Prioritising infant mental health: a qualitative study examining the role of education and training to infant mental health service development in Scotland

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Abstract

Purpose – *Despite the long-established importance of infant mental health, internationally this has not been mirrored in the provision of infant mental health services. Within Scotland in the UK, there has been significant recent government investment in developing infant mental health services. However, existing research identifies a massive knowledge and skills gap that could create barriers to implementation. This study aims to use qualitative methods to consider the views of relevant professional stakeholders on education and training within infant mental health.*

Design/methodology/approach – *The authors completed semi-structured interviews with 14 professional stakeholders working in a health board in Scotland. This study used purposive sampling to include a broad range of professionals across health and social care services and analysed the resulting data using Braun and Clarke's (2006) methodology. This study adopted a reflexive stance throughout, including the research team interviewing each other as part of the process.*

Findings – *Within the theme of education and training, we identified four sub-themes. These included roles for public health and societal education, training for parents, training for professionals and increasing professionals' experience of infant mental health.*

Originality/value – *The issues identified are relevant in any area of the UK or internationally in considering the role of education and training in developing and maintaining new infant mental health services. Further research with families and with wider groups of professional stakeholders would be of further benefit.*

Keywords *Education, Training, Public health, Professionals, Multidisciplinary, Infant mental health*

Paper type *Research paper*

(Information about the authors can be found at the end of this article.)

Introduction

Despite it being long-acknowledged that the mental health of infants is important, there have been challenges in mirroring this within provision of infant mental health (IMH) services. Existing research has identified concerns regarding the extent to which current training provision can enable the provision of a mental health service for infants. For example, in a survey of UK NHS clinicians working in services for patients under the age of 18 years, the Parent Infant Foundation (2021) described a "baby blind spot" in training for professionals. Their findings noted that both pre- and post-qualification training were significantly more likely to focus on the needs of school-aged children. Clinician groups varied in the degree of training they had received: 63% of psychotherapists working with children and young people said they had received "a lot" of training on the needs of infants,

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compared to 15% of psychiatrists and 12% of psychologists. Respondents generally rated both their understanding and their confidence in working with infants and their families at low levels. This lack of training and experience among professionals is despite evidence internationally illustrating the important role of training in enhancing clinicians' understanding and skills within IMH. A Michigan-based study (Shea *et al.*, 2016) of community-based IMH professionals found training on reflective practice for practitioners and supervisors to improve their practice in working with infants and their families.

Similarly, a study by Hughes *et al.* (2019) based in Northern Ireland found that IMH training for professionals in related areas improved their knowledge and self-efficacy in working to meet the mental health needs of infants.

Training and education for professionals sits within a wider context of public health and society as a whole. The Centre on the Developing Child at Harvard University (Centre on the Developing Child, 2021) identify a role for policymakers in improving outcomes for children and families. This includes supporting responsive relationships including parental understanding of IMH, reducing sources of stress for infants and families and strengthening core life skills.

In this paper, we focus on Scotland because, in a small country with a population of 5.5 million, £50m has been invested into the development of new perinatal and IMH services by the Scottish Government over four years (The Scottish Government, 2005), overseen by a Perinatal and Infant Mental Health Programme Board (PIMH-PB). The PIMH-PB Delivery Plan has outlined plans for implementation (The Scottish Government, 2005) that include an aim that staff from all sectors and professions working in both universal and specialist IMH services will have training and skills acquisition around IMH (The Scottish Government, 2005). According to the Parent Infant Foundation survey findings, there is therefore likely to be a massive skills gap that could create barriers to the implementation new IMH services. To understand and address that gap, we used qualitative methods to consider the views of relevant stakeholders on education and training in IMH.

Methods

Study design

This qualitative study involved semi-structured interviews with key stakeholders involved in the development of IMH services within NHS Lanarkshire, a large NHS Board area (with both urban and semi-rural areas), in Scotland, and one of the first to implement the development of new IMH services. We have previously found (Turner-Halliday *et al.*, 2018) that qualitative methods are helpful in building partnerships between participants that can be useful in supporting service development. Whilst the current research stage involves individual interviews, the research team plans to bring participants together in focus groups at a later stage with the aim of gaining a better understanding of differing perspectives and the reasons for these, potentially leading to the development of shared goals. For the study as a whole, we devised two overarching questions to address through the interviews:

Q1. Why is it challenging to build IMH services, despite the fact that we know that the baby's brain is developing so rapidly? and

Q2. How do the professional and personal childhood experiences of stakeholders influence views about new IMH services?

