental surveys once a year. These focus on child wellbeing, satisfaction with staff communication, learning, facilities and so on. The Norwegian Directorate for Education and Training's parental survey is used by a majority of kindergartens, and the results are disseminated via the kindergarten's webpage, as well as on the websites www.barnehaagefakta.no and www.udir.no.

Collaboration with other services

According to Norwegian legislation, all municipal services, including ECEC, have an obligation to collaborate with other systems and services according to the needs of the users. Child health services should have defined routines for collaboration with kindergartens both at the system level (i.e. a municipal plan) and for individual cases, when necessary. In some municipalities, public health nurses from ICH perform health examinations at kindergartens; others have regular collaboration meetings and so on. Municipalities are responsible for facilitating collaborative work, but it varies how this is organized. GPs and the municipality's coordinating unit are key partners for child healthcare, to ensure holistic and coordinated services. The National Guidelines for Children's Health and School Services also recommend a systematic approach to working together, which applies to both universal and preventative services for all children, and easy access to resources for challenging cases. For some children, it may be beneficial to cooperate with specialist services, such as specialist healthcare centres for children and young people, which offer treatment for psychological problems and developmental disorders. Documented routines for working together on assessments and follow-up for children in need of an individual care plan or long-term measures should also be established.

If there are signs of social or emotional difficulties among young children in kindergarten, the municipality conducts an assessment and draws up a resolution (i.e. plan) based on expert opinion. The municipality is responsible for arranging interventions or assistance in accordance with this resolution. The municipality's educational-psychological preventive services (PPT) provide support and follow-up for children in kindergarten with municipal solutions for special educational needs (SEN). They are responsible for ensuring that both daycare staff and children receive the indicated help and assistance required. If the DPS centre for children and young people is involved, they might also provide staff with guidance. How this is delivered is usually described in a special education plan for the child on how the support will be organized.

All ECEC staff have a duty to look out for signs of concern and report to child welfare services if they notice circumstances that may be harmful to children. The kindergarten and child welfare services must collaborate on the development of defined routines for cooperation, including developing set procedures for staff reports to child welfare services. There must be a defined protocol in place, and it must be clear to staff in what sort of cases they should file a report, how to do so

and what it should include. Currently, private kindergartens who are members of the Private Kindergarten Institutions' National Association are establishing children's safety representatives in all their centres (1,920 in total). This is implemented in cooperation with The Stine Sofie Foundation with the aim of ensuring that ECEC staff have sufficient competencies to detect signs of violence and other forms of abuse among children. Recommendations have also been developed by the Ministry of Children and Families ("For the good of children") that provide ECEC staff with tools designed to guide them through the necessary steps when there are concerns about a child. However, it is up to each municipality, kindergarten owner and kindergarten to decide how this information is disseminated and the knowledge implemented.



Sweden

Prenatal care

Prenatal care in Sweden is managed by primary care services at regional level and is provided in prenatal clinics run by midwives. The clinics can be stand-alone, part of a primary healthcare centre or located in a family centre¹⁹⁵. Prenatal clinics can also be private, and the number of private clinics in Sweden has been steadily increasing in recent years. In 2018, over 26% of health clinics were private, and 41% were part of family centres¹⁹⁶. Irrespective of management, prenatal care is free of charge to all pregnant women and accessible regardless of geographical location. The service is meant to accommodate individual needs and interpreters are provided for women who do not understand Swedish¹⁹⁷.

The prenatal team consists of a midwife and a doctor and, in most cases, a psychologist who either works in the prenatal clinic or is available when needed¹⁹⁸. Midwives are responsible for uncomplicated pregnancies and offer the vast majority of prenatal visits. If there are no complications, the midwife is the only health professional many women see during prenatal care. Midwives consult regularly with the physician who has medical responsibility, and all pregnant women are entitled to request an appointment with a physician if they wish¹⁹⁹. In 2018, around half of pregnant women (56%) visited a physician for pregnancy-related reasons²⁰⁰. According to national guidelines, the aim is for women to see the same health professional throughout their pregnancy, and statistics show that 68% of pregnant women saw no more than two midwives²⁰¹.

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195. Swedish Society of Obstetrics and Gynecology (SFOG). (2016 (2008)). Maternal Health Care, Sexual and Reproductive health (Mödrhälsövård, sexuell och reproduktiv hälsa). Rapport 76. [cited 2019-07-13]. Retrieved from <https://vardgivarguiden.se/globalassets/kunskapsstod/bmm/sexuell-reproduktiv-halsa.pdf>
196. The Swedish Pregnancy Register (SPR) (2018). The Swedish Pregnancy Register year report 2018 (Graviditetsregistrets årsrapport 2018). [cited 2019-09-30]. Retrieved from https://www.medscinet.com/GR/uploads/hemsida/dokumentarkiv/2018%20GR%20årsrapport_2.0.pdf
197. Swedish Society of Obstetrics and Gynecology (SFOG). (2016 (2008)). Maternal Health Care, Sexual and Reproductive health (Mödrhälsövård, sexuell och reproduktiv hälsa). Rapport 76.
198. Communication with reference group 2019-09-01-2019-10-30.
199. Swedish Society of Obstetrics and Gynecology (SFOG). (2016 (2008)). Maternal Health Care, Sexual and Reproductive health (Mödrhälsövård, sexuell och reproduktiv hälsa). Rapport 76.
200. The Swedish Pregnancy Register (SPR) (2018). The Swedish Pregnancy Register year report 2018 (Graviditetsregistrets årsrapport 2018). [cited 2019-09-30]. Retrieved from https://www.medscinet.com/GR/uploads/hemsida/dokumentarkiv/2018%20GR%20årsrapport_2.0.pdf
201. The Swedish Pregnancy Register (SPR) (2018). The Swedish Pregnancy Register year report 2018 (Graviditetsregistrets årsrapport 2018). [cited 2019-09-30]. Retrieved from <https://www.medscinet.com/GR/uploads/hemsida/>

Prenatal care takes the form of individual visits and parental group sessions; the same is true for infant and child healthcare. A minimum of nine prenatal visits take place during a normal pregnancy and, according to national guidelines, the first of these should be scheduled as early as possible²⁰². In 2018, the first prenatal visit took place on average in week 9. One or two postpartum visits are also offered at the antenatal care clinic 6–12 weeks after birth to check up on breastfeeding, parent-child attachment and recovery. According to the Swedish Pregnancy Registry, 78% of women attend this visit, with some regional variations²⁰³. The other parent is also encouraged to attend prenatal care and parental group sessions, although they are not offered separate appointments on their own²⁰⁴. In 2018, around 60% of other parents attended the parental group sessions²⁰⁵.

Prenatal services adhere to clinical guidelines that were published in 2016²⁰⁶. These were developed jointly by the Swedish Society for Obstetrics and Gynaecology, the Swedish Midwifery Association and the Association for Psychologists. In addition to the national guidelines, each of Sweden's 21 regions develops and adheres to its own specific guidelines based on the national ones. The content of prenatal visits is very similar in all regions²⁰⁷. Prenatal care is organised according to defined Maternal Health Care Areas (MHCA), and all prenatal care is included in the geographical catchment area of a specified hospital²⁰⁸. A prenatal care team, consisting of a prenatal care obstetrician, a prenatal care coordinator (a midwife) and in some regions a prenatal psychologist, is responsible for evaluating and improving the quality of care, drawing up regional guidelines, and offering continuing education for midwives and physicians in every individual MHCA. Strong consensus has been established regarding the national prenatal guidelines across Sweden through annual conferences, and implementation and adherence are monitored at national level by the Swedish Pregnancy Registry (SPR). The regions follow up local care plans and implementation at regional level.

There is coordinated registration of standard information in prenatal care, but each region may record additional information depending on the focus of its care programme for pregnant women²⁰⁹. Only professionals responsible for the care of pregnant women and unborn children have access to maternity records. The Swedish Pregnancy Registry (SPR) is a certified national quality registry that collects and processes annual information from early pregnancy until a few months after birth²¹⁰. It was established in 2013 through the merger of the Maternal Health Care Registry (MHRC), the Swedish National Quality Register for Prenatal Diagnosis, and the Obstetric Register. The SPR assesses the quality of the care provided in prenatal services, in order to support quality improvements and for research purposes. The

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- dokumentarkiv/2018%20GR%20årsrapport_2.0.pdf
202. Swedish Society of Obstetrics and Gynecology (SFOG). (2016 (2008)). Maternal Health Care, Sexual and Reproductive health (Mödrhälsovård, sexuell och reproduktiv hälsa). Rapport 76.
203. The Swedish Pregnancy Register (SPR) (2018). The Swedish Pregnancy Register year report 2018 (Graviditetsregistrets årsrapport 2018). [cited 2019-09-30]. Retrieved from https://www.medscinet.com/GR/uploads/hemsida/dokumentarkiv/2018%20GR%20årsrapport_2.0.pdf
204. Communication with reference group 2019-09-01-2019-10-30.
205. The Swedish Pregnancy Register (SPR) (2018). The Swedish Pregnancy Register year report 2018 (Graviditetsregistrets årsrapport 2018). [cited 2019-09-30]. Retrieved from https://www.medscinet.com/GR/uploads/hemsida/dokumentarkiv/2018%20GR%20årsrapport_2.0.pdf
206. Swedish Society of Obstetrics and Gynecology (SFOG). (2016 (2008)). Maternal Health Care, Sexual and Reproductive health (Mödrhälsovård, sexuell och reproduktiv hälsa). Rapport 76.
207. Communication with reference group 2019-09-01-2019-10-30.
208. Petersson, K (2016) The Swedish Maternal Health Care Register: internal validity, user perspectives and register outcomes; and experiences by midwives in antenatal care [Doctoral thesis, Umeå:Umeå University, <http://umu.diva-portal.org/smash/get/diva2:998730/SPIKBLAD01.pdf>
209. Communication with reference group 2019-09-01-2019-10-30.
210. The Swedish Pregnancy Register (SPR) (2019) [cited 2019-09-30] Retrieved from <https://www.medscinet.com/GR/engelska.aspx>

register has direct transfer of data from the women's medical journal with a coverage rate of 98.5%²¹¹. In addition, midwives register some information manually.

The prenatal care system is very well established in Sweden. Each region provides information about the system and access to prenatal centres in 20 different languages²¹², and information is also available on the website, Health Guide 1177^{213 214}. All children and young people in Sweden learn about prenatal services during sex education classes at school. Special youth receptions or youth care centres are sometimes organised at primary health centres or local authority facilities²¹⁵. Although there are no national statistics on the number of women in Sweden who do not receive prenatal care, it is thought to be very low. Only about 100–200 women give birth at home each year, and in such cases, a midwife or equivalent assistant registers the birth in the Medical Birth Register²¹⁶.

Mental wellbeing and preparation for parenthood

Encouraging good mental health during pregnancy is an important part of prenatal care, and all women should be given information at prenatal appointments about how to support their mental health and wellbeing²¹⁷. National guidelines include suggestions about the content of such information, including sexual health and lifestyle habits, and about how to address the topics during the visits²¹⁸. According to the psychosocial programme, as contained in the national guidelines, midwives should inform mothers-to-be about what will happen during the different stages of pregnancy and ask them about psychosocial issues²¹⁹. The emphasis is on a salutogenic model, in which healthy psychological functioning, health-promoting attitudes and healthy lifestyle habits are actively encouraged. Often, midwives are given training, guidance and supervision on this from prenatal psychologists, including training in brief counselling methods such as motivational interviewing (MI)^{220 221}. The other parent's mental wellbeing may be addressed during routine prenatal appointments and parental support groups. General information and advice for parents-to-be are also available from the website Health Guide 1177, Sweden's national healthcare hub for advice, information, inspiration and e-services²²². Health Guide 1177 also offers a 24/7, 365-day a year advice hotline²²³.

As previously stated, prenatal care in Sweden takes the form of both individual

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211. The Swedish Pregnancy Register (SPR) (2018). The Swedish Pregnancy Register year report 2018 (Graviditetsregistrets årsrapport 2018). [cited 2019-09-30].
 212. Health Care Guide 1177 (Vårdguiden 1177). (2019) Other languages, 1177 –vårdguiden på flera språk. [cited 2019-08-21] Retrieved from <https://www.1177.se/Stockholm/other-languages/1177-vardguiden-pa-flera-sprak/>
 213. Health Care Guide 1177 (Vårdguiden 1177). (2019) About Vårdguiden. [cited 2019-08-21] Retrieved from <https://www.1177.se/Stockholm/om-1177-vardguiden/om-1177-vardguiden/About1177Vardguiden/>
 214. Health Care Guide 1177 (Vårdguiden 1177). (2019) Stockholm/barn—gravid/gravitet. (cited 2019-08-21) Retrieved from <https://www.1177.se/Stockholm/barn--gravid/gravitet/>
 215. Association for Swedish youth centers (Föreningen Sveriges ungdomsmottagningar (FSUM)). (2019) Guidelines for swedish youth centers. [cited 2019-08-30] retrieved from http://fsum.nu/wp-content/uploads/2018/03/guidelines_2.pdf <https://www.youmo.se/en/>
 216. Communication with reference group 2019-09-01-2019-10-30.
 217. Communication with reference group 2019-09-01-2019-10-30.
 218. Swedish Society of Obstetrics and Gynecology (SFOG). (2016 (2008)). Maternal Health Care, Sexual and Reproductive health (Mödrhälsovård, sexuell och reproduktiv hälsa). Rapport 76.
 219. Swedish Society of Obstetrics and Gynecology (SFOG). (2016 (2008)). Maternal Health Care, Sexual and Reproductive health (Mödrhälsovård, sexuell och reproduktiv hälsa). Rapport 76.
 220. Personal communication with coordinating midwife and professionals at central CHI unit. (Personal communication 2020-01-01-2020-01-30).
 221. Communication with reference group 2019-09-01-2019-10-30.
 222. Health Care Guide 1177 (Vårdguiden 1177). (2019) Stockholm/barn—gravid/gravitet. (cited 2019-08-21) Retrieved from <https://www.1177.se/Stockholm/barn--gravid/gravitet/>
 223. Health Care Guide 1177 (Vårdguiden 1177). (2019) About Vårdguiden. [cited 2019-08-21] Retrieved from <https://www.1177.se/Stockholm/om-1177-vardguiden/om-1177-vardguiden/About1177Vardguiden/>

prenatal appointments and parental group sessions. Parental support groups are based on a general framework contained in the national guidelines and include the provision of information on what happens during each stage of pregnancy, preparations for becoming a parent, the birth of the baby, healthy lifestyle habits and any psychosocial changes that parents may be experiencing²²⁴. Sessions also include information about family-related services, such as family counselling and social services. The overall national goals in terms of the support for parents are: to strengthen parenting skills and the parent-child relationship; to strengthen the parents' social network; to inform parents about children's rights; and children's health and development²²⁵.

Parents can also be offered targeted support, for example, for very young parents, parents with Swedish as a second language, or specific groups for fathers^{226 227}. Most prenatal services organise parental support groups in 2–4 sessions with midwives as group leaders, although other professionals may be involved as well. The regions usually develop their own programmes and material for parental groups^{228 229}. The groups are free of charge and accessible to everyone, but in some instances, such as in certain rural areas where the number of expectant parents is too low to form a group or in cases where the expectant parents don't speak Swedish, midwives can go through the material with each couple individually^{230 231}.

Risk factors in pregnancy

According to national guidelines, all pregnant women should be asked about their social situation (e.g. employment, housing, etc.), immigration, family circumstances, social support, stress, mental health, exposure to intimate partner violence, and alcohol and substance use²³². This should be documented in the woman's digital medical journal. Questions about current or previous mental illness, exposure to violence and alcohol screening (AUDIT) should take place during the first two visits. Some regions use the Edinburgh Postnatal Depression Scale (EPDS) to screen for mental health problems, but the majority use standardised questions on mental health and violence during the first prenatal visits²³³. According to national statistics, around 90% of women in prenatal care were screened for alcohol use and asked about exposure to intimate partner violence in 2018²³⁴.

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224. Swedish Society of Obstetrics and Gynecology (SFOG). (2016 (2008)). Maternal Health Care, Sexual and Reproductive health (Mödrhälsövård, sexuell och reproduktiv hälsa). Rapport 76.
225. Ministry of Social Affairs (Socialdepartementet). (2018) A national strategy to strengthen parental support (En nationell strategi för stärkt föräldrastöd). [Cited 2019-09-30] Retrieved from <https://www.regeringen.se/4a6017/globalassets/regeringen/dokument/socialdepartementet/barnets-rattigheter/en-nationell-strategi-for-ett-starkt-foraldraskapsstod-webb.pdf>
226. Communication with reference group 2019-09-01-2019-10-30.
227. Personal communication with coordinating midwife and professionals at central CHI unit. (Personal communication 2020-01-01-2020-01-30).
228. Region Skåne. Equal parenting (Jämställt föräldraskap. För barnets bästa). (2016) Retrieved from: <https://vardgivare.skane.se/kompetens-utveckling/sakkunniggrupper/barnhalsovard/jamstallt-foraldraskap/>
229. FoU Centrum för vård och omsorg och socialt arbete et al. (2019) Parenting Young Children (PYC). A Co-operation between: FoU Centrum för vård och omsorg och socialt arbete, The Gothenburg Region (GR), FoU Sjuhärad Vålfärd, SUF Resource centre (SUF), Uppsala Region; 2020 [cited 2020-09-30] Retrieved from: <https://www.pyc.se/detta-ar-pyc/>
230. Communication with reference group 2019-09-01-2019-10-30.
231. Personal communication with coordinating midwife and professionals at central CHI unit. (Personal communication 2020-01-01-2020-01-30).
232. Swedish Society of Obstetrics and Gynecology (SFOG). (2016 (2008)). Maternal Health Care, Sexual and Reproductive health (Mödrhälsövård, sexuell och reproduktiv hälsa). Rapport 76.
233. Communication with reference group 2019-09-01-2019-10-30.
234. The Swedish Pregnancy Register (SPR) (2018). The Swedish Pregnancy Register year report 2018 (Graviditetsregistrets årsrapport 2018).

If psychosocial problems arise during pregnancy, there are defined procedures for referral²³⁵. These may vary from region to region depending on the problem and level of care, as the way care is organised differs between regions. According to Swedish healthcare legislation and the Social Services Act, a structured individual care plan (SIP) should be drawn up along with the client whenever care involves both health services and social services^{236 237}. This is usually done when a person needs services from several agencies at the same time (e.g. prenatal care, infant and child healthcare, social services, preschool, or child and youth psychiatry). The SIP can only be drawn up with the person's consent. It specifies treatment goals, roles and responsibilities, activities and time schedules. At regional level, there are specific agreements on how the region and municipality should work together²³⁸. A coordinated individual care plan (VP) is established when care is provided by different levels within the same system, such as prenatal care (primary care), specialist psychiatry (tertiary care) or specialist gynaecology (tertiary care). This is the case, for example, if a pregnant woman has, or has had, alcohol or drug dependency, if there is violence in the family, or if the mother or non-birthing parent has a mental illness or cognitive disability. Both systems may initiate a SIP; which means that the psychiatric care services may contact prenatal services during a pregnancy and vice versa. If there is a structured individual plan (SIP) or a care plan (VP), the routes for referral and collaboration should be defined in the agreement²³⁹.

Mental health difficulties

If previous or current mental health problems are identified in prenatal care, midwives will consult with physicians and prenatal psychologists about further care. Prenatal services can offer appointments with physicians, follow-up visits for person-centred counselling and appointments with the prenatal psychologist, free of charge²⁴⁰. Physicians can also refer the woman to a psychiatrist in primary care for therapy and medication. If the problems are more serious, and if there has been no previous contact with psychiatric care, the woman can be referred to a psychiatric clinic at a hospital. Otherwise, she is referred to the unit of care with which she has had prior contact. The other parent is not offered specific mental health services or referrals through prenatal care, but they can access mental health support through the general primary care system. Usually, there is good access to mental health resources for pregnant women in Sweden as there is consensus that they should receive immediate care²⁴¹. There are no waiting lists in primary care, but there may be some waiting lists in secondary and tertiary care (e.g. 3–13 weeks) since there are more groups who need urgent help at those levels of care^{242 243}. Mental health

235. Communication with reference group 2019-09-01-2019-10-30.

236. Swedish Association of Local Authorities and Regions (SALAR) (Sveriges kommuner och regioner SKR) (2019). Samordnad individuell plan (SIP) [cited 2019-10-22] Retrieved from: <https://skl.se/halsasjukvard/kunskapsstodvardochbehandling/samordnadindividuellplansip.samordnadindividuellplan.html>

237. Health Care legislation. (SFS 2017:30) Stockholm: Stockholm: Ministry of Health and Social Affairs. Retrieved from https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/halso--och-sjukvardslag_sfs-2017-30

238. Association of Local Authorities Stockholms County and Stockholm Region Stockholm (2014). Multisectoral Cross-professional collaboration teams. Cooperation on children in need of special support (BUS). Retrieved from <https://psykiatristod.se/regionala-varldprogram/psykisk-sjukdom-i-samband-med-graviditet-och-spadbarnsperiod/tvarprofessionella-samverkansteam?open.12.320310a816aa18e8d63126=true>

239. Communication with reference group 2019-09-01-2019-10-30.

240. Communication with reference group 2019-09-01-2019-10-30.

241. Swedish National Agency for Education (Skolverket). (2018). Deltagande i förskolan. Retrieved 2019-05-28 from: www.skolverket.se/download/18.6bfaca41169863e6a65d6fb/1553968197013/pdf4023.pdf

242. SALAR (2019). Current wait time mode. (cited 2019-09-30) Retrieved from <https://www.vantetider.se/Aktuellt-vantetidslage-och-ledig-kapacitet/?selection=4>

243. Communication with reference group 2019-09-01-2019-10-30.

services are not free of charge, but the cost to the patient is not very high. If pregnant women have a mental illness or cognitive disability at the start of their pregnancy, a coordinated individual care plan (SIP or VP) can be initiated in prenatal care. Each region (healthcare) and county council (social services) may have specific care programmes and regional guidelines for how they provide specialised care and how they train their professionals. In Stockholm, for example, there are pre-existing multisectoral collaboration teams for new parents who have a history of psychiatric illness or for the identification of mental illness in prenatal care²⁴⁴. The teams have representatives from prenatal care, child healthcare, child and youth psychiatry, adult psychiatry and social services, and may include other professions and stakeholders when needed.

