



Nordic Council
of Ministers

The First 1000 Days in the Nordic Countries

Policy recommendations

The First 1000 Days in the Nordic Countries

Policy recommendations

SIGRÚN DANÍELSDÓTTIR AND JENNÝ INGUDÓTTIR

About this publication

The First 1000 Days in the Nordic Countries: Policy Recommendations

Daníelsdóttir, S. & Ingudóttir, J. (2022)

Contributors from Denmark: Jens Kristoffersen, Liv Lingå von Folsach

Contributors from Finland: Petra Kouvonen, Marjo Kurki

Contributors from Norway: Brit Roland, Gun-Mette Røsand, Kari Slinning, Hege-Maria Aas

Contributors from Sweden: Ann-Cristine Jonsson

Nord 2022:006

ISBN 978-92-893-7231-2 (PDF)

ISBN 978-92-893-7232-9 (ONLINE)

<http://dx.doi.org/10.6027/nord2022-006>

Published: 28/2/2022

© Nordic Council of Ministers 2022

This publication was funded by the Nordic Council of Ministers. However, the content does not necessarily reflect the Nordic Council of Ministers' views, opinions, attitudes or recommendations.

Layout: Gitte Wejnold

All photos: Unsplash.com

Nordic co-operation

Nordic co-operation is one of the world's most extensive forms of regional collaboration, involving Denmark, Finland, Iceland, Norway, Sweden, and the Faroe Islands, Greenland and Åland.

Nordic co-operation has firm traditions in politics, economics and culture and plays an important role in European and international forums. The Nordic community strives for a strong Nordic Region in a strong Europe.

Nordic co-operation promotes regional interests and values in a global world. The values shared by the Nordic countries help make the region one of the most innovative and competitive in the world.

The Nordic Council of Ministers

Nordens Hus

Ved Stranden 18

DK-1061 Copenhagen

www.norden.org

Read more Nordic publications on www.norden.org/publications

Contents

Executive summary	6
Introduction	7
Background	8
The 2019 Situation Analysis	9
The 2020 Scientific Review	10
The development of recommendations	11
Policy recommendations	12
Conclusions	15
Appendix: National workshops	16
Denmark	17
Finland	26
Iceland	35
Norway	44
Sweden	49
References	54

This publication is also available online in a web-accessible version
at <https://pub.norden.org/nord2022-006/>

Executive summary

The First 1000 Days in the Nordic Countries is a three-year Nordic collaborative project launched under 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 pregnancy to the age of two). The project is managed by the Directorate of Health in Iceland with partners 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 Itla Children's Foundation and the Finnish Institute for Health and Welfare (THL).

The project has three main deliverables. The first was a large-scale situation analysis that was undertaken in 2019 with information gathered from across the Nordic countries on practices to support wellbeing and identify risk factors among young children and their families. The second was an extensive scientific review of the evidence base for interventions and assessment instruments used in the Nordic countries to evaluate and support wellbeing and identify risk during the early years. The third and final deliverable is this report where the project's results have been applied to propose further action and policy recommendations to support children's mental health and wellbeing during the early years.

The 2019 situation analysis revealed many common strengths as well as significant weaknesses within the Nordic countries when it comes to supporting a healthy start to life. While each country has its unique set of challenges in this respect, many are nonetheless shared by other Nordic countries as well. The 2020 scientific review also revealed that the Nordic countries share many of the same issues when it comes to availability and implementation of evidence-based practices. Thus, there is a clear foundation for the proposal of common policy recommendations that can benefit all the Nordic countries in supporting children and families during this critical period in their lives. The joint policy recommendations focus on six main areas where the Nordic governments are equally encouraged to:

- Recognize the importance of the first 1000 days of life for lifelong mental health and wellbeing.
- Provide comprehensive support for parents during children's first 1000 days of life.
- Identify and respond systematically to risk factors early in life.
- Improve equity and quality in services for young children and their families.
- Strengthen cross-sectoral collaboration for the benefit of young children and their families.
- Advance research, knowledge and understanding about the first 1000 days of life.



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 pregnancy to the age of two). 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 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 countries¹.

The second phase involved a scientific review of psychosocial interventions and assessment instruments for parents and young children in the Nordic countries. The results were published in a report with detailed profiles for ninety-six interventions and psychological tests that are offered by health and welfare services in the Nordic countries². The final phase of the project involves the development of policy recommendations which is the focus of this report. This was completed in two steps. First, each participating country organized national workshops where national experts and stakeholders gathered to discuss the project's results and propose recommendations for actions. Second, the project's network of partners reviewed results from the national workshops to find common threads that were applied to form joint policy recommendations for the Nordic countries. The conclusions and policy recommendations are found at the end of this report.

-
1. Danielsdottir, S. & Ingudottir, J. (2020). *The First 1000 Days in the Nordic Countries: A Situation Analysis*. Copenhagen: Nordic Council of Ministers.
 2. Martinussen, M. & Kurki, M. (Eds.) (2021). *The First 1000 Days in the Nordic Countries. Psychosocial Interventions and Psychological Tests: A Review of the Evidence*. Copenhagen: Nordic Council of Ministers.