This paper solely focuses on themes regarding education and training while other papers (including Weaver *et al.*, 2022) focus on other aspects.

Ethics approval was granted by the University of Glasgow, College of Medical, Veterinary Life Sciences (reference: 200200026).

Recruitment

NHS Lanarkshire was one of two health boards within Scotland identified by the Perinatal and Infant Mental Health Implementation Programme Board of the Scottish Government as a pilot site for developing IMH services. To support the new developments in Lanarkshire, a multi-agency Lanarkshire Infant Mental Health Stakeholder Group was convened with 31 members, including professionals from a range of backgrounds related to IMH, including health, social care, education and the third sector. We used purposive sampling, from this Stakeholder Group, to identify initial participants to interview from a range of professional backgrounds. Subsequent participants were identified from the Stakeholder Group in an iterative way, based on the findings of the previous interviews. The process was continued until no further themes or sub-themes were identified in the analysis stage.

Eighteen potential participants were contacted by email by one of the researchers (AM) to provide preliminary information on the research project including a participant information sheet. Follow-up researchers (FP, FM and AW) with potential participants. This included forwarding consent forms including to partake in up to three interviews or focus groups, each up to 2 h in duration. Four potential participants were excluded at this stage as each did not respond to two follow-up emails. All 14 individuals who did respond provided informed consent to take part in the project.

Participants

The 14 participants included in the study were professionals from a range of backgrounds and training experiences within NHS Lanarkshire including many working previously in different health or social care professions. The professionals involved included Child and Adolescent Mental Health Services, nursing, social work, neonatal and educational psychology, general adult and perinatal psychiatry, early years care, health improvement, the third sector and a retired medical manager with a background in general practice. The sample comprised 12 female and 2 male participants.

Data collection

A topic guide for semi-structured interviews was developed by the research team. This included broad prompts in keeping with our two overarching research questions. The topic guide was designed to be purposefully conversational in nature, with prompts designed to encourage participants to identify areas of relevance from their own perspectives.

Each interview was conducted by two researchers (all female; varied pairs, comprising FM, FP and AW). FM and FP were doctors training in Child and Adolescent Psychiatry and AW was a medical student. In each interview, one researcher would have a “guide” role, asking broad questions of the participant in keeping with the topic guide. The second researcher would adopt an “enquirer” role, including asking the participant to elaborate, to clarify points or to ask follow-up questions, and to notice any non-verbal communication. The interviews were conducted and audio-visually recorded via MS Teams, and then transcribed and stored in anonymised form. Participant names were not used beyond this stage, and this anonymised form was then used throughout later stages of the study, including the write-up. Interviews lasted between 46 and 60 min (mean length: 54 min). No non-participants were present during the interviews, and no repeat interviews were carried out. Transcripts were not returned to participants; however, participants were asked if they would like notification of any later publications. All participants who were quoted in the results section by job title (which may lead to their identification by others) were provided with a full copy of the paper at the draft stage to ensure their consent.

Analysis

Data was analysed thematically using Braun and Clarke methodology (Braun and Clarke, 2006). All of the researchers independently analysed the initial two transcripts. Following this, the researchers then collectively discussed their identified themes and any differences in themes and in their application of the Braun and Clarke methodology with consensus agreed. Following this, two further transcripts were independently analysed by multiple researchers (FM, FP and AW) and initial themes compared, with high levels of consensus found.

Three researchers (FM, FP and AW) then independently constructed a coding table of themes based on the completed interviews. FM, FP and AW subsequently met to produce one joint coding table, which was consistent with the individual coding frames prepared. Following consensus across the initial four papers, each of the remaining transcripts was coded independently by one of the researchers (FM, FP or AW).

Reflexivity

Before commencing the participant interviews, the research team interviewed each other using the same topic guide as was later used with participants. This was analysed by multiple researchers using Braun and Clarke methodology and considered in light of the themes identified in the initial participant transcripts. The researchers did not have any established relationships with the study participants prior to the study's commencement.

Before each interview, the pair of researchers taking part met for 15–30 min to discuss, reflect on and note any assumptions or possible biases they held about the participant's possible perspectives on the topic. Through email contact in organising the interviews and in introductions at the beginning of the interviews, participants became aware of the interviewers' roles within Child and Adolescent Psychiatry and/or as a medical student.