Social difficulties

If social problems are identified in prenatal care, midwives encourage parents to contact municipal social services for support^{245 246}. They can also help them book an appointment if needed. There are social service bureaux in every municipality, as well as 24-hour hotlines. The services are usually accessible without waiting lists or fees, but each region and county council may have specific care programmes and regional guidelines for how they provide care, follow-up, and so on.

According to the Swedish Social Services Act, citizens who cannot support themselves have the right to financial assistance, which should cover expenses for food, clothes, rent, household electricity and other expenses for living a reasonable life²⁴⁷. Social services also offer other kinds of assistance, such as a contact person or contact family for support in daily life, family counselling for relationship problems, and assistance relating to violence or alcohol and substance abuse in the family. If there is a family centre in the community, social services and prenatal care may be aligned through that service model²⁴⁸. Otherwise, the pregnant woman may be connected with these services through a SIP when her problems call for such coordination. If there are indications that the unborn child is at risk, prenatal care has the right and the obligation to notify social services²⁴⁹.

Relationship difficulties

There is no specific screening for relationship difficulties in prenatal care, but during the first two visits midwives ask women about their family circumstances and explore the quality of support in their relationship as well as general social support²⁵⁰. If they discover that the expectant parents are having difficulties, especially if these might put the relationship and unborn child at risk, they will

244. Association of Local Authorities Stockholms County and Stockholm Region Stockholm (2014). Multisectoral Cross-professional collaboration teams. Cooperation on children in need of special support (BUS). Retrieved from <https://psykiatristod.se/regionala-varldprogram/psykisk-sjukdom-i-samband-med-graviditet-och-spadbarnsperiod/tvarprofessionella-samverkansteam?open.12.320310a816aa18e8d63126=true>

245. Communication with reference group 2019-09-01-2019-10-30.

246. Personal communication with coordinating midwife and professionals at central CHI unit. (Personal communication 2020-01-01-2020-01-30).

247. Social Services Act. (SFS 2001:453) Stockholm: Ministry of Health and Social Affairs. [cited 2019-10-22] Retrieved from: http://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/socialtjanstlag-2001453_sfs-2001-453

248. Communication with reference group 2019-09-01-2019-10-30.

249. Social Board of Health and Welfare. (2014). *Barn som far illa eller riskerar att fara illa. En vägledning för hälso- och sjukvården samt tandvården gällande anmälningsskyldighet och ansvar*. Retrieved from <https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/vagledning/2014-10-4.pdf>

250. Communication with reference group 2019-09-01-2019-10-30.

encourage the parents to seek family counselling^{251 252}. Contact with family counselling services is voluntary and takes place at the family's own initiative, so prenatal staff can only inform them about this resource but not intervene. According to Swedish family law, all municipalities are obliged to provide their citizens with family counselling services, with the aim of helping couples and families handle conflicts, problems and crises. Information about family counselling is available on each municipality's website, and all members of a family can ask for the service²⁵³.

Municipalities also offer mediation, which is a service for couples who are about to separate or are separated, in order to help them find solutions on how to care for their children, including unborn children²⁵⁴. Some municipalities include these services in family centres²⁵⁵. Accessibility may differ from one area to another, as well as the cost. Some municipalities provide the service for free while others may charge up to DKK 340 for each session^{256 257}. At the moment, there is no national data on waiting lists for this service. Since family counselling services are not regulated by primary care, prenatal services do not follow up on them. The municipality's family counselling service is responsible for the follow-up and quality assurance of their own service²⁵⁸. On a national level, the Family Law and Parental Support Authority compile statistics about the use of family counselling services, and the Health and Social Care Inspectorate (IVO) conducts supervision.

Alcohol and substance abuse

As already stated, pregnant women are screened with AUDIT at the first or second prenatal visit²⁵⁹. If any risk is identified, the Time Line Follow Back is routinely applied to build up an overview of the expectant mother's alcohol use and assess any toxins to which the foetus has been exposed²⁶⁰. According to national guidelines, midwives should inform pregnant women about the risks of alcohol consumption and discuss their drinking habits and the consequences of these for the unborn child. If problems arise, the woman is given brief counselling about alcohol and substance use in primary care, where midwives use both AUDIT and motivational interviewing. There may also be region-specific information and materials to motivate and guide expectant mothers towards sobriety²⁶¹. Other resources include appointments with doctors or counselling by the prenatal psychologist (e.g. CBT therapy) and, if

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251. Health Care Guide 1177 (Vårdguiden 1177). Familycounselling (familjerådgivning). Stockholm: Inera AB (på uppdrag av SKR) [cited 2019-08-21] retrieved from: <https://www.1177.se/Stockholm/liv--halsa/psyisk-halsa/att-soka-stod-och-hjalp/familjeradgivning/>
 252. Government offices of Sweden (Regeringskansliet). (2013) Family Law. Information on the rules. Stockholm: Ministry of Justice (Justitiedepartementet). Retrieved from: <https://www.regeringskansliet.se/4a767e/contentassets/4cf277b7c12e48489390d302b12ce77a/family-law.pdf>
 253. Family Law and Parental Support Authority (Myndigheten för familjerätt och föräldraskapsstöd, MFOF). (2019). Family counselling (Familjerådgivning). [cited 2019-09-30] Retrieved from: <https://mfof.se/familjeradgivning.html>
 254. Social Services Act. (SFS 2001:453) Stockholm: Ministry of Health and Social Affairs. [cited 2019-10-22]
 255. The Swedish Association to promote Family Centres (Föreningen För Familjecentralers Främjande). Vad är en familjecentral?(2019) Retrieved from <http://familjecentraler.se/vad-ar-en-familjecentral/>
 256. Government offices of Sweden (Regeringskansliet). (2013) Family Law. Information on the rules. Stockholm: Ministry of Justice (Justitiedepartementet). Retrieved from: <https://www.regeringskansliet.se/4a767e/contentassets/4cf277b7c12e48489390d302b12ce77a/family-law.pdf>
 257. Health Care Guide 1177 (Vårdguiden 1177). Familycounselling (familjerådgivning). Stockholm: Inera AB (på uppdrag av SKR) [cited 2019-08-21] retrieved from: <https://www.1177.se/Stockholm/liv--halsa/psyisk-halsa/att-soka-stod-och-hjalp/familjeradgivning/>
 258. Family Law and Parental Support Authority (Myndigheten för familjerätt och föräldraskapsstöd, MFOF). (2019). Family counselling (Familjerådgivning). [cited 2019-09-30] Retrieved from: <https://mfof.se/familjeradgivning.html>
 259. Swedish Society of Obstetrics and Gynecology (SFOG). (2016 (2008)). Maternal Health Care, Sexual and Reproductive health (Mödrahälsovård, sexuell och reproduktiv hälsa). Rapport 76.
 260. The Swedish Association of Midwives (2018) Sustainable lifestyle- The midwife's conversation about living conditions (Hållbar livsstil. Barnmorskans samtal om levnadsvanor – en handledning). Retrieved from: <https://storage.googleapis.com/barnmorskeforbundet-se/uploads/2018/10/Hallbar-livsstil-klickbar-uppdaterad-september-2018-2.pdf>
 261. Communication with reference group 2019-09-01-2019-10-30.

applicable, medication to help the woman abstain from alcohol or substance abuse during pregnancy. If the woman needs more help or has alcohol or substance abuse problems, she is referred to other services in secondary or tertiary care, such as more intensive counselling, multidisciplinary approaches, detoxification and relapse-prevention²⁶². Sweden has national internet and telephone helplines for people struggling with harmful use of alcohol but not for problems with substance use^{263 264}.

According to national guidelines, if they note indicators of risk due to alcohol or drug use during prenatal care, midwives should refer the woman to social services, dependency clinics in psychiatric specialist care or specialised prenatal care to manage their alcohol or drug dependency. For example, in Stockholm^{265 266}, Gothenburg^{267 268} and Malmö²⁶⁹, there are specialist care units with multiprofessional teams that help pregnant women abstain from alcohol or drugs. The units provide continued support throughout the child's first year, and the team in Gothenburg also offers guidance and supervision to the infant and child healthcare until the child starts preschool. In cases of severe addiction, a coordinated individual care plan (SIP) is initiated, and all responsible organisations are involved. The intention is to create structured support around families with special needs from pregnancy through child healthcare and preschool. Resources for the prevention of alcohol and substance abuse are usually accessible, but there may be geographical differences in the scope of services, depending on the size of the municipality or region^{270 271}. Rural areas with fewer inhabitants do not have the same range of services as large cities. For example, specialist units for women with severe dependency problems are only available in the Stockholm, Västra Götaland and Skåne regions.

Violence and trauma

National guidelines for prenatal care state that midwives should actively seek to identify pregnant women who may be victims of violence, intimate partner violence and abuse. They should offer individual sessions without the presence of the other parent, to allow them to ask about experiences of violence²⁷². According to guidelines, prenatal staff must have a basic knowledge of violence and interpersonal violence, as well as access to supervision. Prenatal clinics are required to have an action plan for how they will respond to the detection of violence and to provide updated information about available resources through the Women's National

262. Personal communication with coordinating midwife and professionals at central CHI unit. (Personal communication 2020-01-01-2020-01-30).

263. Region Stockholm (Beroendecentrum). (2019) Alkohollinjen. (cited 2019-09-30) Retrieved from <https://www.1177.se/alkohollinjen.se>

264. Stockholm Region (Beroendecentrum). Alkohohljälpen [Internet] (cited 2020-01-13) Retrieved from <https://alkohohljalpen.se/>

265. Region Stockholm (Beroende Centrum). Rosenlund Maternal and Child Health Team (Rosenlunds Barnhälsovårdsteam). (2019) [cited 2019-09-30] Retrieved from: <https://www.beroendecentrum.se/var-d-hos-oss/barnhalsovard-och-modravard/>

266. Edenius, A. (2018) Is there a need for a special ICH for parents with drug problems? (Behövs det en special BVC för föräldrar med drogproblematik?) *Barnläkaren*. nr 6, p. 14-15.

267. Nordenfors M, Höjer I. (2012) Kvinnors erfarenheter av stöd från Mödra-barnhälsovårdsteamet i Haga (Rapport 4:2012). Retrieved from Region https://goteborgsregionen.se/download/18.59a3689157fc2c69be75b6d/1477483571285/2012_modra_barnhalsovardsteamet.pdf

268. Rangmar J et al. (2019) Children who face development risks due to maternal addiction during pregnancy require extra medical and psychosocial resources. *Acta Paediatrica*. 108, pp. 101-105. [cited 2019-09-30] Retrieved from <https://pubmed.ncbi.nlm.nih.gov/29781554/>

269. Malmö Region. (2019) Support for pregnant women with addiction. The Ambulatory (Stöd till gravida med missbruk). Retrieved from: <https://malmo.se/Service/Stod-och-omsorg/Missbruk-och-beroende/Stod-till-gravida-med-missbruk.html>

270. Communication with reference group 2019-09-01-2019-10-30.

271. Personal communication with coordinating midwife and professionals at central CHI unit. (Personal communication 2020-01-01-2020-01-30).

272. Communication with reference group 2019-09-01-2019-10-30.

Helpline²⁷³, which is open 24/7, 365 days a year. The contents of the action plan differ between regions, as they are independent service providers.

In Sweden, social services are responsible for offering free support to victims of violence, such as protection, psychotherapy, practical support and help to leave home if needed²⁷⁴. Perpetrators should also be provided with support for free. Social services are not formally linked to prenatal care but instead operate on a referral basis, or collaborate via SIP²⁷⁵. In social services, resources focus on current and past violence, or trauma history, among expectant parents. There are resources in every region and access to a local hotline for counselling²⁷⁶. If exposure to violence is an ongoing problem, pregnant women may need help contacting the hotline at the nearest social service bureau for counselling^{277 278}. They might also need help in filing a police report and, if they are under severe threat, they might need help to contact protected housing, which is available in every region. Women can access protected housing at different security levels (1–3), but there is not always immediate access to all security levels, which are decided on the basis of individual need²⁷⁹. If a pregnant woman has a previous history of violence, a first step would be to offer an appointment with the prenatal psychologist for counselling and support²⁸⁰. If there is a need for it, the psychologist might then refer her to primary care psychiatry for further therapy or medication. If the problems are severe, the primary care physician might refer her to secondary or tertiary psychiatric care.

Infant and child healthcare

Infant and child healthcare (ICH) in Sweden is part of the primary care system in each region²⁸¹. Geographically and organisationally, ICH centres are often part of primary healthcare centres, but they can also be separate clinics or part of family centres. Due to care reforms in Sweden, ICH centres may be either private or public-sector organisations. ICH nurses organise and run preventive work in the field of child healthcare and are the professionals seen most often by the families. ICH nurses are specialists in either primary healthcare or paediatric care; the doctors are specialists in general medicine or paediatrics who are affiliated with the ICH centre. Most ICH centres also have a psychologist²⁸². They work with children and parents in addition to supporting and supervising ICH staff in their work on psychosocial issues. Some regions also have social workers, speech therapists and nutritionists at their ICH centres²⁸³. ICH services in Sweden are free of charge, are accessible to all and accommodate individual needs, for example providing interpreter services for foreign

273. Sweden's National Women's Helpline. (No date) Retrieved from <https://kvinnofridslinjen.se/sv/>

274. Social Services Act. (SFS 2001:453) Stockholm: Ministry of Health and Social Affairs. [cited 2019-10-22]

275. Communication with reference group 2019-09-01-2019-10-30.

276. Personal communication with Sweden's National Women's Helpline (Kvinnofridslinjen). (Personal communication 2020-01-01-2020-01-30) and ROKS <https://www.roks.se/about-roks>.

277. Communication with reference group 2019-09-01-2019-10-30.

278. Personal communication with coordinating midwife and professionals at central CHI unit. (Personal communication 2020-01-01-2020-01-30)

279. Personal communication with Sweden's National Women's Helpline (Kvinnofridslinjen). (Personal communication 2020-01-01-2020-01-30)

280. Communication with reference group 2019-09-01-2019-10-30

281. National Board of Health and Welfare. (2014). Guidance for child health care (Vägledning för Barnhälsovården) (cited 2019-01-03).

282. Psykologer för mödrahälsovård och barnhälsovård. (No date). Retrieved from <https://www.psykologforbundet.se/mbhv-psykologerna/> and <https://www.psykologforbundet.se/globalassets/a-foreningarnatverk/nationella-foreningar/mhvhv/nationell-malbeskr/nat-malbeskrivning-april-2020.pdf>

283. National Board of Health and Welfare. (2014). Guidance for child health care (Vägledning för Barnhälsovården) (cited 2019-01-03).

or sign language.

The ICH programme runs from birth to five years of age²⁸⁴. During the child's first two years, there are at least 12 health visits with the ICH nurse, three of which are a team visit involving both the nurse and a doctor²⁸⁵. Other professionals join in on specific health visits when needed. National guidelines recommend that the family should see the same nurse throughout the ICH period, but this is not always possible due to the length of the programme²⁸⁶. The first ICH appointment should be a home visit, preferably no more than six days after the family returns from hospital after the birth, but within three weeks at the latest²⁸⁷. There are no formal agreements between hospital maternity units and ICH regarding responsibility for the child after it leaves hospital and before the first home visit. The maternity unit usually has the primary responsibility during the first week after delivery, but ICH may take over the responsibility at any time during those seven days.

The next two ICH appointments should take place when the baby is 1–3 weeks old, then at four weeks, 6–8 weeks (two visits for the parents individually), 3–5 months (three visits), six months, eight months (another home visit), 10 months, 12 months and 18 months. However, some regions offer only the initial home visit, and a few regions do not offer any home visits at all²⁸⁸. As previously stated, a follow-up prenatal care visit is also offered at 6–12 weeks postpartum in order to check up on breastfeeding, parent-child attachment and general health, but this service is not part of ICH²⁸⁹. During ICH visits, parents receive counselling for breastfeeding and bottle-feeding, usually in the form of individual counselling and information given by the ICH nurse²⁹⁰. The content of the information and counselling techniques are described in the national guidelines, which emphasise that the information about breastfeeding and bottle-feeding should be impartial so that mothers can make an informed choice and receive the support they need regardless of what choices they make.

Infants are not automatically registered with an ICH centre, nor is it mandatory to attend one²⁹¹. Swedish citizens have "free choice of care", meaning that they have the right to be registered at any primary healthcare centre in the country²⁹². Thus, the exact routine for registering a child in ICH varies between regions. The hospital midwife registers all births in the Medical Birth Register, and this information is sent to the ICH centre, where the parents are listed²⁹³. Due to the different entries in the ICH system, comparisons need to be done continuously between the Medical Birth Register and children registered in the ICH. If parents fail to show up for routine ICH visits, the nurses try to contact them and if they are unreachable, social services are contacted as this may be a sign of child neglect²⁹⁴. Around 99% of all children born in

284. Swedish Paediatric Society. (2018b). The national ICH programme (Nationella barnhälsovårdsprogrammet) (cited 2019-01-03) Retrieved from; <https://www.rikshandboken-bhv.se/metoder--riktlinjer/barnhalsovardens-nationella-program/>

285. Swedish Paediatric Society. (No date). The national ICH programme. Health visits per age (Barnhälsovårdens nationella program. Hälsobesök per ålder) program.(cited 2019-01-03) Retrieved from; <https://www.rikshandboken-bhv.se/halsobesok/>

286. Communication with reference group 2019-09-01-2019-10-30.

287. Swedish Paediatric Society. (2019c). Homevisit (Hembesök). [cited 2019-01-03] Retrieved from: <https://www.rikshandboken-bhv.se/metoder--riktlinjer/hembesok/>

288. Communication with reference group 2019-09-01-2019-10-30.

289. The Swedish Pregnancy Register (SPR) (2018). The Swedish Pregnancy Register year report 2018 (Graviditetsregistrets årsrapport 2018). [cited 2019-09-30]. Retrieved from

290. Swedish Paediatric Society. (No date). Breastfeeding and nutrition (Amning och nutrition). [cited 2019-01-03] Retrieved from <https://www.rikshandboken-bhv.se/amning-och-nutrition/>

291. Communication with reference group 2019-09-01-2019-10-30.

292. Sveriges Kommuner och Regioner. (No date). Valfrihet inom hälso- och sjukvård. Retrieved from <https://skr.se/demokratiledningstyrning/driftformervalfrihet/valfrihetssystemochersattningsmodeller/halsoochsjukvard.1759.html>

293. Communication with reference group 2019-09-01-2019-10-30.

294. Swedish Paediatric Society. (2019f). When the guardian does not take the child to a health visit (När vårdnadshavaren

Sweden are registered in ICH, leaving 1% who do not receive care²⁹⁵. Possible reasons for this could be that the family has moved to another region or country, or because of illness and early death. If ICH identifies a child who is not registered at an ICH centre, it may be difficult to decide whether the child is at risk or not, since it is not mandatory to attend. A child could slip through both systems (i.e. both prenatal and ICH services), although this is extremely rare.

National guidelines for ICH in Sweden were published by the National Board of Health and Welfare (NBHW) in 2014²⁹⁶. The aim was to enhance the homogeneity of ICH services and evidence-based practice. They are currently under revision, with renewed guidelines expected in 2021-2022. The guidelines were published in an online *National Handbook of Child Health Care*, with more detailed instructions on how to implement the recommendations²⁹⁷. The handbook was first published in 2012 by Inera AB, which is owned by the Swedish Association of Local Authorities and Regions and is responsible for coordinating and developing digital services for citizens, professionals and decision-makers. The online handbook is continuously updated and contains items such as the structure and timing of health visits, practices for providing care, information that should be given to parents during each appointment, and so on. The registration of standard information in ICH is coordinated nationally.

Implementation of ICH guidelines and recommendations is managed by the central ICH unit in each region in Sweden (ICHU).²⁹⁸ A National Working Group for Child Healthcare Programmes, made up of elected representatives from each of the 21 regions, monitors the implementation process each year. The main purpose of the ICHU is to improve the quality of the ICH in each region through professional training and skills enhancement, supervision, research and continuous quality monitoring, including workplace visits. Managers at each ICH centre are responsible for ensuring that targets are met. Most regions also have their own ways of monitoring ICH and publish the results online in annual reports^{299 300 301}. A Swedish Children's Health Register (BHVQ) is being developed to create uniform, equitable and fair ICH services for all children in the country³⁰². Data in the register will also be used for following up on implementation and for research. To date, two regions have started to record their data into the national register.

The Swedish ICH programme includes both universal and targeted interventions intended to ensure the equitable provision of services, which are split into three levels of care³⁰³. The first universal tier (I) includes interventions offered to all

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- inte tar med barnet till hälsobesök). Retrieved 3 January 2019 from; <https://www.rikshandboken-bhv.se/metoder--riktlinjer/informationsmaterial/nar-varnadsnavaren-inte-tar-med-barnet-till-halsobesok/>
295. Communication with reference group 2019-09-01-2019-10-30.
296. National Board of Health and Welfare. (2014). Guidance for child health care (Vägledning för Barnhälsovården) (cited 2019-01-03). Retrieved from; <https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/vagledning/2014-4-5.pdf>
297. Swedish Paediatric Society. (No date). National handbook for child health services. Stockholm: Inera AB (cited 2019-01-03). Retrieved from; <https://www.rikshandboken-bhv.se/rhb/om-rikshandboken/rikshandboken---the-national-handbook-for-child-health-services/>
298. National Board of Health and Welfare. (2014). Guidance for child health care (Vägledning för Barnhälsovården) (cited 2019-01-03). Retrieved from; <https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/vagledning/2014-4-5.pdf>
299. Region Stockholm. (2018). Årsrapport: Barnhälsovård i Stockholms län 2018. Retrieved from: <https://www.sll.se/globalassets/1.-halsa-och-varld/bilagor---nyhet/bilagor-nyheter-2019/arsrapport-barnhalsovard-2018-1.pdf> Region Stockholm. Barnhälsovårdsheten: Årsrapport 2018. Att fråga om våld. Page 32
300. Region Sörmland. (2018). Årsrapport: Barnhälsovården 2018. Retrieved from: <https://samverkan.regionsormland.se/siteassets/halsoval/barnhalsovard/arsrapporter/region-sormland-bhv-arsrapport-2018>
301. Västra Götalandsregionen.(2018). Barnhälsovård i Västra Götaland: Årsrapport 2018. https://alfresco.vgregion.se/alfresco/service/vgr/storage/node/content/workspace/SpacesStore/352cd908-dc81-4ba7-a36b-46920ddb2e67/VGR_BVC_arsrapport_2018.pdf?a=false&guest=true
302. Region Uppsala. (No date). Swedish Child Health Register BHVQ (Svenska Barnhälsovårdsregistret). (cited 2019-01-03). Retrieved from; <http://bhvq.se/>
303. Swedish Paediatric Society. (2018b). The national ICH programme (Nationella barnhälsovårdsprogrammet) (cited

children, to promote health and development, and prevent disease, injury and physical, psychological and social problems. These interventions include: engaging in a dialogue with the child and parents; being responsive to and asking about the child's health and development and the family's observations and concerns; identifying and evaluating protective health factors as well as those that put the child at risk; conducting observations and targeted investigations; monitoring the child's health and development over time; and providing health-related guidance that is relevant to the child's age and family needs. The second tier (II) includes additional interventions provided to children on the basis of need, to boost those factors that promote good health and prevent adverse physical, psychological and social health. These include additional assessments that aim to increase the knowledge and understanding of the child's circumstances and tailor interventions to the child's needs. The third tier (III) includes additional needs-based interventions in collaboration with other healthcare providers, ICH psychologists and social services workers, or other resources.