Background

The first years in a child's life are critically important for lifelong mental health and wellbeing^{3 4}. 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^{5 6}. 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 life⁷.

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 status⁸. 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^{9 10}, and the establishment of the UN's Sustainable Development Goals has further underscored societal responsibility to support healthy development and wellbeing for all children^{11 12}. As evidence accumulates to indicate negative developments in young people's mental health^{13 14 15 16}, 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 healthy start in life.

-
3. Britto, P.R., Lye, S.J., Proulx, K., Yousafzai, A.K., Mathews, S.G. et al. (2017). Nurturing care: promoting early childhood development. *Lancet*, 389, 91–102.
 4. Stewart-Brown, S.L. & McMillan, A.S. (2010). *Home and community based parenting support programmes and interventions: report of Workpackage 2 of the DataPrev project*. Coventry: Warwick Medical School.
 5. Black, M.M., Walker, S.P., Fernald, L.C.H., Andersen, C.T. et al. (2016). Early childhood development coming of age: science through the life course. *Lancet*, 389, 77–90.
 6. Shonkoff, J.P. & Phillips, D.A. (2000). From neurons to neighborhoods: The science of early childhood development. *National Research Council and Institute of Medicine Committee on Integrating the Science of Early Childhood Development*. Washington, D.C.: National Academies Press.
 7. Herrman, H. & Jané-Llopis, E. (2012). The Status of Mental Health Promotion. *Public Health Reviews*, 34, 1–21.
 8. Herrman, H. & Jané-Llopis, E. (2012). The Status of Mental Health Promotion. *Public Health Reviews*, 34, 1–21.
 9. Graça, M. (2017). Good early development — the right of every child. *Lancet*, 389, 13–14.
 10. Lo, S., Das, P. & Horton, R. (2017). A good start in life will ensure a sustainable future for all. *Lancet*, 389, 8–9.
 11. Barros, A.J.D. & Ewerling, F. (2016). Early childhood development: a new challenge for the SDG era. *Lancet Global Health*, 4, e873–e874.
 12. Doelmans, N., Darmstadt, G.L., Lombardi, J., Black, M.M., Britto, P.R., Lye, S. et al. (2017). Early childhood development: the foundation of sustainable development. *Lancet*, 389, 9–11.
 13. Sundhedsstyrelsen (2017). *Danskernes sundhed. Den nationale sundhedsprofil 2017*. Copenhagen: Sundhedsstyrelsen.
 14. Anna Rósa Arnardóttir (2016). *Mental health among youth in Iceland*. Stockholm: Nordic Centre for Welfare and Social Issues.
 15. Mona Sommer (2017). *Mental health among youth in Norway*. Stockholm: Nordic Centre for Welfare and Social Issues.
 16. Bremberg, S. (2015). Mental health problems are rising more in Swedish adolescents than in other Nordic countries and the Netherlands. *Acta Paediatrica*, 104. DOI: 10.1111/apa.13075.

The 2019 Situation Analysis

In 2019, a vast situation analysis was undertaken with information and data gathered by participating countries on practices used in their national context to support wellbeing and identify risk factors among young children and their families in prenatal care, infant and child healthcare and early childhood education and care (ECEC). The analysis revealed significant strength as well as important challenges within the Nordic countries when it comes to supporting young children's wellbeing and healthy start in life¹⁷.

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, personalized service and establishing warm and trusting relationships 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 in the Nordic countries on supporting young children's healthy emotional development and the parent-child relationship from pregnancy onwards, as well as responding early to risk factor in the child's first years of life. All the Nordic countries also 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. Finally, the Nordic countries have well-established, universally accessible ECEC systems with most countries having defined ECEC as a legally protected right for all children.

Numerous areas for improvement were also identified in the situation analysis. In general, data registration, quality monitoring and the dissemination of evidence-based practices can benefit from further strengthening. Also, while all the Nordic countries emphasise early detection of risk factors in prenatal and infant and child healthcare, this may not always be done in a systematic manner, or via validated screening instruments. Furthermore, prevention and early intervention typically focus primarily on the mother. Thus, important opportunities for securing child and family wellbeing can be found in better efforts to include both parents in prenatal and infant and child healthcare.

All countries also 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 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 were provided in larger urban areas than in smaller rural locations. 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. Finally, 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.

17. Danielsdottir, S. & Ingudottir, J. (2020). *The First 1000 Days in the Nordic Countries: A Situation Analysis*. Copenhagen: Nordic Council of Ministers.

The 2020 Scientific Review

In 2020, two collaborating research teams conducted a series of scientific reviews on psychosocial interventions and psychological tests that are available in the Nordic healthcare and welfare systems. The teams consisted of fourteen researchers from the Regional Centre for Child and Youth Mental Health and Child Welfare (RKBU North) at UiT the Arctic University of Norway and researchers from the Itla Children's Foundation in Finland. Two editors, Monica Martinussen from RKBU North, and Marjo Kurki from the Itla Children's Foundation, led the work. The aim was to provide an overview and short systematic reviews for psychosocial interventions and psychological tests that are used in the Nordic countries during the first 1000 days of a child's life, including the prenatal period and the child's first two years.