Results

Six major themes were identified within the interview transcripts (see Figure 1). This paper focuses solely on the theme of education and training, whereas other themes are considered in other publications. Four main sub-themes were identified within the education and training theme. These included *public health and societal education, training for parents, training for professionals* and *increasing professionals' experience of infant mental health.*

Public health and societal education

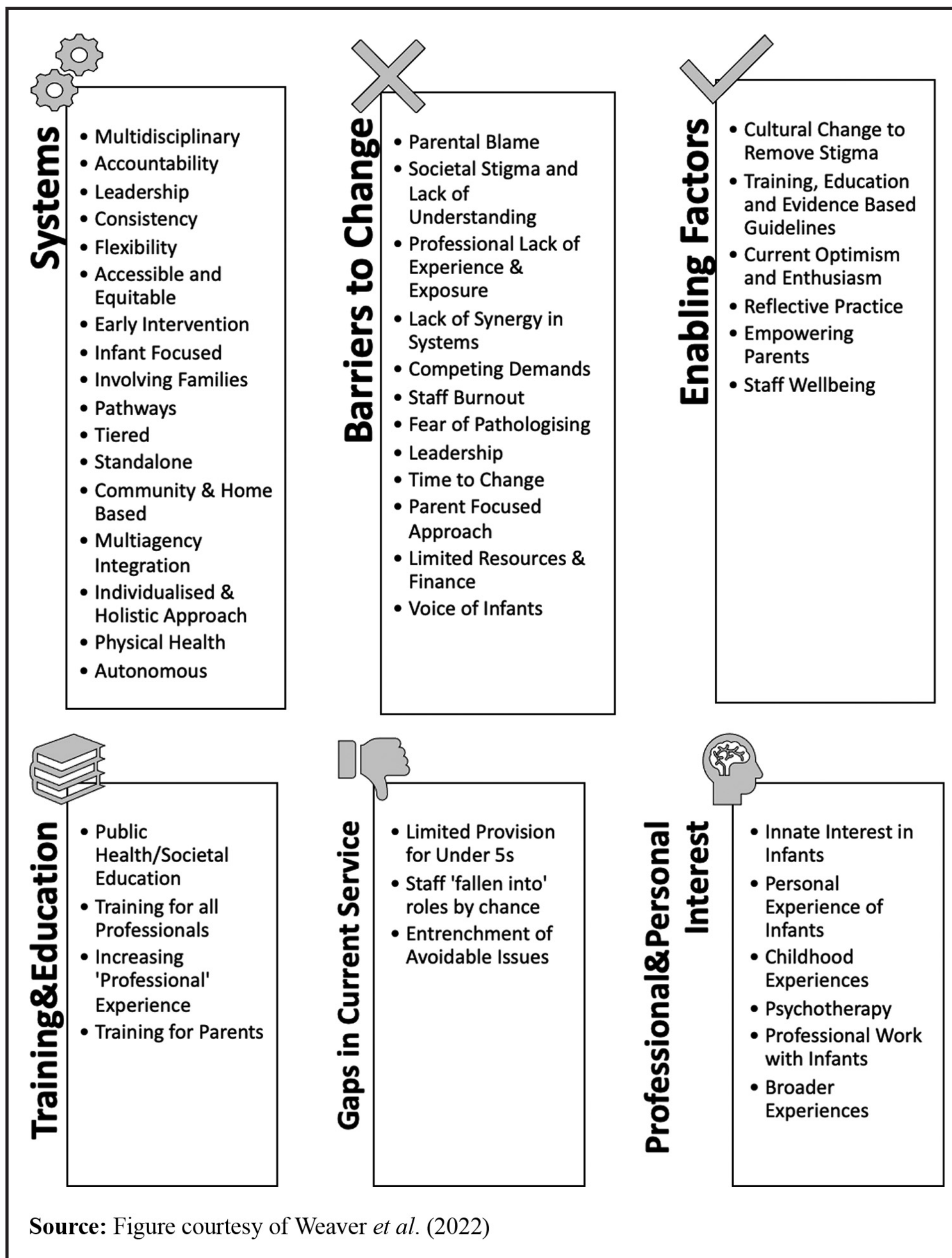
The first of these sub-themes, public health and societal education, was identified by 11 of the 14 participants interviewed. This mirrored discussion of this topic within the research team, with four of the six researchers discussing this theme in their reflexive interviews.