If families need more support, extra home visits can be arranged in accordance with the three-tier ICH structure. Extra health visits can be offered, for instance, if the ICH nurse and parents have concerns that need to be explored further, or if there are indications that there might be a need for interventions at another level of care³⁰⁴. If families need interventions from another care unit, in some Swedish regions they may be referred to a specialised infant care team offering home-visit-based care³⁰⁵. Some regions, including Stockholm and Västra Götaland (VG), also work with a model of six home visits in socioeconomically disadvantaged areas^{306 307 308 309 310}.

Children's emotional wellbeing

ICH nurses provide parents with regular information about healthy social and emotional development in children and how to support it. The *National Handbook of Child Health Care* indicates what topics should be addressed and when³¹¹. The general approach is that information on social-emotional development should be promoted through dialogue with parents during routine appointments and parental support groups³¹². There is no general framework for the content of this information, but ICH nurses promote sensitive care, such as reading to the child, playing with them and singing to them. This is an informal part of the practice; whether and

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- 2019-01-03) Retrieved from; <https://www.rikshandboken-bhv.se/metoder--riktlinjer/barnhalsovardens-nationella-program/>
304. Communication with reference group 2019-09-01-2019-10-30.
305. ALVHA. (no date) <https://malmo.se/Service/Stod-och-omsorg/Psykisk-ohalsa/Hjalp-till-foraldrar-med-psykisk-ohalsa.html>
306. Marttila, A., Lindberg, L., Burström, K., Kulane, A., & Burström, B. (2017). *Utökat hembesöksprogram för förstagsåldrar – samverkan mellan Rinkeby BVC och föräldrarådgivare inom Rinkeby-Kista socialtjänst: Slutrapport utvärdering 2017*. Stockholm: Karolinska Institutet.
307. Burström, B., Marttila, A., Kulane, A., Lindberg, L., & Burström, K. (2017). Study protocol. Practising proportionate universalism – a study protocol of an extended postnatal home visiting programme in a disadvantaged area in Stockholm, Sweden. *BMC Health Services Research* 2017 17(91).
308. Barboza, M., Kulane, A., Burström, B., & Marttila A. (2018). A better start for health equity? Qualitative content analysis of implementation of extended postnatal home visiting in a disadvantaged area in Sweden. *International Journal for Equity in Health*, 17. doi: 10.1186/s12939-018-0756-6 <https://doi.org/10.1186/s12939-018-0756-6>
309. Barboza, M., Kulane, A., Burström, B., & Marttila A. (2018). A better start for health equity? Qualitative content analysis of implementation of extended postnatal home visiting in a disadvantaged area in Sweden. *International Journal for Equity in Health*, 17. doi: 10.1186/s12939-018-0756-6 <https://doi.org/10.1186/s12939-018-0756-6>
310. Göteborgs stad, & Västra Götalandsregionen. (2020). Delrapport 2: Utökade Hembesök Göteborg. Retrieved from 1:an<https://alfresco.vgregion.se/alfresco/service/vgr/storage/node/content/workspace/SpacesStore/d3ce96ad-d636-42f7-8458-336f6a0e5097/Delrapport%202020Ut%c3%b6kade%20hembes%c3%b6k%20G%c3%b6teborg%20April%202020.pdf?a=false&guest=true>
311. Swedish Paediatric Society. (No date). Hälsa och utveckling. Stockholm: Inera AB (cited 2019-01-03) Retrieved from; <https://www.rikshandboken-bhv.se/halsa-och-utveckling/>
312. Communication with reference group 2019-09-01-2019-10-30.

when it takes place is not monitored, and there is no coordinated training for ICH nurses on this element of the work. However, ICH psychologists guide and supervise ICH nurses regularly. Parents are not given information about risk and protective factors for children's emotional wellbeing as such, but this knowledge is fostered implicitly through dialogue on the child's needs and rights³¹³. One widely distributed resource for new parents in ICH is the book "To Live with Children" and a booklet about the UN Convention on the Rights of the Child^{314 315}. The regions have also developed their own online and printed materials. The national Health Guide 1177 offers a variety of web-based information and videos, including materials for print³¹⁶.

Certain age-based social and emotional milestones are monitored and observed during ICH appointments, but no systematic evaluation tool is used at the universal level of care³¹⁷. Instead, this is done in an implicit way by observing the child's behaviour, looking for signs of age-appropriate social and emotional development and asking parents about their child's behaviour, temperament and expressions³¹⁸. Developmental tests during routine visits can also provide important information, and work has started in one region to develop ways of measuring infants' social and emotional health through instruments like the Ages & Stages Questionnaires (ASQ).

During the baby's first year, a major focus in ICH is to support and promote a positive relationship between child and parent through individual support and dialogue³¹⁹. During ICH appointments, nurses look for signs of difficulties in the parent-child relationship and respond if needed. If they notice anything that concerns them, they consult with the ICH psychologists who then monitor emotional difficulties and attachment. They can offer parents support to improve the parent-child relationship or refer them to an infant care team, primary care psychiatrist or child psychiatrist if needed.

Parents' emotional wellbeing

National guidelines emphasise the importance of supporting parental wellbeing, and the mother's mental health is continuously monitored and supported through ICH visits³²⁰. ICH nurses offer parents information about how to promote and maintain their mental health and wellbeing with a new baby, but there are no nationally defined procedures on how to provide such information. Certain measures are taken to ensure that the information about parental wellbeing is accessible to all, irrespective of disability or language difficulties, but more work needs to be done in this area, especially for parents with cognitive or neuropsychiatric difficulties³²¹. There are no special courses or webinars for parents on the topic of mental wellbeing

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313. Swedish Paediatric Society. (2019b). Identifiera skydds- och riskfaktorer. Stockholm: Inera AB (cited 2019-01-03). Retrieved from; <https://www.rikshandboken-bhv.se/metoder--riktlinjer/identifiera-skydds--och-riskfaktorer/>
314. Köhler, M., Reuter, A., & Tell, J. (2016). *Leva med barn*. Stockholm: Bokus.
315. Barnombudsmanen. (2015). Viktigast av allt: Om barnets rättigheter i familjen. [Folder]. <https://www.barnombudsmanen.se/barnombudsmanen/publikationer/genomfora-barnkonventionen/viktigast-av-allt-om-barnets-rattigheter-i-familjen-foldrar/>
316. Health Care Guide 1177 (Vårdguiden 1177). (No date). Att vara förälder. Region Stockholm. (cited 2019-09-20) Retrieved from <https://www.1177.se/barn--gravid/att-vara-foralder/foraldraskap-och-relationen-med-barnet/anknytning-hos-barn/>
317. Swedish Paediatric Society. (No date). The national ICH programme. Health visits per age (Barnhälsovårdens nationella program. Hälsobesök per ålder) program.(cited 2019-01-03) Retrieved from; <https://www.rikshandboken-bhv.se/halsobesok/>
318. Communication with reference group 2019-09-01-2019-10-30.
319. Communication with reference group 2019-09-01-2019-10-30.
320. National Board of Health and Welfare. (2014). Guidance for child health care (Vägledning för Barnhälsovården) (cited 2019-01-03). Retrieved from; <https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/vagledning/2014-4-5.pdf>
321. Communication with reference group 2019-09-01-2019-10-30.

but, as previously stated, every region offers group-based parental support groups as part of their regular ICH service³²². The support groups have a certain focus on maintaining mental wellbeing as a new parent. Each region may also have their own information regarding this and specific parental programmes. In the majority of cases, courses are free of charge.

Family wellbeing

There are 270 family centres in Sweden, where prenatal care, infant and child healthcare, open preschool and social services are united under one roof with activities that offer universal health promotion, early prevention and supportive activities for parents and children³²³. The unique feature of family centres is that they allow regions and other local governments to coordinate their resources to enable cross-sectoral collaboration, prevention and early intervention. The services are low-threshold and allow a drop-in format to which prospective and new parents can turn for advisory, supportive conversations with representatives from social services. The work is multidisciplinary, with collaboration from midwives, paediatric nurses, paediatricians, psychologists, preschool teachers and social workers. Other professionals such as health promotion specialists, family counsellors, community workers and librarians (e.g. for reading encouragement or language development) may work there as well.

As previously stated, parental support groups are offered as a routine service in the national ICH programme. The groups have been offered free of charge in prenatal and ICH services since 1979 with the purpose of empowering parents, strengthening their social networks, informing them about children's rights, children's physical and mental wellbeing, and promoting positive relations between parents and children (as well as between the parental couple)^{324 325 326}. Parent groups are led by ICH nurses, and the content and structure for each session are described in general terms in the national ICH guidelines³²⁷. However, each region usually develops its own specific material as well. Usually, the groups meet at the ICH centre and start when enough participants have been recruited³²⁸. The aim is to suit everyone's circumstances (e.g. diverse family constellations and cultural backgrounds), but this can be difficult to achieve. The development of Swedish family policy over the last 30 years has provided greater incentives for fathers to participate in parental support groups³²⁹. The presence of fathers in the groups has increased since they first started, and

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322. Swedish Paediatric Society. (2018a). Föräldrastöd. Stockholm: Inera AB (cited 2019-01-03) Retrieved from; Föräldrastöd <https://www.rikshandboken-bhv.se/metoder--riktlinjer/foraldrastod-i-grupp/forslag-pa-foraldragruppernas-innehall/>
323. The Swedish Association to promote Family Centres (Föreningen För Familjecentralers Främjande). Vad är en familjecentral?(2019) Retrieved from <http://familjecentraler.se/vad-ar-en-familjecentral/>
324. Socialdepartementet. (1980). *Barn och vuxna: Barnomsorgsgruppens slutbetänkande om föräldrautbildning* (SOU:1980:27). Stockholm: Socialdepartementet.
325. Regeringskansliet. (1978/79). *Föräldrautbildning och förbättringar av föräldraförsäkringen m.m.* (Reg.prop. 1978/79:168). Stockholm: Regeringskansliet. – osäker om det är rätt?
326. National Board of Health and Welfare. (1984). *Föräldrautbildning. Kring barnets födelse och första levnadsår.* (Socialstyrelsen redovisar 1984:12). Stockholm: National Board of Health and Welfare.
327. Swedish Paediatric Society. (2018a). Föräldrastöd. Stockholm: Inera AB (cited 2019-01-03) Retrieved from; Föräldrastöd <https://www.rikshandboken-bhv.se/metoder--riktlinjer/foraldrastod-i-grupp/forslag-pa-foraldragruppernas-innehall/>
328. Personal communication with the Swedish National Agency for Educations and Swedish Schools Inspectorate's information services and universities responsible for the pre-school teacher program or Personal communication with coordinating midwife and professionals at central CHI unit. (Personal communication 2020-01-01-2020-01-30).
329. Ministry of Social Affairs (Socialdepartementet). (2018) A national strategy to strengthen parental support (En nationell strategi för stärkt föräldrastöd). [Cited 2019-09-30] Retrieved from <https://www.regeringen.se/4a6017/globalassets/regeringen/dokument/socialdepartementet/barnets-rattigheter/en-nationell-strategi-for-ett-starkt-foraldraskapsstod-webb.pdf>

some ICH centres have special fathers' groups, although regional reports show the participation of fathers is still low.

Parenting skills

All parents are offered guidance for parenting during the child's first year. New parents are encouraged to be responsive and empathetic towards their children, but the specific content of child-rearing advice and recommendations in ICH varies between regions, and even within the same health centre³³⁰. Usually, parents do not receive information or training on particular upbringing practices from the ICH. Instead, the focus is on a salutogenic approach using motivational interviewing techniques with parents and avoiding didactic approaches. Structured courses in parenting skills for parents with children under the age of two are rare, apart from the parent groups described earlier³³¹.

ICH nurses observe the parent-child interaction during routine ICH appointments, encourage positive parent-child communication and provide information on the importance of the relationship between parent and children, as well as the child's need for sensitive care³³². In this way, nurses inform parents about healthy emotional bonding between parents and children. However, parents do not receive systematic or direct training at the universal level of care. One of the aims of the separate visits for each parent (mothers at week 6–8 and fathers or other parents at 4–6 months) is to identify barriers to sensitive parenting and secure attachment. Referrals to mental health care or parenting interventions are made if problems are identified at these (or other) health visits. In this way, all parents are offered general support to foster a secure attachment and sensitive parenting. ICH staff do not receive regular training about this aspect of the work, but nurses are trained via their professional education in basic attachment concepts, and in many regions they have access to ICH psychologists for guidance and supervision.

No specific methods to promote secure attachment and sensitive parenting are used at the general level for children in this age group³³³. Systematic reviews have been conducted by the National Working Group for the Swedish Child Healthcare Programme, in collaboration with the Research Network for Swedish Infant and Toddler Care and national agencies, and these conclude that programmes like Circle of Security–Parenting (COS-P) and the International Child Development Programme (ICDP) are popular and widespread, despite lack of scientific evidence³³⁴. Two ongoing Nordic randomized-controlled trials (RCTs) are currently studying the effects of these programmes. Other programmes used with this age group in secondary care include Child-Parent Psychotherapy (CPP), Marte Meo, the Marchak

330. Communication with reference group 2019-09-01-2019-10-30.

331. Lindfors, A.-C. (2019). *Föräldrastöd till familjer med spädbarn –en kunskapsöversikt*. Stockholm: Barnhälsovårdsenheten, Södersjukhuset (cited 2019-10-30) Retrieved from: https://www.rikshandboken-bhv.se/globalassets/rhb/media/dokument/informationsmaterial/foraldrastod-till-familjer-med-spadbarn--en-kunskapsoversikt_5juni-002.pdf

332. Communication with reference group 2019-09-01-2019-10-30.

333. Communication with reference group 2019-09-01-2019-10-30.

334. Lindfors, A.-C. (2019). *Föräldrastöd till familjer med spädbarn –en kunskapsöversikt*. Stockholm: Barnhälsovårdsenheten, Södersjukhuset

Risk factors in the early years

The national guidelines state that ICH nurses should explore risk and protective factors related to the infant and family context during regular health visits³³⁶. According to the guidelines, risk groups that should be identified are: children exposed to alcohol, drugs and certain medicines during pregnancy; children who have parents with mental illness and/or cognitive disabilities; children who are victims of violence and neglect; children in families where there has been domestic violence; children living in foster care; children who are refugees from war zones; children in families with negative interaction patterns; and children with specific difficulties (e.g. premature birth, speech impairments, vision or hearing impairments, or chronic illness and disabilities). The *National Handbook of Child Health Care* gives support and suggestions on how professionals in the ICH should proceed with the identification of risk groups, but there is no specific routine for screening at national level. Each region (healthcare) and municipality (social services) may have specific care programmes and regional guidelines for how they offer specialised care, train professionals and give information to each of these groups³³⁷. The use of structured individual care plans (SIPs) can be specified at regional level through local agreements, and an individual care plan (VP) between different levels of the healthcare system is sometimes established. However, there is no national system in place that ensures that all children with psychosocial risk factors are identified and offered individual care plans.

National guidelines recommend that ICH nurses use brief counselling methods, inspired by motivational interviewing, to explore the family's lifestyle habits and risk and protective factors. According to ICH guidelines, advice to families should be based on what parents themselves wish to talk about. This means that risk factors are explored in more depth only if the parents themselves express a need to discuss them further or if ICH staff believe it is needed³³⁸. However, ICH nurses can encourage and motivate discussions on each subject. Thus, the exact procedure and content of the dialogue on risk and protective factors vary. Each region is also independent in terms of the provision of care programmes and guidelines, as well as individual development projects.

According to ICH guidelines, nurses should also ask parents about issues such as family circumstances, living conditions, financial status and social networks, and should talk about the emotional importance of the parent-child interaction, strategies to avoid infant shaking, legislation against corporal punishment and child safety³³⁹. Each region's central ICH unit may also have its own material to provide

335. Furmark, C., & Neander, K. (2018). *Infant mental health centers/teams in Sweden-an overview*. Social Board of Health and Welfare. (cited 2019 Sept 30). Retrieved from http://anhoriga.se/Global/BSA/Bilder/Sp%c3%a4d%20och%20sm%c3%a5barnsverksamhet/BSA-2018-2_Furmark_Neander_webb.pdf

336. Swedish Paediatric Society. (2019b). *Identifiera skydds- och riskfaktorer*. Stockholm: Inera AB (cited 2019-01-03). Retrieved from; <https://www.rikshandboken-bhv.se/metoder--riktlinjer/identifiera-skydds--och-riskfaktorer/>

337. Communication with reference group 2019-09-01-2019-10-30.

338. Communication with reference group 2019-09-01-2019-10-30.

339. Swedish Paediatric Society. (2018b). *The national ICH programme (Nationella barnhälsovårdsprogrammet)* (cited 2019-01-03) Retrieved from; <https://www.rikshandboken-bhv.se/metoder--riktlinjer/barnhalsovardens-nationella-program/>

information for parents. National guidelines recommend discussing parents' alcohol and substance use and smoking habits during the first health visits, but these issues are not screened specifically. Children with, or at risk of, psychosocial difficulties are identified mainly through the mapping of risk and protective factors done by ICH nurses in conversation with families, through questions and observation during health visits³⁴⁰. In some regions, there are developmental projects that aim to form specific routines for risk identification, for example asking about violence³⁴¹, which is not routinely done in ICH, connecting with hard-to-reach groups through extended home visits^{342 343 344}, or using structured manuals to ask about risk factors³⁴⁵. Several national competence centres have also been established to guide evidence-based practices regarding certain risk factors in the early years, such as cognitive disabilities among parents and violence^{346 347 348}.

The Health Care Act obligates professionals to take the child's need for information and support into account when a parent is receiving care for addiction, psychiatric problems or serious illness. Professionals in adult services should ask whether their patients (e.g. those receiving psychiatric treatment, or alcohol or substance abuse treatment, or involved in violent incidents) have children in their custody³⁴⁹. The Social Services Act places a strong responsibility on municipalities to provide with protection and support so that they can grow up in good and safe conditions³⁵⁰. Furthermore, authorities and professionals have an obligation to notify social services if they suspect that a child might be at risk³⁵¹. However, the care services are still working on developing routines and competence in order to be able to fulfil this responsibility. The Swedish National Board of Health and Welfare, in collaboration with The Swedish Family Care Competence Centre (NKA), works with regional health and medical services to apply this provision and publicise it³⁵². If a person receiving treatment for severe mental illness, violence, trauma or alcohol and substance abuse turns out to have young children, a SIP or VP collaboration agreement should be initiated so that care for the family as a whole can be planned in advance. Many regions have also established child representatives in their organisations to fulfil legal obligations regarding children's right to support when a parent receives care. The way children's wellbeing is assessed and ensured under such circumstances varies between regions as there are different resources and

340. Communication with reference group 2019-09-01-2019-10-30.

341. Region Stockholm. (2018). Årsrapport: Barnhälsovård i Stockholms län 2018. Retrieved from: <https://www.sll.se/globalassets/1.-halsa-och-varld/bilagor---nyhet/bilagor-nyheter-2019/arsrapport-barnhalsovard-2018-1.pdf> Region Stockholm. Barnhälsovårdsenheten: Årsrapport 2018. Att fråga om våld. Page 32

342. Burström, B., Marttila, A., Kulane, A., Lindberg, L., & Burström, K. (2017). Study protocol. Practising proportionate universalism – a study protocol of an extended postnatal home visiting programme in a disadvantaged area in Stockholm, Sweden. BMC Health Services Research 2017 17(91).

343. Marttila, A., Lindberg, L., Burström, K., Kulane, A., & Burström, B. (2017). Utökad hembesöksprogram för förstagångsföräldrar – samverkan mellan Rinkeby BVC och föräldrarådgivare inom Rinkeby-Kista socialtjänst: Slutrapport utvärdering 2017. Stockholm: Karolinska Institutet.

344. Göteborgs stad, & Västra Götalandsregionen. (2020). Delrapport 2: Utökade Hembesök Göteborg. <https://alfresco.vgregion.se/alfresco/service/vgr/storage/node/content/workspace/SpacesStore/d3ce96ad-d636-42f7-8458-336f6a0e5097/>

345. Childhood. (No date). Test and evaluation of the model Safe Environment for Every Kid (SEEK). Retrieved from: <https://childhood.se/vad-vi-gor/projekt/barnsakert/>

346. FoU Centrum för vård och omsorg och socialt arbete et al. (2019) Parenting Young Children (PYC). A Co-operation between: FoU Centrum för vård och omsorg och socialt arbete, The Gothenburg Region (GR), FoU Sjuhärad Vålfärd, SUF Resource centre (SUF), Uppsala Region; 2020 Retrieved from: <https://www.pyc.se/detta-ar-ptyc/>

347. Barnafriid Kunskapscentrum. (No date). Retrieved from: <https://liu.se/en/research/barnafriid/about-us>

348. Uppsala Universitet. (No date). Kvinnofrid. Retrieved from: <https://nck.uu.se/>

349. Health Care legislation. (SFS 2017:30) Stockholm: Ministry of Health and Social Affairs. Retrieved from https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/halso--och-sjukvardslag_sfs-2017-30

350. Social Services Act. (SFS 2001:453) Stockholm: Ministry of Health and Social Affairs. [cited 2019-10-22]

351. Social Board of Health and Welfare. (2014). Barn som far illa eller riskerar att fara illa. En vägledning för hälso- och sjukvården samt tandvården gällande anmälningsskyldighet och ansvar. Retrieved from <https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/vagledning/2014-10-4.pdf>

352. Communication with reference group 2019-09-01-2019-10-30.

priorities in different areas. The basic right to care is protected by law, however, so if certain services are not available in the community in which people live, they must be offered those services from neighbouring communities.