Eight participants drew emphasis on the need for a broadly more infant focused society. For example, a consultant psychiatrist noted:

> *I still think as a society that we are not really attuned to children's needs at all, we expect children to behave in a kind of quite uniform way and fit into a uniform system, because people that succeed probably do*'.

The majority of participants considered that IMH services require a wider societal cultural change in this regard, rather than just the development of a separate IMH service. Three participants identified a role for government level change, including education for political leaders. One participant regarded societal change as influential in the allocation of government funding.

Figure 1 Barriers and enablers to IMH service development in Scotland



Source: Figure courtesy of Weaver *et al*. (2022)

Some participants considered that infants are not seen as individuals in their own right, but as extensions of their mothers. A consultant child and adolescent psychiatrist identified a lack of societal awareness on:

> *[. . .] people's perception of the level of need [. . .]. Because in infant mental health, that's an emergency for the baby, you know, and days and weeks and months matter when you are 6 months old [. . .].*

Two participants identified feeling that society does not associate mental ill-health with infancy, and perceived a role for increasing public awareness of this.

Three participants commented on societal change surrounding IMH taking time, with comparisons made to other public health agendas including reducing smoking. One of these participants identified a role for generational change and education through schools as a mechanism for this.

Participants as a whole linked improved IMH in a bidirectional way with positive and long-term effects on society. An educational psychologist participant reflected:

> *[. . .] it makes a difference to CAMHS, [Child and Adolescent Mental Health Services] it makes a difference to people's life expectancy, it makes the difference to just living next-door each other, it makes such a difference [. . .]*

Training and education for parents

The sub-theme of training for parents was identified within 9 of the 14 interviews. This sub-theme was also included within three of the six reflexive interviews carried out with the research team.

A key aspect of this sub-theme identified by four participants and mirrored in reflexive research-team interviews was that a majority of parents know their infants well and want to do what is best for them. A neonatal psychologist participant reflected on training for parents as introducing an infant to parents as an individual "whole person" and noted:

> *[. . .] ultimately parents do want what's best for their children, they just don't always know what they are looking for.*

One participant identified negativity surrounding a labelling of such training as "parenting skills", and two participants emphasised that training should be a collaborative approach between providers of this and families. A service improvement co-ordinator participant identified training as a way of supporting parents to make positive associations to IMH:

> *My thoughts on it are that it is something that everybody including parents should absolutely be aware of and understand what it means as well, so that they don't look at it in a negative perceptive way. Like, oh that infant mental health, that's like an illness [. . .]*

The prenatal period was suggested by two participants as an opportune time for training. Parental exhaustion was identified as a barrier to accessing training and the outcomes from training, once the baby is born. A midwife participant reflected:

> [. . .] *parents want to learn because they are waiting for their baby to born so they are wanting to engage in additional education, they want to learn more about it, so maybe they are more influenced within that stage than when they are trying to manage a baby that is going to be crying all the time.*

Practical availability of training for parents was highlighted by three participants as of relevance. Possible barriers identified including a possible lack of consistent funding for training or a lack of consistent pathways to accessing training between local areas. Online training was suggested by one participant as a form of training, which might be most accessible to parents.

Training and education for professionals

All 14 participants identified a need for training for professionals, Similarly, this theme was identified by all six researchers in the reflexive interviews.

The most frequently identified aspect of training for professionals was a need for training to be universally accessible to relevant professionals. This was identified as relevant by ten participants. Relevant professional groups noted included health, social care, education and childcare staff working with infants and families. Two participants emphasised that

training should be available to a wider range of professionals. For example, a neonatal psychologist noted:

It is possible that those parents will be picked up somewhere, so adult services [. . .]. If those professionals have the training to know to look at the infant, that that kind of covers those risk families.

Four participants identified gaps in current training programmes as limiting the knowledge and experience of IMH in those entering roles subsequent to these. Particular training programmes where gaps were felt to occur included health visiting, general practice, child and adolescent psychiatry as well as teaching.

A further three participants noted the importance of resourcing a sustained, ongoing approach to training and supervision in IMH, rather than short courses, to ensure most effective translation of training into practice.

As regards the content of training, four participants identified that education on the features in infants that indicate that an IMH service would be helpful was a useful focus for training.

An early years childcare quality officer reflected on changes within her practice after IMH she received:

I found that fascinating because I then, when I observe the infants and children and that interaction, parents in particular, I viewed it completely differently, yeah completely differently, and you know I started to really kind of pick up on some very small cues and signals from children, and you know the potential kind of emotions or stress that they might be experiencing at the time.

Two participants alluded to education about risk factors that might make an infant more likely to require an IMH service as important to include in training for professionals. Three participants noted a relevance for training to include initial interventions that could be used by staff in universal services, as noted by a service improvement co-ordinator:

[. . .] Obviously we can't have an expectation that specialist services like CAMHS will then accept a referral and start interventions when actually there is opportunity for universal frontline staff to do that themselves. So, we have to provide them with what's the most effective interventions that they can take forward and parenting has been one that we've constantly applied, positive parenting strategies and interactive guidance [. . .]

Six participants identified a desired outcome of training being to develop a shared language between professionals around IMH.

A midwife identified that in her area of practice, for example, good practices may exist whilst not being recognised or understood in the context of their relevance to IMH:

[. . .] when we are talking about those, we are doing it from a midwifery perspective without maybe having some of the background insight and how important that is from an infant mental health perspective. It is not taught that way to midwives, it is taught as 'skin-to-skin regulates temperature, it regulates you know breathing rate, heart rate, after delivery,' which is obviously very important for the physical well-being of the neonate, but there is so much more for that skin-to-skin.

An education and families social worker manager noted:

I was introduced to the infant mental health training at that point and could absolutely see the value in training multi-agencies groups, social workers, early years colleagues in education, health visitors, people who were having direct contact all having the same level of understanding, speaking the same language, working with parents and with infants in the same way.

A role for training in changing values in practice was reflected on by two participants, including, as noted by an early years childcare quality officer, approaches towards families where IMH can be problematic as "less judgmental, much more understanding and wanting to try and kind of understand what was causing the behaviour".

Increased experience for professionals

Seven of the 14 professionals interviewed identified a need for professionals having increased experience of IMH Three of the six researchers also identified this as a sub-theme in the reflexive interviews.

One participant, a midwife, reflected feeling that experience of IMH currently is limited to health-visitors. Another participant, a consultant child and adolescent psychiatrist, noted experience among child and adolescent psychiatrists in the UK is very limited, compared with where she completed her training, elsewhere in Europe.

Three participants reflected anticipating that it would take a lot of time for professionals to gain experience with infants to implement training confidently into their practice. A consultant child and adolescent psychiatrist noted:

> *It is definitely about practicing, you know, it is a clinical practice, and in order to becomecomfortable and confident you just have to have more clinical practice.*

Discussion

The study identified several types of education, experience and training as pertinent in the development of an IMH service, including from a public health perspective: training focused on parents, as well as training and increased experience for a range of professionals.

Public health and societal education

As regards the role of public health and societal education, key aspects identified included the importance of a more infant-focused society, the need for wider social change generally to support IMH services and current society not associating mental disorder with infancy, as well as the opportunity for bidirectional positive effects between IMH and society, which take time to establish. The societal level education required to enable long-term benefits to society from positive IMH reflects the work of Sander (2000), who regards "the field of infant mental health as holding the key to the future, the future of both individual development and larger social organisation" and to enable this, we need to recognise "the significance of the present awakening of societies to the critical place of infant mental health for the future of social organisation". Work by economist, Heckman (2006), similarly notes the importance on a societal level of recognising signs of disorder in infancy, in the context of appropriate early interventions being available, for maximal resultant economic gains to society.

Previous public health campaigns, such as smoking cessation, which was identified by several participants, have also found that increasing public awareness of health issues takes time. A systematic review on educational campaigns on smoking cessation (Sadeghi *et al*., 2020) noted the importance of educating communities as well as political leaders with consistent messages over time.

The relevance of educating political leaders as a part of wider societal change is noted in the findings from participants, as well as in existing research. Tomlinson (2015) noted the challenge of political change in support of providing IMH services, when political issues that yield more obvious immediate effect, rather than longer term outcomes, are prioritised.

Training and education for parents

Participants identified relevant aspects in training and education for parents as highlighting parents' awareness of their infants as individuals and bringing positive associations to the concept of IMH. The findings suggested the prenatal period as an opportune time for this.

Previous research by Cameron *et al.* (2013) highlighted the role for training in increasing parental awareness of their infants' individuality in regards to their temperament and

subsequent adaptation of parenting to this, with positive associations with later mental health outcomes within adolescence.