Mental health difficulties

All mothers are screened with the EPDS for postnatal depression during an individual health visit at 6–8 weeks postpartum³⁵³. Since 2019, ICH services have also begun to implement an individual counselling session on mental health for the other parent at one of the health visits 3–5 months after the child's birth³⁵⁴. If mental health difficulties are identified, a follow-up visit is booked with an ICH nurse, who consults with the ICH psychologist about further steps³⁵⁵. If the scores on the EPDS indicate that difficulties are mild, the parents may be referred to a doctor or psychologist in the healthcare centre for decisions about continued care. If the scores are high, and the situation is urgent, an appointment is made with the doctor and the ICH centre for referral to psychiatric care. National guidelines also state that an infant mental health team should be contacted when needed. If there are signs that the relationship between parent and infant is not working well, a referral can be made to any of Sweden's 34 teams at an attachment psychotherapy unit in healthcare or social services³⁵⁶. However, access to the teams is uneven as 10 of the 21 regions do not provide this service at all.

As with other risk factors, parents may be offered a SIP/VP care plan when mental health problems are identified³⁵⁷. The centre that holds the main responsibility according to the SIP agreement is also responsible for follow-up. Mental health resources for new mothers are generally accessible in Sweden as there is consensus that they (and the other parent) should receive help promptly³⁵⁸. However, there may be waiting lists in secondary and tertiary care due to the prioritisation of other patient groups with urgent needs. There is no charge to see an ICH psychologist, but parents pay the normal patient fee in other areas of healthcare. Parents living in sparsely populated areas may need to travel further to clinics. However, there is a legally protected right to care in Sweden, so the service is guaranteed even though it may require some travel^{359 360}.

Social difficulties

Under Swedish law, parents with financial difficulties are entitled to contact municipal social services and apply for aid to cover expenses for food, clothes, rent, household electricity, and so on³⁶¹. In order to receive financial aid, families need to

353. Swedish Paediatric Society. (2020). Screening med EPDS. Stockholm: Inera AB (cited 2019-01-03). Retrieved from <https://www.rikshandboken-bhv.se/metoder--riktlinjer/screening-med-epds/>

354. Swedish Paediatric Society.(2019a). Enskilda föräldrasamtal. Stockholm: Inera AB (cited 2019-01-03). Retrieved from <https://www.rikshandboken-bhv.se/metoder--riktlinjer/enskilda-foraldrasamtal/>

355. Communication with reference group 2019-09-01-2019-10-30.

356. Furmark, C., & Neander, K. (2018). Infant mental health centers/teams in Sweden—an overview. Social Board of Health and Welfare. (cited 2019 Sept 30). Retrieved from http://anhoriga.se/Global/BSA/Bilder/Sp%c3%a4d%20och%20sm%c3%a5barnsverksamhet/BSA-2018-2_Furmark_Neander_webb.pdf

357. Swedish Association of Local Authorities and Regions (SALAR) (Sveriges kommuner och regioner SKR) (2019). Samordnad individuell plan (SIP) [cited 2019-10-22] Retrieved from: <https://skl.se/halsasjukvard/kunskapsstodvardochbehandling/samordnadindividuelltplan.samordnadindividuelltplan.html>

358. Communication with reference group 2019-09-01-2019-10-30.

359. <https://www.vantetider.se/veta-mer/varoggaranti/>

360. Sveriges Kommuner och Regioner. (No date). Valfrihet inom hälso- och sjukvård. Retrieved from <https://skr.se/demokratiledningstyrning/drifformervalfrihet/valfrihetssystemochersattningsmodeller/halsoochsjukvard.1759.html>

361. Social Services Act. (SFS 2001:453) Stockholm: Ministry of Health and Social Affairs. [cited 2019-10-22] Retrieved from: <http://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/>

fulfil certain conditions³⁶². Social services also offer other forms of help, such as a contact person or contact family for support in daily life, family counselling in case of relationship problems, and support for violence or addiction problems. There are social bureaux in every municipality and no waiting lists for the service^{363 364}. There is also a 24-hour hotline.

Social services collaborate with ICH if the family has a structured individual care plan (SIP), but otherwise these services are not connected. However, ICH staff can offer parents information about how to contact the social services office or help them book an appointment. Another initiative is the three-way conversation that can be initiated by ICH if they have concerns about a child. This is a meeting where the family, social services and ICH get together and go through the family's needs for support. According to Swedish law, if children are identified as being at risk, ICH and social services should work together to help them³⁶⁵. The ICH professionals are obliged to refer to the social bureau if they observe signs that a child's needs are not being met or if there are other signs of maltreatment, so that an evaluation of the child's circumstances and need for added support can be initiated. The routes for referral are different in each region and vary depending on the psychosocial problem at hand, as well as the level of care.

Relationship difficulties

There is no specific screening for relationship difficulties between the parental couple in ICH, but these problems are among the risk factors that are explored when the family situation is discussed during the first ICH visit³⁶⁶. This topic is also addressed in the previously mentioned individual parent visits. ICH nurses ask about the parents' relationship in general terms and, if problems become evident, parents are informed about the availability of family counselling, which is a part of social services. All municipalities are legally obliged to provide family counselling^{367 368 369}. Families have the right to 3–5 family counselling sessions for marital or family difficulties, with further help available if needed, and all members of a family can request this service. Municipalities also offer counselling for couples planning to separate on how best to care for their children. Municipalities may use their own staff or pay for private counsellors to provide this service.

Applying for family counselling is voluntary, and ICH staff can only give parents information about this resource. However, if staff are concerned that the family conflict is severe enough to pose potential harm to a child's wellbeing, they are

socialtjanstlag-2001453_sfs-2001-453

362. Socialstyrelsens allmänna råd om ekonomiskt bistånd (SOSFS 2013:1). Stockholm: National Board of Health and Welfare. Retrieved from <https://www.socialstyrelsen.se/regler-och-riktlinjer/foreskrifter-och-allmanna-rad/konsoliderade-foreskrifter/20131-om-ekonomiskt-bistand/>

363. Personal communication with the Swedish National Agency for Education and Swedish Schools Inspectorate's information services and universities responsible for the pre-school teacher program or Personal communication with coordinating midwife and professionals at central CHI unit. (Personal communication 2020-01-01-2020-01-30).

364. Communication with reference group 2019-09-01-2019-10-30.

365. Social Board of Health and Welfare. (2014). Barn som far illa eller riskerar att fara illa. En vägledning för hälso- och sjukvården samt tandvården gällande anmälningsskyldighet och ansvar. Retrieved from <https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/vagledning/2014-10-4.pdf>

366. Communication with reference group 2019-09-01-2019-10-30

367. Family Law and Parental Support Authority (Myndigheten för familjerätt och föräldraskapsstöd, MFOF). (2019). Family counselling (Familjerådgivning). [cited 2019-09-30] Retrieved from: <https://mfof.se/familjeradgivning.html>

368. Government offices of Sweden (Regeringskansliet). (2013) Family Law. Information on the rules. Stockholm: Ministry of Justice (Justitiedepartementet).

369. Health Care Guide 1177 (Vårdguiden 1177). Familycounselling (familjerådgivning). Stockholm: Inera AB (på uppdrag av SKR) [cited 2019-08-21] retrieved from: <https://www.1177.se/Stockholm/liv--halsa/psyisk-halsa/att-soka-stod-och-hjalp/familjeradgivning/>

obliged to contact social services³⁷⁰. In some municipalities, there are also family centres that offer family counselling or couples therapy³⁷¹. Finally, parents can seek couples counselling from private counsellors, and many municipalities use private practices for this³⁷². In such cases, the services may still be free of charge. Family counselling services are also available and accessible. In some municipalities, this service is free, and some charge up to DKK 340 for each session³⁷³. The municipality's family counselling service is responsible for the follow-up and quality assurance of their service³⁷⁴.

Alcohol and substance abuse

There is no universal screening for alcohol or substance abuse in ICH, but national guidelines recommend addressing alcohol use when lifestyle habits are discussed during the 6–8-week appointment, the home visit at eight months and in the parental groups³⁷⁵. If problems have been previously identified in prenatal care, the ICH may already have been notified or a SIP established. In the event of problems, ICH nurses first talk with the parents and offer them an opportunity to discuss their thoughts on how their alcohol consumption might affect their baby or toddler³⁷⁶. ICH nurses should offer brief counselling and complete the AUDIT with the parent or parents. ICH guidelines offer guidance on how to structure the conversation and give information to parents, but each region may also have its own information material and guide for such conversations. If the AUDIT results indicate a problem, the mother or parent should be offered more intensified care. According to the guidelines, each ICH unit should have a routine for referral, but if the mother or parent declines the offer of help, ICH nurses should continue to motivate them to accept support and refer the case to more intensified substance abuse services if needed. Nurses are obliged to refer the case to the social bureau if they observe signs that a child's needs are not being met or if there are other signs of maltreatment, so that social services can initiate an evaluation of the child's circumstances and need for added support³⁷⁷.

As previously mentioned, in the Stockholm^{378 379}, Västra Götaland^{380 381} and Malmö regions³⁸², there are specialist units for helping new mothers to abstain from alcohol

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370. Swedish Paediatric Society. (2019d). Orosanmälan till socialtjänsten. Stockholm: Inera AB (cited 2019-01-03). Retrieved from <https://www.rikshandboken-bhv.se/livsvillkor/barn-som-riskerar-att-fara-illa/orosanmalan-till-socialtjansten/>
371. The Swedish Association to promote Family Centres (Föreningen För Familjecentralers Främjande). Vad är en familjecentral?(2019) Retrieved from <http://familjecentraler.se/vad-ar-en-familjecentral1/>
372. Health Care Guide 1177 (Vårdguiden 1177). Familycounselling (familjerådgivning). Stockholm: Inera AB (på uppdrag av SKR) [cited 2019-08-21] retrieved from: <https://www.1177.se/Stockholm/liv--halsa/psykisk-halsa/att-soka-stod-och-hjalp/familjeradgivning/>
373. Government offices of Sweden (Regeringskansliet). (2013) Family Law. Information on the rules. Stockholm: Ministry of Justice (Justitiedepartementet).
374. Family Law and Parental Support Authority (Myndigheten för familjerätt och föräldraskapsstöd, MFOF). (2019). Family counselling (Familjerådgivning). [cited 2019-09-30] Retrieved from: <https://mfof.se/familjeradgivning.html>
375. Swedish Paediatric Society. (No date). The national ICH programme. Health visits per age (Barnhälsovårdens nationella program. Hälsobesök per ålder) program. [cited 2019-01-03] Retrieved from; <https://www.rikshandboken-bhv.se/halsobesok/>
376. Communication with reference group 2019-09-01-2019-10-30.
377. Swedish Paediatric Society. (2019d). Orosanmälan till socialtjänsten. Stockholm: Inera AB (cited 2019-01-03). Retrieved from <https://www.rikshandboken-bhv.se/livsvillkor/barn-som-riskerar-att-fara-illa/orosanmalan-till-socialtjansten/>
378. Region Stockholm (Beroende Centrum). Rosenlund Maternal and Child Health Team (Rosenlunds Barnhälsovårdsteam). (2019) [cited 2019-09-30] Retrieved from: <https://www.beroendecentrum.se/vard-hos-oss/barnhalsovard-och-modravard/> And Prima Maria: <http://www.prima.se/maria-beroende/>
379. Edenius, A. (2018) Is there a need for a special ICH for parents with drug problems? (Behövs det en special BVC för föräldrar med drogproblematik?) Barnläkaren. nr 6, p. 14-15.
380. Nordenfors M, Höjer I. (2012) Kvinnors erfarenheter av stöd från Mödra-barnhälsovårdsteamet i Haga (Rapport 4:2012). Retrieved from Region https://goteborgsregionen.se/download/18.59a3689157fc2c69be75b6d/1477483571285/2012_modra_barnhalsovardsteamet.pdf
381. Rangmar J et al. (2019) Children who face development risks due to maternal addiction during pregnancy require extra medical and psychosocial resources. Acta Paediatrica. 108, pp. 101-105. [cited 2019-09-30] Retrieved from <https://pubmed.ncbi.nlm.nih.gov/29781554/>
382. Malmö Region. (2019) Support for pregnant women with addiction. The Ambulatory (Stöd till gravida med missbruk). R

or drugs. The units provide continued support throughout the infant's first year, and the team in Gothenburg also offers guidance and supervision to the ICH until the child starts preschool. In other regions, new mothers might be referred to a nurse specialising in alcohol and substance problems at a primary care centre, a drug dependency unit in primary care psychiatry, the social services' drug dependency centre or a drug-dependency unit in psychiatric hospital care^{383 384}. If parents have severe addiction problems, a SIP plan can be initiated, or this may already have been initiated in prenatal care. The intention is to create a formal support structure around families with special needs, all the way from pregnancy through infant and child healthcare and preschool. In general, resources for drug and alcohol problems are accessible to all parents, but the scope of interventions may be more limited, for example, in rural or sparsely populated areas. The responsibility for follow-up and continuity of care lies with the care unit that is responsible for the SIP.

Violence and trauma

Currently, how and when the ICH should ask parents about violence is under evaluation in Sweden. Results from ongoing projects in certain regions will offer input on how to continue and develop national guidelines regarding this subject. According to the Social Services Act, all healthcare staff, including prenatal and ICH services, are obliged to notify the social bureau if there are indications that a child is at risk due to violence in the family or because they have witnessed violence in the family³⁸⁵. According to ICH national guidelines, each centre or region should develop an action plan for situations where violence is discovered in a family³⁸⁶. Each region should also have its own plan for prevention of violence in the family, to which ICH centres should adhere³⁸⁷. If new mothers have had previous experience of violence and suffer from PTSD or other mental health consequences, steps are taken similar to those for mental health difficulties. The same applies if the other parent has had previous experience of violence³⁸⁸. If exposure to violence is ongoing, ICH should contact the social services bureau immediately to discuss the need for support and protection^{389 390}. The mother will be offered help to contact a women's shelter if the situation is acute, and will be offered help to file a police report. In Sweden, social services are responsible for giving support to victims of violence, such as protection, counselling, psychotherapy, practical guidance and help to leave home³⁹¹. If a woman is under severe threat, social services will investigate whether she can be provided with protected housing. Protected housing is available in every region and may be run by NGOs, although finding protected housing for women is the responsibility of social services³⁹². Staff in these services can offer support, psychosocial care and

etrieved from: <https://malmo.se/Service/Stod-och-omsorg/Missbruk-och-beroende/Stod-till-gravida-med-missbruk.html>

383. Communication with reference group 2019-09-01-2019-10-30.

384. Personal communication with coordinating midwife and professionals at central CHI unit. (Personal communication 2020-01-01-2020-01-30).

385. Social Services Act. (SFS 2001:453) Stockholm: Ministry of Health and Social Affairs. [cited 2019-10-22]

386. Swedish Paediatric Society. (2019d). Orosanmälan till socialtjänsten. Stockholm: Inera AB (cited 2019-01-03). Retrieved from <https://www.rikshandboken-bhv.se/livsvillkor/barn-som-riskerar-att-fara-illa/orosanmalan-till-socialtjansten/>

387. Communication with reference group 2019-09-01-2019-10-30.

388. Social Board of Health and Welfare. (2014). Barn som far illa eller riskerar att fara illa. En vägledning för hälso- och sjukvården samt tandvården gällande anmälningsskyldighet och ansvar. Retrieved from <https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/vagledning/2014-10-4.pdf>

389. Communication with reference group 2019-09-01-2019-10-30.

390. Personal communication with coordinating midwife and professionals at central CHI unit. (Personal communication 2020-01-01-2020-01-30).

391. Social Services Act. (SFS 2001:453) Stockholm: Ministry of Health and Social Affairs. [cited 2019-10-22]

392. Personal communication with employed by Sweden's National Women's Helpline (Kvinnofridslinjen). (Personal communication 2020-01-01-2020-01-30) and ROKS <https://www.roks.se/about-roks>.

guidance. They can also accompany women when to meetings with the police, lawyers or the social services.

Young children who have experienced abuse or witnessed violence in the family can also be referred to child psychiatry³⁹³. The exact routine and steps for referral will vary and should be described in the region's action plan for violence in the family. In cases of violence and abuse, the service can be offered by the social services (e.g. for various psychosocial interventions, counselling and practical help) or primary care psychiatry (e.g. for psychotherapy or medication)^{394 395}. In some municipalities, such as Stockholm, the family counselling bureau has specific centres that offer support and treatment to family members who have experienced intimate partner violence or domestic violence, without referral³⁹⁶.

Some regions also have Children's Houses, child protection teams, and infant care teams^{397 398 399}. In Children's Houses, the police, social services, paediatricians and infant and child psychiatrists work together in a multisectoral way throughout the investigation process to provide child-friendly support to children in cases of violence and abuse. The practices and settings are adapted to children's needs, and the staff are specifically trained in talking to children about violence and abuse. In some Children's Houses, such as in Stockholm, it is also possible to get emergency support through the child and youth psychiatry services. In some Swedish regions, there are specialised multiprofessional child protection teams that work as consultants and provide support and training for healthcare professionals in the area of child abuse and neglect. Their aim is to increase knowledge, improve quality and create a sustainable structure for child protection in the regional healthcare system. There are also other forms of multisectoral collaboration that may be a resource for the ICH centre, such as Operation Kvinnofrid in Stockholm, which is a large-scale, cross-sectoral operation to reduce domestic violence⁴⁰⁰. Some regions also have competence centres on interpersonal violence and violence prevention that cover either the region or the whole country^{401 402 403 404}.

393. Communication with reference group 2019-09-01-2019-10-30.

394. Personal communication with employed by Sweden's National Women's Helpline (Kvinnofridslinjen). (Personal communication 2020-01-01-2020-01-30) and ROKS <https://www.roks.se/about-roks>.

395. Personal communication with employed by Sweden's National Women's Helpline (Kvinnofridslinjen). (Personal communication 2020-01-01-2020-01-30) and ROKS <https://www.roks.se/about-roks>.

396. Stockholms Stad. (2020). Våld I nära relationer. Stockholm: Stockholms stad (Familj och barn) (cited 2019-10-30). Retrieved from: <https://www.stockholm.se/FamiljOmsorg/Stod-till-familj--barn/Vald-i-nara-relationer/Relationsvaldscentrum-RVC/>

397. Barnafriid Kunskapscentrum (2019). Slutrapport. Utvärdering av barnahus-2019. Retrieved from: <https://www.barnafriid.se/kunskapsbank/slutrapport-utvardering-av-barnahus-2019/utvarderingen-av-barnahus>

398. Barnahus Linköping. (No date). (cited 2019-10-30). Retrieved from: <http://barnahuslinkoping.se/>

399. Infantcare teams (cited 2019-10-30) Region Ostergotland: https://vardgivarwebb.regionostergotland.se/Startsida/Verksamheter/Regiondirektor/Ledningsstaben/Barnskyddsteam-Region-Ostergotland/Region-Stockholm:https://www.karolinska.se/for-patienter/alla-mottagningar-och-avdelningar-a-o/tema-barn-och-kvinnosjukvard/akutsjukvard-barn/barnskyddsteamet/Region-Skane:https://vardgivarwebb.skane.se/kompetens-utveckling/sakkunniggrupper/barnhalsovard/barn-som-far-illa/Region-Uppsala:https://www.akademiska.se/barnskyddsteametRegion-VG:https://www.vgregion.se/halsa-och-varld/vardgivarwebben/amnesomraden/barnskyddsteam/Region-Sormland:https://samverkan.regionsormland.se/for-vardgivarvald-i-nara-relationer/kompetenscentrum-mot-vald-i-nara-relationer/barnskyddsteam/Region-Jonkoping:https://plus.rjl.se/info_files/infosida43233/manadsblad_okt_barnskyddsteam_2019.pdf

400. Operation Kvinnofrid. (No date). (cited 2019-10-30) Retrieved from: <http://www.operationkvinnofrid.se>.

401. Stockholms Stad. (2020). Våld I nära relationer. Stockholm: Stockholms stad (Familj och barn) (cited 2019-10-30). Retrieved from: <https://www.stockholm.se/FamiljOmsorg/Stod-till-familj--barn/Vald-i-nara-relationer/Relationsvaldscentrum-RVC/>

402. Uppsala Universitet. (No date). Kvinnofrid. Retrieved from: <https://nck.uu.se/>

403. Barnafriid Kunskapscentrum. (No date). Retrieved from: <https://liu.se/en/research/barnafriid/about-us>

404. Region Skåne. (No date). Kompetenscentrum våld. Retrieved from <https://kompetenscentrumvald.se/index.html>

Parental leave

In Sweden, parents have the right to 16 months of parental leave or eight months for each parent. Parents may also divide the leave in other ways if one of them is unable to take their share, except for 90 days that are exclusively reserved for each parent⁴⁰⁵. Single parents have the right to take the entire period and parents of twins have extended leave of 180 days. When on leave, parents receive approximately 80% of their income to a maximum of about DKK 673 per day. The Swedish Social Insurance Agency manages applications and payments for parental leave. It is not an automatic service; parents need to apply when they wish to start their leave. There is no extended paid leave for parents who want to stay at home with their children after the regular parental leave comes to an end.