Concerns from participants about a stigmatised perception of "parenting skills" classes are reflected in previous research. Dempster *et al.* (2012) found that higher levels of parental stigma around parenting classes were associated with lower levels of engagement in the training offered. Whilst existing research does not shed light on reducing stigma specific to IMH training and education for parents, work by Heflinger and Hinshaw (2010) on stigma within accessing mental health–related services in general highlights the importance of involving stakeholders, including families, in continual communal decision-making and reflection about the service offered, as well as increasing providers' sensitivity to this as a potential barrier.

In regards to the prenatal period as the most opportune time to provide training and education to parents, there is a current lack of research about the comparable effect of this, specifically on IMH. This approach was embraced by the Scottish Government's framework, noting that "interventions focused on pregnancy and at a time around the birth are likely to be the most effective in preventing mental health problems in the child". Yet, in regards to more general parenting education for expectant and new parents, a meta-analysis (Pinquart and Teubert, 2010) noted no significant difference in the inclusion of a before-birth component of training compared with training and education focused on new parents.

Training and education for professionals

The emphasis participants placed on accessible training for all professionals providing services to infants and their families is reflected in the aims of existing training programmes for IMH internationally. Weatherston *et al.* (2009) noted that competency guidelines for professionals developed in Michigan in 1996 were focused across "many disciplines" involved with infants and their families. Within the UK, the Leeds Infant Mental Health Service (Hunter *et al.*, 2020) delivers training to "groups and services within health, education, third sector, local authority and the judiciary".

Within Scotland, a revised framework for maternal and infant mental health was developed by the National Health Service Education for Scotland (NES) in 2019. As our findings would suggest, NES seeks to guide curriculum development of undergraduate programmes as well as continued professional development for professions "already working in health, social care and the third sector" (NHS Education for Scotland, 2019).

Increased experience for professionals

Similar to what this study notes, previous literature has reflected upon the need for ongoing professional practice to integrate knowledge acquired through training into benefits to infants. Eggbeer *et al.* (2007) noted the role of reflective supervision for professionals in supporting them to develop and maintain best practice in their practical work with children under the age of three years.

Study limitations and strengths

The study is limited in representativeness by the limited demographic range of participants because 12 of the 14 participants were female and all were white, reflecting the population of the area, where the most recent census recorded 98.1% as white (Office for National Statistics, 2016). In addition, the use of a pre-existing stakeholder group means that the included participants are not likely to be representative of all professionals in the locality studied, because of their high levels of

engagement already in the development of IMH services. The current participants did not include families who are service users of related services or members of the general public. Views of these families and wider society are likely to differ from those identified from interviews with professionals. Future research on the perspectives of families and wider societal attitudes would be of benefit as well as larger studies involving a wider range of professional stakeholders.

In regards to strengths, the study benefits from a high level of uptake among the 18 professionals approached to take part in the study. Only four of these professionals did not respond, though the reasons for this are unknown. The use of purposive sampling ensured a diverse range of professional backgrounds among the participants interviewed. Participants had a broad range of training experiences, including many working previously in different health or social care professions and some working in split roles.

Conclusion and implications for clinical practice

In summary, this study used semi-structured interviews with 14 multi-agency participants to identify views regarding the relevance/importance of education and training in the development of IMH Services in Scotland. Through the interviews, four sub-themes emerged: an emphasis on public health and societal education around IMH and related services; training for parents; training for professionals; and increasing the experience of professionals working in related areas around IMH.

Clinicians across disciplines can contribute to this social change by highlighting and normalising the relevance of IMH within their clinical encounters, similar to the role of health professionals as instigators of previous widespread social changes, such as the benefits of smoking cessation. Clinicians who work with parents and families in a range of services from the prenatal period onwards have a role to contribute towards parental education on IMH with a focus on collaborative discussion and a reduction of stigma. This study also highlights the importance of clinicians being able to access training on IMH and, where appropriate to their role, contribute to the education of other professionals, both pre- and post-qualification in this crucial area. Ongoing professional contact with patients under the age of five years is suggested by this research as integral in integrating acquired knowledge with increasing experience, with a role for supportive professional supervision.

Although the issues identified relate to a Scottish health-care setting, they are relevant within any area in the UK or internationally in considering how new IMH services can be developed and best practice maintained.

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