Early childhood education and care

According to Swedish legislation, children have the right to early childhood education and care (ECEC) from the age of one in the form of either preschool or pedagogical care (usually home daycare)⁴⁰⁶. Municipalities are obligated to provide care in accordance with the parents' wishes⁴⁰⁷. They are required to provide a place for the child within four months of the date of the parent's request. Children in need of special support because of physical, psychological or other conditions should be offered a place as soon as possible. If municipalities cannot offer a preschool place after four months, they must offer an alternative form of care, such as home daycare. According to Swedish legislation, municipalities may also offer open preschool. The most common age for children to start preschool and ECEC is 18 months⁴⁰⁸. In 2018, 50% of all 1-year-olds and about 90% of 1–2-year-olds were enrolled in preschool⁴⁰⁹. However, national statistics show that participation in preschool and ECEC is lower for certain groups, such as children whose families have a low income, or whose parents had a short education, are unemployed or have recently immigrated to Sweden⁴¹⁰.

Home daycare

Pedagogical care, or home daycare, is not part of the educational system but is an alternative to preschool in Sweden⁴¹¹. This system is not widely used and has continuously declined over the years, while the preschool system has expanded. In

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405. Försäkringskassan (No date). Information about parental leave. Retrieved 2019-09-19 from: https://www.forsakringskassan.se/privatpers/foralder/ut/p/z1/O4_Sj9CPykssy0xPLMnMz0vMAfljo8ziLQl8TDy8Dlx8LYDTA0cjb3NTU18DIzdvY30w8EKDHAARwP9KEL6o8BKTDxcnA3dnQ28LDyNgUoCAwyNTfyNvLyCDaAK8FgRnJqnX5AbYZBI4agIAR3FAY/dz/d5/L2dJQSEvUUt3QS80TmxFL1o2XzRIREMxROMwS081UOQwQZTJUTFWU0UyRUly/
406. Swedish National Agency for Education. (2020e). *Så här fungerar förskolan*. (cited 2020-01-15) Retrieved from: <https://www.skolverket.se/for-dig-som-ar.../elev-eller-foralder/skolans-organisation/sa-har-fungerar-forskolan>
407. Swedish National Agency for Education. (2020d). Rätt till förskola. Retrieved 2019-09-29 from <https://www.skolverket.se/regler-och-ansvar/ansvar-i-skolfragor/ratt-till-forskola>
408. Swedish National Agency for Education (Skolverket) (2016) Beskrivande fakta. Retrieved from: <https://www.skolverket.se/getFile?file=3758>
409. Swedish National Agency for Education (Skolverket). (2018). Deltagande i förskolan. Retrieved 2019-05-28 from: <https://www.skolverket.se/download/18.6bfaca41169863e6a65d6fb/1553968197013/pdf4023.pdf>
410. Swedish National Agency for Education (Skolverket). (2018). Deltagande i förskolan. Retrieved 2019-05-28 from: www.skolverket.se/download/18.6bfaca41169863e6a65d6fb/1553968197013/pdf4023.pdf
411. Swedish National Agency for Education. (2020a). *Ansvar i skolfrågor*. (cited 2019-09-30). Retrieved from: <https://www.skolverket.se/regler-och-ansvar/ansvar-i-skolfragor/pedagogisk-omsorg>

the mid-1990s, 130,000 children were in pedagogical care but by 2018, the figure had fallen to 11,680⁴¹². The Swedish Education Act specifies requirements for home daycare and provides directions for the work, for example, that the location should be appropriate for children, activities should be based on the best interests of the child and groups must have a suitable composition and size⁴¹³. At the local level, municipalities are responsible for regulations, surveillance and follow-up. Under the Education Act, anyone working in home daycare should have prior experience that enables them to meet the children's needs for care and good pedagogical activities^{414 415}. Other than that, the training required for a person working in pedagogical care is not regulated⁴¹⁶. Results from a recent study show that the majority (68%) of those working in home daycare or other similar forms of pedagogical care have no specific education in working with children⁴¹⁷.

The national preschool curriculum should be indicative (albeit not binding) for pedagogical care, with the aim of providing a safe and engaging environment that stimulates learning^{418 419}. There is no universal, ongoing training offered to childminders in home daycare⁴²⁰. Municipalities put together specific local requirements for the content and conditions of pedagogical care, which an individual must meet in order to be approved as a childminder in home daycare⁴²¹. In this sense, municipalities operate as a "principal", formulating local goals for home daycare and the requirements that home daycare staff must meet in order to comply with the Education Act. This includes protocols on the obligation to collaborate with and notify social services if there are signs that a child is at risk, action plans concerning abuse, privacy, and so on. There is no common public training offered to childminders in home daycare, although municipalities may offer local training⁴²².

The Swedish Schools Inspectorate conducts regular evaluations of pedagogical care, including home daycare, albeit not on an annual basis⁴²³. An evaluation from 2016 showed that – as per the objectives laid out in the curriculum – most children were provided with good activities, sensitive care and security, and the prerequisites for learning and growing were met⁴²⁴. The evaluation also revealed that staff generally succeeded in adapting activities to the infant group's experiences, needs and interest, and that parents were satisfied. However, it also indicated there was a wide

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413. Swedish National Agency for Education. (2020a). *Ansvar i skolfrågor*. (cited 2019-09-30). Retrieved from: <https://www.skolverket.se/regler-och-ansvar/ansvar-i-skolfragor/pedagogisk-omsorg>
414. Swedish National Agency for Education. (2020a). *Ansvar i skolfrågor*. (cited 2019-09-30). Retrieved from: <https://www.skolverket.se/regler-och-ansvar/ansvar-i-skolfragor/pedagogisk-omsorg>
415. Education Act (2010:800). Stockholm: Ministry of Education. Retrieved from: https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/skollag-2010800_sfs-2010-800
416. Personal communication with the Swedish National Agency for Educations and Swedish Schools Inspectorate's information services and universities responsible for the pree-school teacher program. (Personal communication 2020-01-01-2020-01-30).
417. Swedish National Agency for Education. (2019). *Annan pedagogisk verksamhet: Barn och personal per 15 oktober 2018*. Retrieved from: <https://www.skolverket.se/download/18.6bfaca41169863e6a65ee4e/1555053785787/pdf4069.pdf>
418. Education Act (2010:800). Stockholm: Ministry of Education. Retrieved from: https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/skollag-2010800_sfs-2010-800
419. Swedish National Agency for Education. (2020a). *Ansvar i skolfrågor*. (cited 2019-09-30). Retrieved from: <https://www.skolverket.se/regler-och-ansvar/ansvar-i-skolfragor/pedagogisk-omsorg>
420. Personal communication with the Swedish National Agency for Educations and Swedish Schools Inspectorate's information services and universities responsible for the pree-school teacher program (Personal communication 2020-01-01-2020-01-30).
421. Swedish National Agency for Education. (2020a). *Ansvar i skolfrågor*. (cited 2019-09-30). Retrieved from: <https://www.skolverket.se/regler-och-ansvar/ansvar-i-skolfragor/pedagogisk-omsorg>
422. Personal communication with the Swedish National Agency for Educations and Swedish Schools Inspectorate's information services and universities responsible for the pree-school teacher program (Personal communication 2020-01-01-2020-01-30).
423. Personal communication with the Swedish National Agency for Educations and Swedish Schools Inspectorate's information services and universities responsible for the pree-school teacher (Personal communication 2020-01-01-2020-01-30).
424. Swedish Schools Inspectorate. (2016). *Barnens lärande i pedagogisk omsorg: Den lilla gruppens möjligheter och begränsningar*. (cited 2019-09-30). Retrieved from: <https://www.skolinspektionen.se/globalassets/02-beslut-rapporter-stat/granskningsrapporter/tkg/2016/pedagogisk-omsorg/slutrapport---barnens-larande-i-pedagogisk-omsorg.pdf>

variety in the quality of activities in pedagogical care.

Preschool

The Education Act defines preschool as the first level of education, and it is subject to a national curriculum^{425 426}. Preschools are a local government responsibility, and each municipality is responsible for quality assurance and monitoring preschool facilities in their area under the Act. Each preschool is also required to engage in systematic quality enhancement. The way each of the approximately 300 municipalities in Sweden conducts its monitoring varies, but on a national level, the Schools Inspectorate also conducts periodic external evaluations of quality⁴²⁷. Preschools can be run either by municipalities or private owners but according to 2018 statistics, 72% were run by municipalities⁴²⁸.

Under the Education Act and the preschool curriculum, certified preschool teachers are responsible for the pedagogical part of preschool teaching. Thus, there needs to be at least one certified preschool teacher employed at a preschool, but other staff with appropriate training and experience for children's development and learning may be employed for care-related activities, for example, leisure leaders or childminders (*barnskötare*) who have high-school level training in caring for children⁴²⁹. However, only certified preschool teachers can be employed permanently, while staff without certification may be employed for one year at a time⁴³⁰. In 2018, about 40% of preschool staff were certified preschool teachers, and the ratio of employed staff with a degree in preschool teaching has been decreasing since 2014⁴³¹. During the same period, the proportion of staff without full training in working with children has increased to 31%. However, there is wide variation between municipalities in terms of the proportion of trained staff, and this ranges from 31% to 48%. The average salary for preschool teachers in Sweden is DKK 21,697, which is 98% of the national mean income (DKK 21,982)⁴³².

The Education Act states that the head of the school must ensure that the groups of children have an appropriate composition and size. In 2018, the most frequent group size was 13–15 children, but 9% of all groups had 22 children or more⁴³³. According to national statistics from all Swedish preschools, there was one staff member for every 5.1 children and one preschool teacher for every 12.9 children⁴³⁴. Staff density has been largely constant in preschools in Sweden over the last decade, but the

425. Education Act (2010:800). Stockholm: Ministry of Education. Retrieved from: https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/skollag-2010800_sfs-2010-800

426. Swedish National Agency for Education. (2011). *Curriculum for the pre-school*. (cited 2019- 10-01) Retrieved from: <https://www.skolverket.se/publikationsserier/styrdokument/2011/curriculum-for-the-preschool-lpfo-98-revised-2010?id=2704>

427. Personal communication with the Swedish National Agency for Educations and Swedish Schools Inspectorate's information services and universities responsible for the pre-school teacher program or Personal communication with coordinating midwife and professionals at central CHI unit. (Personal communication 2020-01-01-2020-01-30).

428. Swedish National Agency for Education. (2019b). *Barn och personal i forskolan 2018*. Retrieved from: <https://www.skolverket.se/getFile?file=4068>

429. Education Act (2010:800). Stockholm: Ministry of Education. Retrieved from: https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/skollag-2010800_sfs-2010-800

430. Swedish National Agency for Education. (No date). *Regler och ansvar*. (cited 2019-05-28) Retrieved from: <https://www.skolverket.se/regler-och-ansvar/lararlegitimation-och-forskollarlegitimation/regler-och-krav-for-lararlegitimation/larar--och-forskollarlegitimation-och-krav-for-att-fa-anstallning>

431. Swedish National Agency for Education. (2019b). *Barn och personal i forskolan 2018*. Retrieved from: <https://www.skolverket.se/getFile?file=4068>

432. Swedish Statistics (SCB) Lonesok. (No date). Lönestatistik.se. Retrieved from: <https://www.scb.se/hitta-statistik/sverige-i-siffror/lonesok/Search/?lon=f%C3%B6rskoll%C3%A4rare>

433. Swedish National Agency for Education. (2019b). *Barn och personal i forskolan 2018*. Retrieved from: <https://www.skolverket.se/getFile?file=4068>

434. Swedish National Agency for Education. (2019b). *Barn och personal i forskolan 2018*. Retrieved from: <https://www.skolverket.se/getFile?file=4068>

gender ratio is still very uneven, with men taking just over 4% of the full-time positions. In terms of recruitment, it is estimated that about 38,000 full-time preschool teachers will be needed between 2019 and 2029, but the estimated graduation rate for preschool teachers does not meet that need⁴³⁵. In addition to this, a large recruitment need is identified for childminders and pupil assistants per annum until 2022^{436 437}. There have been reports about occupational related stress and illness in Swedish preschools⁴³⁸. High noise levels, heavy workload, understaffing in relation to children's group sizes and difficulties in finding substitutes are reported causes of stress among preschool staff^{439 440 441}.

On average, children are in preschool for 31 hours per week, but national numbers are not available for particular age groups⁴⁴². The benchmark for the group size for 1–3-year-olds in Swedish preschools is 6–12 children⁴⁴³. Generally, when a child starts preschool, the induction process should meet the needs of the individual child, but the exact format varies from one preschool to the next. It has become more common to use a fast-adjustment approach, in which parents stay with their children all day for three days^{444 445}. However, this approach means that the child may not have the time to become familiar with the staff member who will take care of them. Another approach uses a 14-day adjustment period, in which each child is assigned to a specific staff member and forms a special relationship with them.

Social and emotional development

It is an overarching goal in preschool to give each child an opportunity to grow and develop, learn about human diversity, respect others, be responsible, show empathy and see other people's points of view⁴⁴⁶. These are fundamental social-emotional skills that are promoted through the national preschool curriculum. While there is no universal continuing education or training for preschool staff regarding social-emotional learning (SEL) among young children, individual municipalities may offer such training for their preschool staff and some regions have implemented manualised ECEC programmes that include such training⁴⁴⁷. Apart from the national

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435. Swedish National Agency for Education. (2017). *Recruitment needs in school*. (cited 2019-05-28). Retrieved from: <https://www.skolverket.se/getFile?file=3876> and <https://www.skolverket.se/publikationsserier/regeringsuppdrag/2017/uppdrag-att-ta-fram-aterkommande-prognoser-over-behovet-av-forskollarare-och-olika-lararkategorier?id=3876>
436. Statistiska centralbyrån (SCB) (2018) Arbetskraftsbarometern. Retrieved from https://www.scb.se/contentassets/4b009ad5765046629999afe2e77cd821/uf0505_2018a01_am78br1803.pdf
437. Swedish National Agency for Education. (2017). *Recruitment needs in school*. (cited 2019-05-28). Retrieved from: <https://www.skolverket.se/getFile?file=3876> and <https://www.skolverket.se/publikationsserier/regeringsuppdrag/2017/uppdrag-att-ta-fram-aterkommande-prognoser-over-behovet-av-forskollarare-och-olika-lararkategorier?id=3876>
438. Försäkringskassan. (2018). *Sjukfrånvaron på svensk arbetsmarknad: Sjukskrivningar längre än 14 dagar och avslut inom 180 dagar i olika branscher och yrken*. Retrieved from: <https://www.forsakringskassan.se/wps/wcm/connect/5b9d37a9-a56d-4453-896f-fed299534d91/socialforsakringsrapport-2018-02.pdf?MOD=AJPERES&CVID=>
439. Swedish National Agency for Education. (2020c). *Leda och organisera skolan*. (cited 2019-09-30). Retrieved from: <https://www.skolverket.se/skolutveckling/leda-och-organisera-skolan/vardegrund-och-arbetsmiljo/arbetsmiljon-i-skola-och-forskola>
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441. Villaneuva Gran, T. (2015). Allt fler blir sjuka av stress. (cited 2019-08-25). Retrieved from <https://forskolan.se/allt-fler-blir-sjuka-av-stress/>
442. Skolverket. (2015) *Föräldrarnas syn på förskolan-resultat på kommunivå*. Retrieved from: <https://www.skolverket.se/getFile?file=3479>
443. Swedish National Agency for Education. (2020a). *Ansvar i skolfrågor*. (cited 2019-09-30). Retrieved from: <https://www.skolverket.se/regler-och-ansvar/ansvar-i-skolfragor/pedagogisk-omsorg>
444. Matzinger, A. (2016). Hur lång inskolning är bäst? (Cited 2019-08-31). Retrieved from: <https://www.viforaldrar.se/barn/forskola/hur-lang-inskolning-ar-bast/>
445. Lunback, M. (2013). Barnen förlorar på kort inskolning. (cited 2019-08-31). Retrieved from: <https://forskolan.se/barnen-forlorar-pa-kort-inskolning/>
446. Swedish National Agency for Education. (2011). *Curriculum for the pre-school*. (cited 2019- 10-01) Retrieved from: <https://www.skolverket.se/publikationsserier/styrdokument/2011/curriculum-for-the-preschool-lpfo-98-revised-2010?id=2704>
447. Personal communication with the Swedish National Agency for Educations and Swedish Schools Inspectorate's information services and universities responsible for the pre-school teacher program or Personal communication with

curriculum, it is not known to what extent individual preschools have detailed plans on how to promote social and emotional skills among young children. However, desired behaviour is taught through positive support and age-appropriate training, and there is an emphasis on staff coordination to support young children's emotional needs and promote their social and emotional competence. Some preschools have also implemented specific programmes for SEL promotion, such as Triple P in Uppsala region⁴⁴⁸, and the International Child Development Programme (ICDP) in the SALUT project in preschools in Vasterbotten region⁴⁴⁹. Physical punishment and other offensive treatment is forbidden, and all types of school must draw up action plans to prevent it and to report back on it every year⁴⁵⁰. Under the Social Services Act, all professionals working with children also have a legal duty to notify social services if there are indicators of risk to a child⁴⁵¹. Preschool administrators are required to inform staff about their duty to notify them about these risks, and establish routines for how staff should respond to indicators of risk (e.g. violence or neglect). Under the Education Act, preschools are also obliged to collaborate with other sectors involved in any process where a child is at risk.

Collaboration with parents

There is collaboration with parents in Swedish preschools through parents' associations and individual consultation⁴⁵². Parents usually do not contribute to the content of the work, except perhaps in private preschools where parents serve on the school board. Municipalities conduct annual surveys of parents with children in preschools, to assess the children's wellbeing, satisfaction with facilities and relationships with staff, and parents are routinely informed of the results⁴⁵³. There is an emphasis on maintaining a good working relationship with parents, and they are contacted immediately if concerns arise regarding a child's wellbeing or social relations.

Collaboration with other services

In general, collaboration between preschools and other services for young children's social and emotional wellbeing is on the basis of need⁴⁵⁴. Preschools have access to school psychologists and other specialised professionals in the education system, but each municipality has its own routines and ways of responding to difficulties among young children. There is usually no pre-existing venue for routine consultation between preschools and family or health services, except in areas where there is a family centre in the local community. According to a survey from 22 municipalities,

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- coordinating midwife and professionals at central CHI unit. (Personal communication 2020-01-01-2020-01-30).
448. Uppsala municipality. (No date). Triple P. (cited 2019-09-30). Retrieved from: <https://www.pubcare.uu.se/forskning/chap/projekt/aktuella-projekt/triple-p/>
449. Region Vasterbotten. (2020). SALUT satsningen för barn och ungas hälsa. Retrieved from: <https://www.regionvasterbotten.se/folkhalsa/salut-satsningen-for-barn-och-ungas-halsa> and <https://www.regionvasterbotten.se/folkhalsa/salut-satsningen-for-barn-och-ungas-halsa/salut-i-forskolan> and <https://www.regionvasterbotten.se/VLL/Filer/Salut%20poster%20engelska%202014-06-03.pdf>
450. Education Act (2010:800). Stockholm: Ministry of Education. Retrieved from: https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/skollag-2010800_sfs-2010-800
451. Social Services Act. (SFS 2001:453) Stockholm: Ministry of Health and Social Affairs.
452. Personal communication with the Swedish National Agency for Educations and Swedish Schools Inspectorate's information services and universities responsible for the pre-school teacher program (Personal communication 2020-01-01-2020-01-30).
453. Brukar undersökningar. (no date) Tyck till om förskolan. Stockholms stad. <https://start.stockholm/om-stockholms-stad/utredningar-statistik-och-fakta/undersokningar/brukarundersokningar/tyck-till-om-forskolan/> and Göteborgs stad. <http://www.enkater.goteborg.se/ListEnkater.aspx?kat=2018%5cBARN F%3c%96RSKOLA>
454. Communication with reference group 2019-09-01-2019-10-30.

systematic and structured collaboration between preschools and ICH is rare⁴⁵⁵. The organisation that should have responsibility for collaboration around healthcare in preschool has not been defined, and there is no statutory "school healthcare" at the preschool level as there is at the compulsory school level⁴⁵⁶.

Another example of collaboration on the basis of need is when a structured care plan (SIP) is established for the child or family, in which case the multisectoral approach may include the preschool as well as social services and healthcare⁴⁵⁷. In some regions and municipalities, there are also examples of permanent teamwork that involves the preschool, such as the multiprofessional infant team, ALVHA, in Skåne region, which works with parents with long-term mental illness who have infants^{458 459}. The support provided by the team consists of extensive home visits and interaction to promote positive relations and attachment, as well as collaboration with other services around the family, including the preschool. The team first establishes collaboration with the preschool administration before the child starts preschool, to make sure the preschool is suitable for a child with extra needs. The team meets the preschool to identify a staff member who can function as an attachment person for the child, and when the child starts preschool, the team offers support to the parent as well as training and supervision to the preschool staff. This collaboration lasts throughout the child's first six months in preschool.

Another example of systematic collaboration between preschools and other services is found in Jönköping region, where a structured collaboration on health monitoring has been established between the child healthcare service and preschools in the county's municipalities. Together, these services have developed a questionnaire about children's mobility, play, interaction, language, communication skills and daily routines, which ICH services send to parents before the child's 2½-year health visit. Parents are asked to answer the questions together with the child's preschool teacher, in order to get a wider perspective of the child's development and identify any special needs, which the parents can then discuss with ICH staff during the health visit.

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458. ALVHA spädbarnsteam, Region Skåne. (no date) <https://malmo.se/Service/Stod-och-omsorg/Psykisk-ohalsa/Hjalp-till-foraldrar-med-psykisk-ohalsa.html>

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Comparison between the Nordic countries

Availability of information

The participating countries reported some challenges in gathering information for this report, as has been discussed in the methodology section. One reason for this is that, since different systems and subsystems frequently keep their own records, it was often difficult to find information regarding how services were provided at different locations or within different systems, such as social services or tertiary mental health care. In most countries, information about how things were *supposed* to work was readily available but finding out how things were *in practice* was often difficult and sometimes impossible. For example, while national guidelines may recommend systematic screening for risk factors in pregnancy and the early years, information on whether this was actually done was often not available. Similarly, national guidelines and other official recommendations may call for certain topics to be addressed or certain information to be provided to parents, but it is often not known whether this has been done in practice. National online registration systems for prenatal and infant and child healthcare have been established in Sweden, Finland and Iceland but are still being developed in Denmark and Norway. Although most healthcare centres in Norway report using an electronic patient journal as standard, the registration of information concerning prenatal and infant and child healthcare is not coordinated at national level and it is not specified what information must be entered for each appointment.

Structure of prenatal care

Prenatal care is free of charge in all the Nordic countries. The first appointment takes place in the first trimester, and the number of prenatal sessions is similar across all countries, although Finland offers the most sessions in standard prenatal care. Table 1 presents the number of prenatal appointments for uncomplicated pregnancies but all countries offer optional ultrasound appointments in addition to this, and these are not included in the table. All the countries offer more frequent appointments for high-risk pregnancies and vulnerable groups, and aim to meet individual needs (for example, by providing translations and interpreters where necessary and accommodating people with disabilities). The other parent is invited to participate in prenatal care in all the Nordic countries, but they are not offered individual appointments on their own except in Finland, where extensive health examinations should be offered to both parents (and siblings if applicable). In all the countries, however, there have been discussions on how to involve the other parent more, so this may be an area for future development.

	First appointment	Total number of appointments
Denmark	GW 5–10	7–10
Finland	GW 8–10	10–11
Iceland	GW 8–12	7–10
Norway	GW 6–12	7
Sweden	GW 9	9

Table 1: Standard prenatal appointments across the Nordic countries

Prenatal care is provided by individual municipalities or regions in all the Nordic countries except Iceland, where all healthcare is state-run. The service is usually provided at general primary healthcare centres, but in Sweden and Finland it may also be offered at separate clinics or as part of multi-service family centres. In Denmark, prenatal care is shared between GPs' offices and midwives' clinics. Regardless of who is responsible and where it is provided, all the Nordic countries place an emphasis on ensuring continuity of care, with women seeing the same professionals throughout their pregnancy. In Norway and Denmark, the standard prenatal team consists of a midwife and a GP, but in other countries, GPs are less involved. In Finland, prenatal care is usually provided by public health nurses, although some are also trained as midwives. GPs are involved in two regular check-ups, the extensive health examinations and as needed. Norway is the only country where pregnant women can choose to see a GP or midwife exclusively during pregnancy, and the only country where a shortage of midwives is reported to result in some women not being able to see a midwife at all during their pregnancy. In Sweden and Iceland, on the other hand, provided there are no complications, prenatal appointments may involve seeing only a midwife.

Structure of infant and child healthcare

The main structure of infant and child healthcare is similar to that of prenatal care in the Nordic countries, and these services are usually all provided at the same facility. Infant and child healthcare is free of charge in all the Nordic countries but it is managed at different levels in different countries. In Norway and Finland, it is managed by municipalities; it is managed by regions in Sweden; and in Denmark it is shared by both municipalities and regions. In Iceland, all healthcare is state-run. As with prenatal care, infant and child healthcare is usually provided in general primary healthcare centres, although it may also be offered in separate clinics or as part of multi-service family centres. In Denmark, infant and child healthcare is shared between GP offices and home visits by health visitors. Health visitors are nurses with additional education who work with health promotion and prevention in the community. They have their own offices and are part of the primary care sector but provide their services mainly through home visits during the child's first year.

The form and number of infant and child healthcare sessions varies between the countries. In Denmark, the service is almost exclusively offered in the form of home visits, apart from four GP examinations during the first two years of the child's life. In Finland, Norway and Sweden, however, only one or two home visits are offered as standard although more are provided for those who need them. Table 2 presents an overview of the number of sessions in infant and child healthcare over the first two years of a child's life. Most of the sessions are provided in the child's first year. Usually, there are 3–4 visits in the first month after childbirth except in Iceland, where 7–10 visits are offered. Iceland provides the highest number of home visits as standard (up to 11), which is accounted for mainly by the intensive follow-up in the first 10 days after childbirth, as well as the highest total number of appointments during first two years of the child's life (up to 20).

	First visit after hospital discharge	Number of home visits in the first year	Number of appointments in the first 2 years
Denmark	Within 1–3 days	2–8	6–12
Finland	Within 7 days	2	13
Iceland	Within 1 day	7–11	16–20
Norway	Within 3 days	1–2	13
Sweden	Within 6 days	2	14

Table 2: Health visits after hospital discharge and during the first two years of life in the Nordic countries

The first contact after discharge from hospital also varies from within 24 hours to

seven days postpartum (see table 2). It should be noted that although national guidelines in Norway recommend a home visit from a midwife within three days after hospital discharge, data shows that most municipalities do not arrange this visit but 90% of them conduct a home visit 7–10 days after childbirth. In Denmark, first-time mothers get a home visit from a midwife within 24 hours after leaving the hospital but those who have given birth before receive a phone call within the same period, followed by a home visit 2–3 days after hospital discharge. In Iceland, women get a home visit from a midwife on the same day that mother and baby leave the hospital (or the next day if they are discharged in the evening). First-time mothers in Iceland usually stay in hospital for approximately 36 hours (24 hours if they have given birth before) but if they feel up to it, and both mother and child are healthy, they can leave the hospital as early as 4 hours after giving birth. In Denmark, first-time mothers have the option to stay in hospital for 48 hours after childbirth but those who have given birth before typically stay for only 4–6 hours. In Norway, the average hospital stay is 2.8 days and in Finland, it is 2–3 days for first-time mothers and 1–2 days for those who have given birth before. In Sweden, the average stay for first-time mothers is 2.3 days and 1.4 days for those who have given birth before.

Not all appointments shown in table 2 are part of the infant and child healthcare system. Most countries have a follow-up service directly after childbirth that is not provided by the infant and child healthcare system but by various other agencies. For example, in Sweden, prenatal staff offer an extra visit after the baby is born and in Finland, it is recommended that maternity clinics offer two visits after the baby's birth, neither of which is part of infant and child healthcare services. Also, the intensive follow-up immediately after the birth of a child in Iceland is provided by midwives who work as contractors and are not part of the infant and child healthcare system, although these are affiliated services. Nevertheless, these extra visits are included in the total number of visits presented in table 2, as they are part of the services that these countries offer after a baby is born in order to support the wellbeing of both mother and child.

All the Nordic countries except Iceland offer group sessions for new parents in standard infant and child healthcare to promote good parent–child relations, although there are some differences in the provision of these sessions. In Denmark, home visits in the child's first year are supplemented with group sessions at which mothers, or both parents, network with other parents and learn about the parenting role, child development and other important issues. The groups are led by health visitors and are often formed around factors that parents have in common, such as being a first-time parent, having twins, having a premature baby, special groups for fathers, and so on. Norway also includes group activities in the main programme at four weeks and at four months. In Sweden, parent groups are an integral part of both prenatal and child healthcare services and are based on a framework outlined in the national guidelines. Similarly, group activities in Finland are offered in both prenatal and child healthcare.

National guidelines

All countries adhere to national guidelines in prenatal and infant and child healthcare services, but they differ in terms of how these are implemented, to what degree, how often they are reviewed and so on. In Finland, infant and child healthcare guidelines were last issued 16 years ago (see table 3) although other recommendations and guides for infant and child healthcare have since been issued. The oldest prenatal guidelines were reported from Denmark and Iceland, but in both cases they are currently under revision. New prenatal guidelines are expected in Denmark in 2020 but the publication year for Iceland has not yet been fixed. In Sweden, revised national infant and child healthcare guidelines are expected in 2021.

	Prenatal care	Infant and child healthcare
Denmark	2009	2011
Finland	2013	2004
Iceland	2008	2016
Norway	2018	2014/2017
Sweden	2016	2015

Table 3: Publication year of national guidelines in prenatal and infant and child healthcare

The Norwegian infant and child healthcare service is based on two sets of national guidelines: the National Guideline for Postnatal Care (2014) and the National Guidelines for Health Promotion and Preventive Work in the Child and Youth Health Centres and School Health Service (2017). In both Finland and Sweden, the national guidelines are supplemented with an online National Handbook of Child Health Care, which is continuously updated with detailed instructions on how to perform the recommendations in the national guidelines. Interestingly, Finland has also issued a guide on contraindicated practices ("*vältä viisaasti*") that aims systematically to eradicate non-evidence-based, obsolete or harmful practices in healthcare services.

The countries differed in terms of the systematic implementation and practical application of their national guidelines. In Iceland and Finland, specific agencies are responsible for following up on implementation at a national level but adherence to recommendations may still vary in practice. In Denmark, Sweden and Norway, each region is independently responsible for implementing clinical guidelines in prenatal and infant and child healthcare and there is no coordinated system at the national level. In Sweden, implementation of national guidelines is the responsibility of centralized prenatal and infant and child healthcare units in each region. However, they are not strictly bound by national guidelines and may choose different ways to fulfill their legal obligations for care. Similarly, Norwegian municipalities are not bound by national guidelines in that they may perform their services differently, providing they document acceptable reasons for doing so and fulfil their legal duty of care. Thus, monitoring in Norway is not specifically focused on adherence to

national guidelines, although county governors are responsible for providing instructions and guidance to the municipalities. In Denmark, each administrative region is responsible for implementation although municipalities are responsible for implementing the recommended practices.

Child wellbeing

All the Nordic countries report a strong focus on supporting healthy emotional development in children and positive parent–child interactions. Nurses observe the parent–child relationship during routine appointments in infant and child healthcare and provide information to parents about children's social-emotional development, healthy attachment and mental wellbeing in the early years. However, it is often not defined how this information should be provided, or monitored whether or not it has been given. While all countries monitor children's social and emotional milestones at certain ages during routine appointments, some do this in a more implicit way while others have implemented systematic evaluation tools for this purpose.

Some of the countries also have systematic methods of evaluating and supporting early parent–child interactions. For example, several healthcare centres in Norway use the Newborn Behavioural Observation (NBO) method to increase parental sensitivity and understanding of infant communication signals. In Denmark, the Alarm Distress Baby Scale (ADBB) is widely used to monitor parent–child interactions, and a standard assessment of emotional problems in infancy is being pilot tested. Some Danish municipalities have also introduced NBO and Marte Meo. In Finland, the VaVu approach is widely used to support early parent–child interactions and address risk factors. Sweden and Iceland, however, have not implemented systematic approaches to monitoring parent–child interactions in standard infant and child healthcare.

If problems with children's emotional wellbeing or the parent–child relationship are identified, most countries begin by offering more in-depth guidance and counselling from nurses, sometimes in collaboration with primary care psychologists. Specialized services, such as infant mental health teams, can also be offered but the service may be limited and access may be unevenly distributed within the country. All the countries except Iceland report that they offer special courses to support the parent–child relationship within universal healthcare or social services. Usually, these courses focus on emotional attachment, mentalization and reflective responses to children's needs (e.g. ICDP, COS-P or Marte Meo). Another important factor in this context is to successfully identify and respond to barriers to sensitive parenting and care, such as parental mental illness or substance abuse. Thus, effective screening and treatment for such problems are critical in order to support healthy parent–child relationships and children's emotional wellbeing.

Family support

Support for family life varies somewhat between the Nordic countries. In Denmark, Sweden and Finland, expectant parents are offered courses in prenatal care to prepare for the parenting role, but in Iceland and Norway, universal courses in prenatal care primarily focus on birth preparation and breastfeeding. In Norway, however, the content of such courses varies between municipalities and parents can also be offered a free web-based programme that includes psychological preparation for parenthood. In general, parenting classes offer peer support, discussions and modelling of effective parenting practices. They also provide a good venue for identifying and reaching out to parents with social, emotional or substance use difficulties. In Denmark, preparation courses are primarily offered to first-time parents and can vary between regions. Some municipalities only offer courses to parents at risk, and some offer no courses at all. In Sweden, there is a long tradition of parent support groups both before and after the baby's birth, dating back to 1979. The groups are intended to prepare parents for their upcoming role, facilitate social networking and offer support. They can take the form of multisectoral cooperation if necessary and can be offered on a universal level or a specified level, for example for young parents, parents with Swedish as a second language or special father groups.

In Finland, courses are also sometimes offered to mothers and fathers separately. According to the government decree on prenatal and infant and child healthcare services, all families expecting their first child should be offered multidisciplinary family classes, including parent group activities and childbirth counselling. Often, these are organized by prenatal and infant and child healthcare staff, but the format and number of sessions may vary by municipality. Immigrant parents expecting their first child in Finland can be considered as first-time parents and are particularly encouraged to attend family classes. In Finland, all parents are also given a "maternity package" (also known as a "baby box") to prepare for parenthood, which includes a variety of items such as baby clothes, care products and a parent handbook ("Meille tulee vauva", or "We're having a baby") that is available in six languages and online.

The quality of the parental relationship is critical for family wellbeing, but in prenatal or infant and child healthcare, there are often few systematic attempts to identify difficulties a couple may be having. Most countries report that marital status and the parental relationship are discussed during routine visits, along with general discussions about life circumstances, but this seems to be a less highlighted area *in terms of risk* to family wellbeing except when it comes to violence. However, in Finland, a more thorough exploration of the quality of the parental relationship, including healthy communication and sex life, is available via the extensive health examination offered to both parents during pregnancy and after childbirth. This is still an area that needs further improvement in Finland, however, in that there is insufficient availability of preventive or early intervention services for couples' difficulties.

In effect, all Nordic countries have imposed legal requirements on municipalities to offer some form of family counselling but the extent of the service may differ and in some cases the demand exceeds capacity. All the countries except Iceland have also set up low-threshold, multidisciplinary family centres where preventive and early intervention services for families have been brought together under one roof. Family

centres bring together prenatal care, infant and child healthcare, open daycare and preventive social and psychological services. They often facilitate a drop-in format where prospective and new parents can come for advisory, indicative and supportive conversations with representatives of the health and social services. Sometimes, family counselling or parenting skills training is also included. The aim of family centres is to offer a comprehensive and united chain of actions in all primary services, which are adapted to family needs and influenced by users' experiences and views.

In Finland, the governmental aim is to combine all primary services in healthcare, social support, early education and care, and NGO services for children and families, in family centres as part of the national social and healthcare reform. Family centres have already been established in all Finnish regions, although work is still ongoing to change all services to the family centre model. In Sweden, there are 270 family centres. About a third of municipalities in Norway, mostly the larger ones, have "Family Houses" based on the family centre model. In Denmark, the Family House model has been introduced in two municipalities, and several others have different types of family centres in accordance with local needs. In Iceland, while there are no family centres, some municipalities have aligned their services to work together in a more intersectoral manner across education, social services and healthcare, with the emphasis on prevention, early intervention and the coordination of services.

Identification of risk factors

The importance of identifying women and children at risk of adverse health and social outcomes is highlighted in guidelines for prenatal care and infant and child healthcare in all the Nordic countries. Risk factors, such as smoking, drinking alcohol, mental health problems, violence and low socioeconomic status, are usually addressed at the first visits but this may not always be done in a systematic manner and depends on the risk factor in question. The countries also differ in terms of whether practitioners receive regular training in assessing risk factors, and in some cases follow-up or monitoring may be lacking on whether enquiries have been made about certain risk factors.

In Iceland, defined screening procedures for depression and anxiety have been implemented on a national level using the EPDS and GAD-7 during pregnancy and after the birth of a child. This includes regular training for nurses and midwives. In Finland, depression is screened via the EPDS in the second trimester and again near the end of pregnancy and after the birth. Finnish practitioners also receive regular training in assessing various risk factors. In Sweden, all regions use standard questions in prenatal care to ask pregnant women about mental health, and some use the EPDS to screen for depression. All new mothers are also screened for postpartum depression via the EPDS 6–8 weeks after a child is born and the other parent is offered an individual session focusing on mental health 3–5 months after the child's birth. In Norway, national guidelines highlight the importance of identifying women at risk for anxiety, depression and other mental health problems before and after childbirth. However, universal screening for depression during pregnancy and after childbirth is not a national recommendation. Nonetheless, several municipalities have implemented the EPDS, either universally or specified, to

screen for depression. In Denmark, the EPDS is sometimes used in municipalities that offer home visits during pregnancy and many municipalities use it to screen for postpartum depression during home visits after childbirth.

Systematic identification of alcohol and substance abuse also varies from country to country. The Danish Health Authority recommends using the TWEAK scale to screen for alcohol abuse, in addition to a locally developed questionnaire, but this is not done systematically. The same applies in Norway, where national guidelines recommend screening via AUDIT or TWEAK in prenatal and infant and child healthcare, but this may not be done systematically throughout the country. In Iceland, alcohol and substance use is only specifically addressed in prenatal care, but validated screening instruments are not used. In Sweden, women are screened for alcohol use (via AUDIT) at the first prenatal visit, but not after the child is born, although discussing these risk factors with parents is recommended. In Finland, screening for alcohol abuse via AUDIT and a substance abuse questionnaire are included in the extensive health examinations for both parents before and after childbirth.

All countries reported an increased emphasis on the detection of violence among expectant and new parents in recent years. National guidelines recommend enquiring about violence in prenatal care in all countries; however, systematic and universal screening is not always applied, and none of the countries have implemented validated assessment tools to identify violence or trauma. Also, not all countries include enquiries about violence in infant and child healthcare except if healthcare staff believe there might be a problem. Finland was the only country to report that both parents should be asked about intimate partner violence, and this is done individually during the extensive health examinations.

Accessibility of services

Most Nordic countries reported wide variations in the availability and quality of services at different locations, primarily due to the size of local communities and to the administrative autonomy of the municipalities and regions. In all the countries, more extensive services (e.g. for mental health problems or substance use) were provided in larger urban areas than in smaller rural locations. Municipalities also appear to have very different resources and priorities, and this affects their services for parents, families and young children. In other words, unequal access to quality services was reported in most of the countries.

Accessibility also depends to a great extent on the type of service in question. While basic services in prenatal care, infant and child healthcare and social services are readily available and free of charge in all Nordic countries, significant differences in the availability and cost of other services were reported, for example, family support or mental health services. In Finland and Norway, waiting lists were reported for some services in some regions (e.g. family counselling, child welfare services and specialist mental health services), while in Iceland, waiting lists are common in most services outside primary care, although pregnant women and families with young infants are prioritized groups. All countries reported geographical differences in terms of accessibility, and sometimes information about waiting lists from different services or locations was not available.

Iceland and Sweden reported good access to mental health services for expectant and new parents, especially mothers. They have universal access to both group and individual psychotherapy through a stepped-care model in primary care for mild to moderate mental distress, with more intensive or specialized options available as needed. These resources are publicly available, with short waiting lists, either for free or for a modest fee. While psychological services are also offered in primary care in Norway, availability can be limited, and not everyone has access to this service. In Finland, psychological treatment is not universally available in primary care, although it can be accessed through referral and collaboration with other sectors, such as outpatient mental health clinics or private practice. In Denmark, psychological services are not part of the primary system either and are not free except with a referral, which is only given under special circumstances (e.g. serious illness, violence, trauma, death of a family member or significant clinical problems). As treatment for mild depression or anxiety is only available in private practice, it can involve a substantial cost although there are free internet options available.

In general, women and families struggling with alcohol and substance abuse have good access to resources in the Nordic countries. All countries reported that women with alcohol and substance abuse problems receive specialized, multidisciplinary care during pregnancy, but they differ in the scope and structure of long-term follow-up. In Iceland, follow-up and continuity of services are limited by a lack of structured cross-sectoral collaboration and unclear roles and responsibilities. It is the only Nordic country where intersectoral teams are not routinely formed around vulnerable families, and collaboration across systems is not a legal obligation. In the other Nordic countries, pregnant women and new mothers have a legal right to prompt social services to support a substance-free life, such as housing support, but in Iceland there may be waiting lists for such support and follow-up is often lacking. However, even in countries that report high quality services and good continuity of care, the availability, structure and quality of resources for substance abuse usually vary between regions within the same country, with fewer resources available in smaller or rural areas.

In Denmark, special family outpatient clinics operate in the field of mental health and substance abuse during pregnancy and the child's early years. These clinics offer extensive multidisciplinary services free of charge to pregnant women and new mothers, which can involve substitution treatment (e.g. methadone) and rehabilitation, including specialized help with socioeconomic issues and comorbidity after prolonged alcohol or substance abuse. While family clinics are mostly an outpatient service, they can be residential and include full-time care for pregnant women with alcohol or substance use problems. Children receive extensive follow-up services from the clinics in most regions until they reach compulsory school age, in order to assess and treat any developmental, neurological or psychosocial difficulties resulting from intoxication during pregnancy. Norway has also established family outpatient clinics, although there may be differences in the way they are run from one area to the next. Some, but not all, offer continuing services after the child is born. In addition, there are 18 "Parent and Child Centres" across Norway that offer a live-in service for vulnerable pregnant women. Norway also has the only competence centre in the Nordic countries that is specifically focused on the clinical assessment, diagnosis and treatment of children exposed to alcohol or drugs before birth.

Specialized units similar to family outpatient clinics are also found in Sweden, albeit

only in certain areas (e.g. Stockholm, Skåne and Gothenburg); and in Finland, pregnant women and their partners can be referred to special outpatient clinics for alcohol and substance abuse problems (HAL clinics). In addition, special homes and shelters are available for pregnant and new mothers with alcohol and substance abuse problems, albeit with regional differences in availability. The homes and shelters for mothers and children are run in close collaboration with child protection and prenatal or infant and child healthcare services; midwives and public health nurses offer home visits at the homes and shelters and participate in their parent groups. Although the growth and development of children living in families exposed to substance abuse in Finland is supposed to be followed up closely by child welfare services, primary care and specialized medical care, it has been noted that these follow-up services may currently be insufficient and need to be improved.

Denmark and Norway are the only Nordic countries where it is legal to use some form of coercive measures to prevent substance abuse among pregnant women. All municipalities in Denmark are required to offer pregnant women in inpatient care a voluntary contract that includes a detention option allowing the centres to detain a woman against her will when less intrusive measures prove inadequate. However, women are not forced to enter into the contract and they can withdraw from it at any time as long as the conditions for detention are not met. If they choose not to accept the contract, they will still have complete access to treatment. In Norway, it is legal to detain pregnant women with severe alcohol or substance abuse problems against their will if necessary, in order to prevent harm to the unborn child. However, the application of such measures is very rare as most pregnant women want to work with social services for the sake of their unborn child, even if they do not plan to raise the child themselves.

Finally, there are various services for violence and trauma in the Nordic countries, although geographic restrictions may limit access to them. For example, while all the countries have shelter services, and sometimes also specialized assault units, these may only be easily accessible in more densely populated areas. However, all the countries also reported access to hotline or internet services, which improves outreach. In Sweden, Denmark and Finland, victims of violence are offered free psychological treatment, within either the healthcare system or social services, but in Iceland and Norway, the service comes at a minimal cost. A more significant problem in Iceland, however, lies in geographical limitations and long waiting lists for trauma-based treatment.

All the Nordic countries have Children's Houses, which offer multidisciplinary, child-friendly services in cases of abuse. However, the service may not always be applicable to children under two years old. Norway was the only country to report specific prevention efforts for violence against children in prenatal and infant and child healthcare. Initiatives such as *In Safe Hands* and the *Stine Sofie Parenting Package* have been widely implemented in Norwegian health services to inform parents about how frequent fighting and yelling causes harm to young children, and to teach them helpful strategies for coping with stressful or demanding family situations.

Quality assurance

The quality of services is promoted through various means, such as staff training and supervision, guidance on evidence-based practices and regular monitoring. National guidelines and recommendations also serve to improve the quality of care and promote effective practices. However, if there is little monitoring of whether or not they are implemented, or insufficient support in terms of training and supervision, recommended practices may not always be translated into clinical service. Indeed, while all the Nordic countries have issued national guidelines and recommendations, the monitoring and follow-up of whether recommendations are implemented in clinical practice may sometimes be lacking. Since regions, municipalities and sometimes even individual providers are highly independent in terms of their service provision, it can also be difficult to draw general conclusions about how the Nordic countries ensure and support the quality of care in their services to parents and children. This also pertains to staff training, which is usually dependent on the needs and priorities of individual municipalities and regions, and thus may be quite varied from one place to another. Information about this factor is often not readily available.

Several Nordic countries have competence centres for various services, such as childhood mental health, substance abuse, parenting skills or violence and trauma. Competence centres aim to enhance the quality of services in a particular area by disseminating evidence-based knowledge, offering training and professional support, and issuing information for the public. In Denmark, family outpatient clinics assume the role of competence centres in the area of alcohol and substance abuse and their effects on young children. In Finland, the Institute for Health and Welfare (THL) operates as a competence centre in many areas within maternity and child healthcare. In addition to this, developments are underway to establish competence centres in the area of families and children with specific needs. Norway and Sweden appear to be most advanced compared to the other Nordic countries in this regard, with numerous national competence centres in a wide variety of fields. However, the independence of municipalities and regions to choose their own programmes and practices, regardless of whether or not they correspond to official recommendations, remains a challenge. Also, while competence centres may exist in certain areas, vast geographical distances can lead to unequal access to resources, such as staff training in different municipalities. As an example, Finland covers more than 300,000 km², Norway nearly 400,000 km² and Sweden more than 450,000 km². Thus, services provided by competence centres may not be accessible to all municipalities or specialist services. Iceland has not established any competence centres as such, although the aim is for the newly established Development Centre for Primary Health Care in Iceland (DCPHI) to serve as a competence centre for certain areas within primary care.

Cross-sectoral collaboration

All the Nordic countries have passed or are in the process of passing laws and implementing structural reforms to promote effective and systematic collaboration between such sectors as healthcare, social services, education and child welfare. In Denmark, an interdisciplinary team is established for all vulnerable families and, by law, a healthcare professional must be appointed as a contact person and service coordinator when support is provided by different systems or levels of service. In instances of severe problems, social workers have the role of maintaining an overview of the overall need for support and consistency of services as long as problems persist. Danish legislation also allows schools, healthcare services, the police, daycare facilities and other official agencies working in the area of vulnerable children to exchange information on private matters if this is deemed necessary as part of early or preventive collaboration on behalf of vulnerable children and to prevent abuse. In general, follow-up and continuity of services are reported to be good in Denmark.

Cross-sectoral collaboration is also statutory in Norway, and when a person or family needs long-term coordinated care, they have a legal right to a service coordinator and an individual care plan. Thus, all agencies in specialist services that offer interdisciplinary mental health and substance abuse treatment must appoint a coordinator for the assessment and treatment process. When problems call for medical management, the coordinator will be a doctor, but otherwise it can be anyone in the interdisciplinary team and usually the one with the most contact with the person or family. The person can also be allowed to choose who will be the coordinator for their care. As a general rule, the obligation to provide information takes precedence over the duty of confidentiality when considerations of life, health and social security are more important than the patient's privacy. All Norwegian municipalities are also obliged to have a coordinating unit to manage individual care plans and appoint coordinators for long-term coordinated services. All healthcare centres must also have defined routines for the necessary cooperation with relevant municipal, regional and government services. However, it has been reported that some municipalities have not established such structures and systems. Service coordinators, individual care plans and coordinating units are supposed to ensure that various service providers live up to their responsibilities to people in need of long-term coordinated services, but the reality is sometimes different.

Enhancing cross-sectoral collaboration has also been a major focus in Finland. All Finnish municipalities have multidisciplinary teams to which prenatal and child healthcare clinics have access, and which function as a link to related services, such as social services and early childhood education and care (ECEC). All institutions are required to have joint agreements with other agencies on how their services will be organized and linked together; these agreements cover screening methods, case management, contact persons, allocation of responsibilities, care pathways and staff training. There is also close collaboration between prenatal and infant and child healthcare services, which are organized so that they function as one system in a continuum across pregnancy and childhood. However, in Finland the link is weaker between primary care, including prenatal and infant and child healthcare services, and certain other sectors, such as mental health services.

In Sweden, a structured individual care plan (SIP) or a coordinated individual care plan (VP) is drawn up for families when care involves collaboration between sectors,

such as healthcare and social services, or different levels within the same system, such as prenatal care (primary care) and specialist psychiatry or gynaecology (tertiary care). These individual plans define routes for referral and collaboration between services. In Iceland, cross-sectoral collaboration has not been implemented systematically throughout the country but current legal reforms aim to make services for children and families more comprehensive and integrated, for example by dictating the roles and responsibilities of different sectors in a tiered fashion across the universal level to tertiary care. The reforms will also establish a legal right to service coordinators for those children and families who require services across multiple sectors, and will facilitate the sharing of information across agencies when necessary.

Child wellbeing in adult services

There is a growing emphasis in all the Nordic countries on considering the needs of children in adult services, such as when their parents receive treatment for mental illness or substance abuse. All countries have passed legislation that obliges service providers to ask adult clients whether they have children in their custody and, if so, take steps to secure the children's wellbeing. However, the follow-up on these practices may not always be sufficient. In Finland, family matters are required as a general rule to be considered in a holistic way; for example, when providing care to a child, the situation of the entire family should be taken into account, and vice versa. However, this is not always the case, and there is no systematic monitoring or follow-up regarding this part of adult services despite several laws addressing children's right to support. In Sweden, many regions have special children's representatives in their organizations to fulfil legal obligations regarding the child's right to information and support when their parent is receiving care. However, the organization and resources for this work vary and it has recently been revealed that, despite legal requirements, social services do not receive adequate notifications about children at risk. Thus, more work needs to be done to implement these procedures in every organization and at all care levels.

In Norway, all adult specialist services are also required to appoint special children's representatives who are responsible for securing support and follow-up for children whose parents are receiving treatment for mental illness or other problems that might affect the children's wellbeing. Children's representatives have a responsibility to be aware of all relevant services, both in-house and those offered by other systems, and to protect the children's best interests, including filing reports of concern or prompting action when needed. Despite this, reports have shown that collaboration between services for adults and services for children is often lacking and less than half of municipalities in Norway report that collaborative agreements with specialist services within different areas of mental health and substance abuse are working well. Taken together, this is an area that needs improvement in most of the countries.

Parental leave

All Nordic countries offer substantial parental benefits after the birth of a child with a specific quota for each parent, as parenting is generally seen as a gender equality issue. However, the duration of parental leave differs between the countries, with the longest in Sweden and the shortest in Iceland (see table 4), although Iceland aims to increase parental leave to 12 months in 2021. All countries also offer the option of extending parental leave over longer periods with lower benefits. Coverage of previous salaries during parental leave is quite similar in all the countries (70–80%), and all the countries have defined maximum and minimum monthly amounts. However, in Denmark, parents either receive full pay during their leave or the state benefit, which was a maximum of DKK 4505 per week in 2020. In Finland, Norway and Denmark, parents can also receive a subsidy for minding their own children at home instead of enrolling them in ECEC when their formal parental leave comes to an end.

	Duration of leave	% coverage	Home-care allowance
Denmark	12 months	N/A	Yes
Finland	12 months	70%	Yes
Iceland	10 months	80%	No
Norway	13 months	80%	Yes
Sweden	16 months	80%	No

Table 4: Parental leave, coverage of previous wages and home-care allowance

Early Childhood Education and Care

All the Nordic countries except Iceland have defined early education and care (ECEC) as a legally protected right for all children, usually from 1 year of age. In Denmark, this is effective from the age of 6½ months but it is rare that children are enrolled in ECEC before their first birthday as parental leave is still in effect during that period. Apart from kindergarten or preschool, all the countries also offer some form of daycare in private homes, which in Finland and Norway is recognized as family daycare, although the structure and take-up rate for such systems varies from country to country. In Iceland, daycare in private homes is quite common as it is currently the only system that covers the gap between the end of parental leave and the start of preschool, which can last for over a year. In Denmark and Finland, many children also attend ECEC in private homes – although not the majority of children – but in Norway and Sweden, this is very rare and the number has fallen consistently. Less than 2% of children attending ECEC in those countries are enrolled in such facilities.

In Denmark, Norway and Finland, family or home daycare follows the national ECEC curriculum, and in Sweden, the national preschool curriculum is supposed to be

indicative although not binding in home daycare. In Iceland, home daycare is not part of the education system at all, and no specific educational requirements are made regarding the content of the work. In most countries, few professional requirements are made for those working in family or home daycare, although in Finland, they are required to have some professional ECEC skills. According to the Education Act in Sweden, people working in home daycare should have experience that enables them to meet children's needs for care and provide good pedagogical activities, but data shows that in the majority of cases they have no specific training for working with children.

In Denmark, home-based daycare seems to be both quite common and professionally advanced, where childminders work under the close supervision of pedagogues employed by the municipality, who meet with them regularly, provide professional guidance and make routine visits to the home daycare location. Also, childminders in Denmark often collaborate within the local community so that children can meet and play with a larger group of children and connect with a larger group of childminders. Monitoring of the service differs between countries, but in general it appears to be rather minimal, although pedagogical supervision in Denmark is likely to contribute to the quality and safety of the service. In Sweden, the School Inspectorate conducts regular evaluations of home daycare, albeit not annually.

The terms used for the ECEC system are different in each of the Nordic countries. In this report, the term preschool has been used for Iceland and Sweden, ECEC centres for Finland, daycare centres for Denmark and kindergarten for Norway. Regardless of terminology, ECEC facilities adhere to national ECEC curricula in all the Nordic countries, although in Norway it is defined as a national framework plan for kindergartens. All the countries also report a strong emphasis on children's social and emotional development in the ECEC system and a focus on meeting children's individual needs. An interesting system has been established in Finland, where each child has an individual ECEC plan in which their individual needs for development, learning and care are defined in cooperation with their parents. Young children's social and emotional learning (SEL) is mostly promoted through routine ECEC activities in the Nordic countries, and specific SEL programmes are not widely used, especially for the youngest children, although they have been introduced in some ECEC facilities.

Some common challenges are faced in the Nordic ECEC systems. These seem to be a shortage of professionally trained staff, large group sizes, high levels of stress and a lack of budget and resources. These challenges can contribute to an environment where it may be difficult to meet children's individual needs for sensitive care, especially for the youngest and most vulnerable groups. In some cases, the legally protected right to a place in ECEC from 1 year of age, which is established in most Nordic countries, can also pose a challenge for individual ECEC centres. The obligation to register all children who have the right to a place can be at the expense of ensuring quality – for example, that staff have sufficient competence and children's group sizes are not too large. Furthermore, in most Nordic countries, salaries for preschool staff are significantly lower than the national average, which may contribute to difficulties in attracting and retaining professionally trained staff. Compared to the other Nordic countries, Iceland has by far the lowest percentage of staff who are certified preschool teachers and it was the only country to report a chronic lack of staff in general, whereas in other Nordic countries, staff shortages

mostly apply to professionally trained staff. Average salaries for preschool teachers, as a percentage of national wages, are lowest in Iceland and Finland (see table 5).

	Preschool teachers/ pedagogues (% of staff)	Percentage of national salaries
Denmark	59%	84%
Finland	N/A	76%
Iceland	28%	75%
Norway	40%	86%
Sweden	39%	98%

Table 5: Professionally trained staff (as % of all staff) and mean salary (as % of national mean wages)

Interestingly, legal requirements concerning professional training for ECEC staff do not seem to be a defining factor in this regard. For example, while Iceland and Norway have statutory requirements for a minimum ratio of professionally trained ECEC staff, these requirements have not been met in either of these countries. In fact, the highest ratio of professionally trained staff was found in Denmark, where no specific legal demands are made for staff education, and yet 60% are university educated pedagogues. However, the comparison in table 5 is incomplete because, while there are legal requirements for professional education among ECEC staff in Finland, current data on the number of university educated ECEC teachers was not available.

Finally, there are significant differences in the structure of collaboration between the ECEC and child healthcare services in the Nordic countries. While some countries have regular collaboration between these sectors, few or no ties exist between them in other countries. Finland has close collaboration between ECEC and child healthcare as well as family counselling centres, with jointly agreed methods of collaboration and information exchange. Subject to parental written consent, extensive health examinations in infant and child healthcare also include ECEC staff's evaluation of children's wellbeing, which can help with the early identification of any needs for special support. In addition, representatives from ECEC centres participate in family service networks and multidisciplinary early intervention teams at Finnish child healthcare clinics.

In Norway, child healthcare services also have defined routines for ECEC collaboration, and sometimes public health nurses from infant and child healthcare perform health examinations at kindergartens. Routine venues for collaboration between daycare and child healthcare have not been established in Denmark but network meetings are held if and when they are needed as part of general cross-sectoral collaboration. Many Danish municipalities are also currently running pilot projects in which health visitors' examinations of children at 1½ and 3 years are conducted in daycare centres. In Sweden and Iceland, no routine venues exist for

collaboration between the ECEC system and child healthcare services, and systematic collaboration between these services is rare. Thus, important opportunities for further development may be found by strengthening the links between these services, both of which play an instrumental role in securing the wellbeing of young children.



Examples of good practice

Denmark

The health visitor system

Denmark's health visitor system performs activities around health promotion and disease prevention for children and young people up to the age of 15, and their families. The system is unique because the same health visitor visits the family in their own home, including before the birth if the family is vulnerable. Families are offered several home visits during the child's first year of life, as well as consultations if the family have further needs. Health visitors also undertake health promotion tasks in the daycare system and schools, as well as acting as school nurses with responsibility for regular screenings and discussions about health. All health visitors have a relevant qualification, such as a BA in nursing, and have at least 1.5 years of further education. Almost all Danish families (98%) receive services from the health visitor system. Health visitors help to ensure children's wellbeing and development and, together with parents, contribute to the healthy upbringing of children.

Recently, 10 projects have been designed to strengthen maternity (prenatal) care, with a particular focus on vulnerable families. The projects are anchored in the health visitor system and particularly seek to strengthen the following competencies in vulnerable pregnant women: 1) the pregnant woman's ability to care for herself and her unborn child; 2) parental care for the child and preparation for the emotional relationship and parent-child attachment; 3) the ability to build and maintain a structured everyday life; and 4) concrete knowledge of the infant's needs and the skills required to meet them.

The projects are aimed at pregnant women with: 1) mental vulnerabilities (anxiety, depression, eating disorders, trauma, ADHD, OCD etc.); 2) social vulnerabilities (sparse networks, conflict-filled conditions, poor attachment experiences from own upbringing, age/mental immaturity, lack of jobs/education/finances); 3) physical vulnerabilities (diabetes, obesity, smoking, gastric bypass, fibromyalgia, back

problems, etc.); and 4) other vulnerabilities (lack of feelings or engagement in pregnancy, previous abortions/lost children, changing partners, partners in prison, etc.).

The projects aim to initiate early interventions to strengthen vulnerable pregnant women. An evaluation of the projects shows that an intervention initiated by week 20 of pregnancy strengthens the vulnerable pregnant women. Both the pregnant women and the new parents involved in the projects have talked about their increased confidence and belief in their own abilities. The vulnerable pregnant women obtain specific advice, for example on how to care for the child, communicate with it and keep eye contact while changing the baby. The projects have also focused on involving the baby's father.

Examples of the projects' offers and actions include: 1) early pregnancy home visits from health visitors, midwives, social workers and others (preferably interdisciplinary); 2) parent preparatory teaching in teams; 3) birth preparation teaching in teams (e.g. yoga or swimming); 4) therapist-run groups with a focus on particular issues (e.g. birth depression, anxiety or grief); 5) interdisciplinary networking meetings involving the pregnant woman and her partner; 6) integration of sectors (e.g. an advanced maternity counsellor, a home visit from both the midwife and health visitor during pregnancy, or the health visitor visiting the maternity ward); 7) informal networking for vulnerable pregnant women/families (e.g. at a café); and 8) referrals outside maternity care (e.g. to a job centre, educational guidance, dietician, social worker, nursery practice, physical therapy, dentistry, psychiatrist, psychologist etc).

In 1930, the infant mortality rate in Denmark was almost 8%, which was higher than the other Nordic countries. Denmark chose to address this through disease prevention initiatives, specifically by setting up the health visitor system. Health visitors educated mothers to look after their children according to the scientifically agreed principles of Calmness, Cleanliness and Regularity, and advise them on how to feed their infant properly. A three-year trial period was planned but by the end of the first year, the National Board of Health had already concluded that the visits were well received. At the end of the trial, the nurses had been welcomed into 98.8% of homes in rural areas, and in Vesterbro (a poor part of Copenhagen) the figure was 85%. This was the first time a practical attempt had been made to form the basis of a new law, the Law on Combating Morbidity and Mortality among Children in the First Year of Life. The law was passed on 31 March 1937 and entered into force the following day.

The health visitor system has a long history, having been enshrined in law since 1937, and was quickly hailed as a success due to the resulting decrease in child mortality. Since then, the health visitor system has been extended and health visitors continue to play an important role in reducing inequality. Because almost every family opens their home to the health visitor, there is no stigma attached to the service, and the health visitor's access to the family in their own home means they have a unique opportunity to guide the family on health issues, based on the family's particular needs.

Family outpatient clinics

Since 2011, all Danish regions have established family outpatient clinics linked to one

or more maternity wards. The clinics seek to strengthen regions' endeavours to prevent and treat substance-related physical, mental and social harm and diseases in children. They are intended to optimize regional health services' contribution to the efforts to help pregnant women who have harmful alcohol and substance use or whose partners have problems with alcohol and other drugs. The clinics cooperate with the municipal authorities responsible for social work and drug and alcohol treatment.

Pregnant women, their partners and all other relatives can contact the regional family outpatient clinic directly if they are concerned about a pregnant woman or her partner's consumption of alcohol and other intoxicants, or about whether a child may be harmed by alcohol or other intoxicants. General practitioners, obstetricians, midwives, health visitors and other health and social care professionals can refer pregnant women, their partners and children up to school age to the regional family outpatient clinic. Pregnant women can also attend the clinics without referral.

Family outpatient clinics offer substitution treatment (e.g. methadone) as well as rehabilitation after detoxification, which includes specialized help with physical and socioeconomic issues and comorbidities that can endure after prolonged alcohol or substance abuse. The treatment is free, and there are no waiting lists. The other parent can also receive counselling at family outpatient clinics for their own alcohol or substance use. Treatment at family outpatient clinics can extend over a long period of time, from early pregnancy until the child reaches school age. Currently, children are followed up in only three of the five regions.

Staff at family outpatient clinics consist of doctors, midwives, psychologists and social workers, who provide interdisciplinary care, prevention and treatment from as early as possible in the pregnancy. The main emphasis is on pregnancy, childbirth, and neonatal and postpartum care. After the birth, the child's physical and psychosocial development is monitored, along with the care situation, and the family is assisted with medical, psychological and social counselling. The clinics take an interdisciplinary, cross-sectoral, holistic approach, based on the philosophy that intervention, prevention and treatment must be implemented early and intensively, not only in relation to drug use but also in relation to the woman's overall life situation and physical, mental and social health, and that of her family.

Alcohol and other drug use during pregnancy can result in harm to the foetus, as well as complications during pregnancy and childbirth that risk permanent damage to the baby. Where the mother and/or father have substance abuse problems, there are additional health and psychosocial risk factors in relation to pregnancy, birth and the child's development. Pregnant women who might use drugs are therefore an obstetric high-risk group, and their children are a paediatric high-risk group. Children who have been exposed to drugs, alcohol or addictive drugs in utero have a greater risk of being born prematurely, and are often affected by many serious diseases and malformations. They are also likely to face a range of social issues, such as attachment problems, behavioural disorders and learning difficulties. In a large number of cases, the children grow up in insecure and unstable circumstances, which can worsen the consequences of these impairments. The purpose of family outpatient clinics is to prevent damage to children who have been exposed to alcohol and/or substance use.

In March 2015, COWI carried out an evaluation for the Danish Health Authority. The

main conclusions of the evaluation were that all five regional outpatient clinics were well established in the gynaecological-obstetrical departments and that the clinics were integral parts of the regional health services for the relevant target group. The evaluation also concluded that, given the degree of difficulty of the patients and issues with which the clinics work, they deliver a service that is greatly valued by the municipalities, drug centres and hospital partners. Their efforts are also appreciated by the service users. Very few women reject the offer to work with a family outpatient clinic and 95% of the women referred complete their course.

In the Health Agreement 2015-2018, it was decided that an annual quality follow-up should be carried out, including a study of quality as experienced by the service users. Generally, it has been found that service users experience the process as meaningful; mothers see helping their children as meaningful. Many confirm that the goal of security has been met. It is clear that having the same therapist throughout the process is perceived by service users as positive and reassuring.

From an evidence-based point of view, the nature of the data means that nothing tangible can be concluded about the effect of family outpatient clinics. An evaluation of the figures on the family outpatient clinic database indicates that during pregnancy the majority of the women who attend the clinics reduce or stop their use of alcohol and cannabis, by far the most frequently used drugs. There is no data regarding relapse after the end of pregnancy, however. Based on the figures on the database, therefore, it can be stated that family outpatient clinics contribute to a reduction in the drug use of pregnant women but no conclusions can be reached about the extent to which the risk or frequency of birth defects is reduced as a result of the clinics.

Finland

VaVu – Supporting parent-child interaction in basic-level work

Supporting Parent-Child Interaction (varhainen vuorovaikutus, VaVu) is a universal form of early support that is primarily intended for healthcare professionals working with pregnant and post-natal women and young children (under 3 years old) and their families. The method is based on the results of studies on the benefits of the early identification of psychosocial risk factors and supporting interactions between the parents and child. The method is influenced by resource-oriented, systems theoretical, constructive and cognitive-behavioural philosophies. The training programme also includes research and practical procedures concerning the psychological development of small children and their early interactions. The method is based on an international project in which similar methods were developed and studied.

The method provides information and tools for supporting the psychological development and health of the child and the interaction between the parent and child, increasing the resources of the family and developing their own problem-solving abilities. The VaVu method gives healthcare professionals an opportunity to develop their own interactions, their skills in supporting the interaction between the parent and child and their ability to help parents in making changes. The duration of VaVu training program is two years, and it consists of basic training, further guidance and supervision for using the VaVu method and regular group meetings. The interview forms used are: Prenatal early interaction support interview; and Postnatal early interaction support interview.

The purpose of an early interaction support interview is to promote the ideal progress of early interaction between the child and the parents. The themes of the interview forms are designed to help identify and discuss any perceptions, worries or possible issues related to pregnancy, childbirth and the baby, and to assess the need for support. The forms also help in assessing the resources of the family and the help that is available to them, and finding solutions. The preferable location of the interview is the family home, with both parents present. The ideal times of the prenatal and postnatal early interaction support interviews are during the final three months of pregnancy (weeks 27–40) and 4–8 weeks after childbirth, if possible.

Some studies indicate that there is lower occurrence of mild depression among mothers who participate in the method and that the observed interaction between mothers and children is better than that between mothers and children who participate in conventional maternity and child health clinic activities without the VaVu intervention. VaVu has established its permanent role as a method used in maternity and child health clinics. The method is cost-efficient. It is commonly used in maternity and child health clinics throughout Finland. There are thousands of professionals trained in basic and specialised healthcare, day care and social welfare services. The VaVu interview forms are used as the basis of a structured assessment method for nurses and physicians, to be used at appointments to assess the interaction between 0–18-month-old children and their parents.

The quality of the interaction between the baby and the parent can be assessed by observing the behaviour of both parties (behavioural level), emotions expressed in the interaction (affective level) and whether the parent and baby share interaction and a mutual understanding about each other (psychological level). Both the prenatal and postnatal interviews can be considered small steps towards helping parents talk about the joys and worries related to the baby and their family. The interviews can also help parents seek help for their own health issues. It is particularly important to assess whether the mother experiences any symptoms related to anxiety or depression.

Extensive health examinations

The majority of Finnish children and families are doing well. Finland also has new concerns, however, around mental health problems, alcohol misuse, domestic violence, psychosocial problems, lack of family time, divorce and unemployment. Research evidence^{460 461 462} shows that parental mental illness, problems in couples' relationships, unemployment, alcohol misuse, smoking and domestic violence have an impact on children's health and wellbeing. Finland's legislation on maternity and child health care (e.g. Health Care Act 1326/2010⁴⁶³, Government Decree 338/2011⁴⁶⁴) focuses on health promotion, preventive work, the empowerment of parenthood and targeted support for those who need it. Practical experience has also revealed the need for new innovations such as extensive health examinations in the context of primary health care.

During the normal course of a pregnancy, an expectant mother will attend a maternity clinic eight or nine times and will be examined twice by a physician. These visits also include an extensive health examination for the whole family⁴⁶⁵. After childbirth, women have two health examinations. Additional visits are scheduled as required⁴⁶⁶. Between the ages of 0–6 years, a child has at least 15 visits with a public health nurse at the child health clinic, five of which are also attended by a physician. There is frequent monitoring during the first year of an infant's life, including nine scheduled health examinations. These visits include three extensive health examinations for the whole family. Extra visits are arranged if there is any need for follow-up⁴⁶⁷.

According to Government Decree (338/2011), at least one extensive health examination is provided at a maternity clinic for the family expecting a baby. In addition to this, there are three extensive health examinations for the family at the child health clinic when the child is 4 months, 18 months and 4 years old. Extensive health examinations include an assessment of the health and wellbeing of both

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465. Government Decree 338/2011 on maternity and child clinic services, school and student health services and preventive oral health services for children and youth. In Finnish: www.finlex.fi/fi/laki/alkup/2011/20110338
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parents and the entire family. The five main themes for discussion and assessment for support are: 1) parents' health and wellbeing; 2) the family's internal interaction and structure; 3) living conditions and social support; 4) the child's health and wellbeing; and 5) siblings' health and wellbeing. Discussion helps to identify the strengths and resources within each family and how these can be built on. The five themes are discussed on the basis of the support needs of the family. Following a health visit, an additional visit can be arranged later if needed, to continue the discussions^{468 469}.

According to research evidence^{470 471}, frequent health examinations allow the need for special support for children and families to be detected. Since the Government Decree (338/2011) entered into force on May 2011, municipalities have been required to provide a new kind of health examination for their families with small children. According to a nationwide survey⁴⁷², most municipalities provide services that are mainly in line with legislation, and most parents in Finland are satisfied with the services provided by maternity and child health clinics^{473 474}. Evidence reveals that parents have benefited from the extensive health examinations in terms of empowerment⁴⁷⁵. International study evidence shows that parenting support, for example, increases mothers' self-esteem and reduces anxiety and stress levels^{476 477 478}. More information is still needed about the content and benefits of the extensive health examinations provided in the maternity and child health clinics.

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Iceland

Midwives' home visits after childbirth

All new mothers in Iceland are offered frequent home visits from midwives in the first days after giving birth, and after this the family is visited by a nurse from the infant and child healthcare system. The exact number of visits varies depending on factors such as the length of hospital stay after childbirth and the presence of risk factors but, unless they need specialised around-the-clock care, all mothers are offered between five and eight visits in the first 10 days after hospital discharge. The service is tailored to individual needs in collaboration with the mother, on a case-by-case basis. The average duration of each visit is one hour.

The home visiting service was first introduced in 1993 on the premise that most women do not need a long hospital stay after birth if there are no complications, but instead benefit from support and guidance in their own homes according to their needs. Women are generally more secure in their home environment, with their own support system on hand, than in clinical settings such as hospital. Being "on their own turf" supports their self-esteem in the parenting role and gives them the opportunity to learn to take care of the infant in the home environment. It also gives the other parent and the new baby's siblings an earlier opportunity to take part in the care of the new family member and bond with him or her. Issues of sibling jealousy can be mitigated if the older sibling can take some part in the baby's care as early as possible. The midwives see themselves as guests in the family's home and are happily received as such. They have a chance to witness and support the family bonding in the home and initiate support as needed.

In its first year, only 2.5% of women giving birth at the National University Hospital opted for the service and the earlier hospital discharge associated with it. Since then, numbers have grown steadily and in 2012, over 77% of all women giving birth nationwide received this service. The midwives who offer home visits work as contractors for the national health insurance system but they may also work at the healthcare centre where the family receives prenatal and infant and child healthcare. Thus, while the midwifery service is not part of the Icelandic infant and child healthcare system as such, the services are integrated and are sometimes even delivered by the same health professionals. The midwifery service is free and optional for all families.

In preparation for their home visits, midwives receive information about the health of mother and baby from the hospital maternity unit, including written information about the birth, the hospital stay and any risk factors. Midwives are obliged to keep records of their home visits, which they deliver to the healthcare centre that takes over the service once the midwifery service is no longer involved. At that point home visits still continue, and two or three additional visits are offered by nurses in infant and child healthcare services until the child is 6 weeks old.

The Directorate of Health in Iceland has issued special guidelines for midwives that outline professional, evidence-based criteria to ensure the quality and safety of the service during home visits. An emphasis is placed on delivering the service in an individualized way, meeting women and families with friendliness and respect,

considering families' different cultural, religious and ethnic backgrounds, accommodating special needs and offering information and guidance to women and families that encourage health, wellbeing and self-confidence in the parenting role.

The home visits include examinations of the child's growth and development, as well as guidance on issues such as breastfeeding, infant behaviour, cognitive stimulation, safety in the home, caretaking and emotional bonding with the baby. There is a focus on the mother's physical and psychological wellbeing and the life changes that a new baby brings to the family. If two parents take care of the infant, the emphasis is on including them both. The midwife also assesses the social support available to the family and helps them to recognize the support they have available to them. A large part of the service involves monitoring the physical health of both mother and child, as the symptoms of some serious issues might not have presented themselves at the time of an early hospital discharge. In such cases, the midwife guides the family to additional services if needed.

Research indicates that frequent home visits have a positive influence on parent–infant attachment, breastfeeding, maternal wellbeing, family communication and participation in caring for the infant.⁴⁷⁹ In general, women and families have positive attitudes towards the service and regard it as one of the main benefits of early hospital discharge. Additional benefits for society are seen in lower healthcare costs resulting from early discharge.

Universal screening for depression and anxiety

In recent years in Iceland, an increased focus has been placed on the prevention and early detection of mental health difficulties during pregnancy and the child's early years. The Edinburgh Postnatal Depression Scale (EPDS) has been used since 2000 to screen for postnatal depression in infant and child healthcare in the capital area, and this has been followed by screening in an increasing number of healthcare centres around the country. Initial protocols for the screening of postpartum depression were developed in 2005 and linked to the Icelandic national guidelines for infant and child healthcare in 2009. In 2016, Iceland's first Mental Health Policy and Action Plan passed through congress with a special focus on strengthening mental health services in primary care. In the ensuing years, the number of psychologists in primary care has multiplied, bringing significant service benefits to the prenatal and infant and child healthcare that is provided within the primary care system. Most Icelandic primary healthcare centres now offer pregnant women and new parents psychological treatment for mild to moderate problems.

Around the same time, the Development Centre for Primary Health in Iceland (DCPHI) began forming standardised procedures for the screening of anxiety and depression among women in prenatal and infant and child healthcare services, as well as a stepped-care treatment protocol, which has now been adopted by most healthcare centres around the country. In 2016, universal screening among pregnant women was implemented in all prenatal services, and two years later the same procedures were implemented for new mothers in infant and child healthcare. To support nationwide implementation, the DCPHI offers regular training courses for midwives and nurses on screening methods and giving clinical support to women in

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their care.

The screening process is based on recommendations according to the NICE guidelines (2014)⁴⁸⁰ and involves asking all pregnant women two questions about depression (Whooley questions) and two about anxiety (GAD-2) at their first prenatal appointment. If they respond positively to any of these questions, the GAD-7 scale and Edinburgh Postnatal Depression Scale (EPDS) are administered for further assessment. At the 16-week prenatal appointment, the EPDS and GAD-7 are administered in full. During the first home visit from a nurses in infant and child healthcare within 14 days of the child being born, the two Whooley questions and GAD-2 are again administered, followed by the EPDS and GAD-7 if needed. Finally, all new mothers are screened for depression and anxiety, using EPDS and GAD-7, during the 9-week infant and child healthcare appointment.

According to a stepped-care protocol for the treatment of depression and anxiety during pregnancy and after childbirth, the first step if problems are detected is to offer more frequent appointments from a midwife or nurse, with guidance and supervision from the healthcare centre's psychologist. The next step is a referral to short-term transdiagnostic CBT group therapy, led jointly by a midwife and a psychologist. The third step involves collaborating with the healthcare centre's GP and/or psychologist for further evaluation of clinical problems and individual treatment needs. The fourth and final step is to issue a referral to a hospital psychiatric inpatient or outpatient unit for further evaluation and treatment.

The purpose of universal screening during pregnancy and after childbirth is the early identification and good management of mental health problems, in order to support quality of life and family wellbeing. A multidisciplinary team consisting of nurses, midwives, GPs and psychologists in prenatal and infant and child healthcare collaborate to provide the necessary psychological support or treatment as indicated by the severity of the symptoms. Early detection and intervention for mental health difficulties serves to support the wellbeing of mother and child during this sensitive period, and prevent the escalation of problems. As the mother's mental health and wellbeing significantly influences her ability to care for and bond with her baby, it is imperative that any problems are identified and treated as early as possible. A critical component, therefore, is the easy access to evidence-based treatment in a stepped care fashion. The availability of mental health services in primary care is a key factor in this regard but if more serious or complex mental health difficulties are detected, women are referred to specialized services and appropriate psychiatric care.

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Norway

Improved Interdisciplinary Efforts

Improved Interdisciplinary Efforts (Bedre Tverrfaglig Innsats; BTI) is a collaborative framework for use in municipalities to improve the work done within and between services aimed at pregnant women, children, young people and families. The model is a tool for organizing services and implementing measures. It outlines how to address, talk about, discuss, make decisions about and implement measures if there is any concern about pregnant women, children, adolescents or families.

The model describes health-promoting and preventive efforts, by detecting and following up challenges as early as possible in the risk process. It helps to address challenges that can arise from a factors such as conditions in the home, the child's characteristics or the environment around the child. The model can be used at both individual and system level. BTI consists of three main components:

1. **An action guide** for municipal employees, which describes specific procedures, routines and tools at four levels. The individual municipality prepares its own action guide, based on existing measures and routines with which it is satisfied. Therefore, the development work always starts with the municipality mapping its own measures, actions and cooperation forums. The four levels are as follows:

Level 0 describes how an employee who is concerned about a child can clarify with the people involved whether there is a reason for action

Level 1 describes the start-up and implementation of appropriate measures/ actions within the service involved

Level 2 describes how to organize collaboration when two services need to collaborate with users

Level 3 describes more comprehensive interdisciplinary collaboration between several services.

2. **A log**, which is created for the individual child/parent. (The log is changed to an IP when particular legal requirements are met.)
3. **A coordinator**, or "relay guard", who is appointed to take responsibility for coordination.

The purpose of the BTI model is to ensure that actions conducted for the individual child, pregnant woman or parents are properly coordinated. The model highlights the benefits of early intervention so that services can be coordinated with participation from the user group. It provides an overview of the course of action taken, and may help to correct any problems that arise in the interaction between services at local, regional and state levels.

BTI is suitable for collaboration across professional groups and sectors. It can contribute to a mutual understanding of each other's tasks, so that efforts and responsibilities are better coordinated for pregnant women, children and families at risk. The BTI model is effective because each municipality can decide its own content and design its own processes between sectors and services. It is a framework that

helps the municipality to identify strengths and weaknesses. Based on this, the need for competence, routines, measures and meeting places can be planned.

Further reading:

<http://tidliginnsats.forebygging.no/Aktuelle-innsater/BTI/>

The report, "Experiences with BTI in Eight Key Municipalities":

https://www.korusoslo.no/wp-content/uploads/Rapport_BTI_Nokkelkommuner.pdf

The training programme: Early Intervention

Evidence shows that pregnant women and parents who are struggling with mental challenges or drug and/or alcohol use, or who live in families with violence, can expose the child to stress and injury. Pregnancy and the early years are an important period for brain development, psychological and/or social development. The competence centres (KoRus, RBUP/RKBU, RVTS and the Office for Children, Youth and Family Affairs (Bufetat)) have created a joint training programme for services and professionals in the municipality. The Early Intervention Training Programme (Tidlig Inn) includes specific tools, conversation methods and exercises to strengthen individual skills. Recommendations related to cross-sectoral interactions, guidelines and the exchange of experience between services and professionals are also included. The training programme uses motivational interviews as a method of establishing dialogue about sensitive topics. The goal is to identify risk and motivate for change.

An important topic in the programme covers monitoring and talking with pregnant women and parents about alcohol, mental health difficulties and violence in close relationships. Talking about sensitive topics and identifying risk factors can be a challenge for services. The Early Intervention training programme is a national initiative, funded by the Norwegian Directorate of Health and the Norwegian Directorate for Children, Adolescents and Families. The goal is to empower practitioners in sensitive conversations and increase the likelihood of identifying risks and providing early intervention to pregnant women and families. Competence in identifying and conversing with pregnant women and parents about alcohol use, psychological difficulties and violence will increase the likelihood that the goals of early intervention will be achieved. A total of 163 municipalities have so far participated in the training programme.

Improved Interdisciplinary Efforts and the Early Intervention training programme complement and support each other. Improved interdisciplinary efforts provide an organizational framework that emphasizes processes and relationships between the municipal services, and complement it with knowledge and practical work. Early Intervention provides employees in services with tools and methods to ensure better skills. Overall, improved interdisciplinary efforts and early intervention will increase the quality of a comprehensive and coordinated service and enable it to identify risks and implement appropriate measures.

Further reading:

The training programme - Early In

<https://munin.uit.no/handle/10037/6704>

<https://www.nkvts.no/content/uploads/2015/08/asporeomvoldvedsvangerskapskontroll.pdf>

Evaluation of the training programme "Early In
www.nkvts.no/content/uploads/2015/08/asporeomvoldvedsvangerskapskontroll.pdf

Sweden

Support through parental groups

All expectant and new parents in Sweden are offered early parenting support by professionals working in prenatal and infant and child healthcare clinics. Parenting support aims to strengthen parenting skills, promote social-emotional development and support parents in their role. In addition to individual support offered through dialogue with professionals during health visits, this is achieved through specific parental group sessions (both universal and selective)^{481 482}. Typically, parental groups have four or five one-and-a-half hour sessions, for between four and seven couples. The midwife or child health nurse is the group leader, but they might invite other professionals as well (for example from psychiatry, infant and toddler care, social services, child psychiatry and obstetric care). The group sessions usually start during the 20th week of pregnancy and end when the child is 11 months old. Some regions offer specific group sessions and groups for fathers. Today, parenting support may also be offered in fewer sessions in bigger groups, in the form of theme-based open groups or big-screen lectures. Web-based knowledge about parental support is provided for parents at www.1177.se/gravid and for professionals at www.rikshandboken-bhv.se.

The work of the parental groups is based on a framework outlined in the national guidelines, and includes themes such as the stages of pregnancy, preparations for becoming a parent, giving birth, the infant, parenthood, healthy lifestyle habits, rights to childcare, family counselling, social services⁴⁸³, becoming a family, the infant's needs, nutrition, growth, wellbeing, daily life with an infant, child security, language and play⁴⁸⁴.

According to Sweden's national strategy for parenting support, the goal is for all parents to be offered parenting support throughout the child's upbringing⁴⁸⁵. Parental education for all parents has been part of prenatal and infant and child healthcare since 1979, when it was determined by the Swedish parliament⁴⁸⁶. The intention behind making parental education available to all was to improve children's living conditions through educational efforts, and to make children a common responsibility for all of society. According to the guidelines for prenatal and infant and child healthcare, the goal is to promote children's health and development by focusing on and strengthening parental development and parents' ability to meet the needs of the expected and newborn child.

481. Swedish Society of Obstetrics and Gynaecology (SFOG). Mödrahälsovård, sexuell och reproduktiv hälsa [Maternal Health Care, Sexual and Reproductive health]. Stockholm: Swedish Society of Obstetrics and Gynecology (SFOG); 2016 (2008). Rapport 76 (cited 2019-07-13). Available from: <https://vardgivarguiden.se/globalassets/kunskapsstod/bmm/sexuell-reproduktiv-halsa.pdf>

482. Swedish Paediatric Society. Föräldrastöd [Internet]. Stockholm: Inera AB (cited 2019-01-03) Available from: Föräldrastöd <https://www.rikshandboken-bhv.se/metoder--riktlinjer/foraldrastod-i-grupp/forslag-pa-foraldragruppernas-innehall/>

483. Swedish Society of Obstetrics and Gynaecology (SFOG). Mödrahälsovård, sexuell och reproduktiv hälsa [Maternal Health Care, Sexual and Reproductive health]. Stockholm: Swedish Society of Obstetrics and Gynecology (SFOG); 2016 (2008). Rapport 76 (cited 2019-07-13). Available from: <https://vardgivarguiden.se/globalassets/kunskapsstod/bmm/sexuell-reproduktiv-halsa.pdf>

484. Swedish Paediatric Society. Föräldrastöd [Internet]. Stockholm: Inera AB (cited 2019-01-03) Available from: Föräldrastöd <https://www.rikshandboken-bhv.se/metoder--riktlinjer/foraldrastod-i-grupp/forslag-pa-foraldragruppernas-innehall/>

485. Socialdepartementet. En nationell strategi för stärkt föräldrastöd. 2018. Stockholm: Socialdepartementet. www.regeringen.se/4a6017/globalassets/regeringen/dokument/socialdepartementet/barnets-rattigheter/en-nationell-strategi-for-ett-starkt-foraldraskapsstod-webb.pdf

486. Regeringens proposition 1978/79:168. Föräldrautbildning och förbättringar av föräldraförsäkringen med mera. Stockholm: Regeringskansliet, 1979

Sweden's prenatal and infant and child healthcare is a free-of-charge service offered to all children aged 0–5 years. Almost 100% of families agree to participate in the services offered⁴⁸⁷, with almost 77% of all expectant parents participating in a parental group in 2018⁴⁸⁸. This indicates that the service is of relevance for future and new parents and has a high rate of acceptance among them. Parents who participate in parental groups report that they feel strengthened in their parental role and appreciate the opportunities to meet, socialize and network with other parents⁴⁸⁹. The individual supportive relationships built between professionals and parents in these sessions are also an important foundation in case further interventions in the parent–child relationship are needed.

487. National Board of Health and Welfare, NBHW (2014) Vägledning för barnhälsovården. (In Swedish) English translation by the author: Guideline for child healthcare]. Stockholm: National Board of Health and Welfare.

488. The Swedish Pregnancy Register (SPR).The Swedish Pregnancy Register year report 2018 (Graviditetsregistrets årsrapport 2018). Solna: Karolinska University Hospital [cited 2019-09-30] www.medscinet.com/GR/uploads/hemsida/dokumentarkiv/2018%20GR%20årsrapport_2.0.pdf

489. *The Journal of Perinatal Education*, 28(1), 19–27, <http://dx.doi.org/10.1891/1058-1243.28.1.19>