To this end, each participating country provided information about interventions and tests used for the target groups (i.e., children and parents from pregnancy to the first two years of life) in their country. This resulted in a total of 63 interventions and 33 tests to be reviewed. A systematic and standardized literature search was performed for each intervention and test, using specific databases that provide reviews about interventions and tests. Each review was performed by at least two trained researchers and included a review process conducted by the editors.

The results showed that, of the 63 psychosocial interventions reviewed, over half (57%) were rated at level 1, with no or low quality evidence, and only 3% at level 4, with a high quality of evidence¹⁸. Of the 33 psychological tests, 12% were rated at level 1 and 12% at level 4, with the vast majority (61%) receiving a rating at level 2, with some but inadequate level of quality. Thus, even though a large number of interventions and tests are available for the target groups (i.e., children and parents from pregnancy until the age of two) in the Nordic countries, evidence on their effectiveness or psychometric properties is often lacking or insufficient. The authors note that the lack of evidence does not necessarily mean that the interventions "do not work". It simply underscores that the effectiveness is not known because there is so little (or no) quality research available. Thus, time and resources spent on these interventions may not be well invested. The authors also note that, while there are some interventions with good or strong evidence, these interventions do not seem to receive any more dissemination support than interventions with less evidence. Therefore, it is important that research efforts be enhanced in the Nordic region to strengthen the evidence-base of interventions and instruments that practitioners rely upon in order to assess and support mental wellbeing for children and families during this critical period in their lives. Further, it is important that the dissemination of available evidence-based tests and interventions receive more consistent and systematic support.

18. Martinussen, M. & Kurki, M. (Eds.) (2021). *The First 1000 Days in the Nordic Countries. Psychosocial Interventions and Psychological Tests: A Review of the Evidence*. Copenhagen: Nordic Council of Ministers.



The development of recommendations

The development of policy recommendations was completed in two steps. First, each participating country organized one or more national workshops to discuss the project's findings with national experts and stakeholders and form recommendations for action that would fit their national context. Second, the project's Nordic network of partners reviewed results from the national workshops to find commonalities that would provide the basis for joint policy recommendations for the Nordic countries.

The national workshops took place in the first half of 2021 when all the Nordic countries were experiencing social restrictions resulting from the COVID-19 pandemic. Thus, all workshops were held online. As an output of the workshops, each country was asked to deliver a set of national recommendations for action for each of the project's four main themes:

- promoting wellbeing and the preparation for parenthood during pregnancy
- supporting positive parent-child relationships
- identification and response to risk factors in pregnancy and the early years
- supporting the wellbeing of the youngest children in early childhood education and care (ECEC)

Apart from this, the countries had autonomy in how they chose to structure and organize their workshops, i.e., how they would set-up their workshop, how many workshops they would have, how they would conduct their follow-up and so on. The Nordic partners also had autonomy in how they presented their workshops' conclusions and recommendations. For this reason, summaries from the national workshops vary somewhat from country to country but all are constructed around the aforementioned four main themes. It should also be noted that the national workshops were held in the respective Nordic language and thus the summaries presented in this report are English translations of the country's original summary. It will be up to each individual country to decide how they will use the conclusions and recommendations from the national workshops to benefit their local context. The summary for each country's national workshops can be found in the appendix at the end of this report.



Policy recommendations

After the results of the national workshops had been delivered, the project's Nordic network of partners reviewed the results and recommendations from each country in order to identify common themes. Based on these, the partners collaborated over a period of several weeks in the fall of 2021 to form joint policy recommendations for the Nordic countries. The recommendations are as follows:

Recognize the importance of the first 1000 days of life for lifelong mental health and wellbeing

- Strengthen policy focus on the first 1000 days of life by reviewing existing policies and action plans to include a focus on the early years or develop new ones that focus specifically on the first years of a child's life, including pregnancy.
- Support implementation through clearly defined implementation plans.
- Ensure protection of the rights of the child in all policies by inserting ways to safeguard the rights of the youngest children in existing policies and action plans.
- Prioritize funding for services for expectant and new parents and children under two years old.

Provide comprehensive support for parents during children's first 1000 days of life

- Active involvement of both birthing and non-birthing parents in prenatal and infant and child healthcare.
- Offer group and individual parent support to all expectant and new parents with a focus on preparing for the parenting role, supporting the development of parenting skills, promoting positive parent-child relationships, supporting the parental relationship and strengthening the parents' social network.
- Include digital solutions in providing care, information and interventions for parents.
- Explore ways to increase flexibility in combining work and family life for parents of young children.

Identify and respond systematically to risk factors early in life

- Implement valid and reliable methods for identifying mental health difficulties, social difficulties, relationship difficulties, alcohol and substance abuse, violence and trauma in prenatal and infant and child healthcare.
- Ensure that assessment and interventions reach both the parents and the child when applicable.
- Establish systematic and tiered routines for follow-up after assessment and screening.
- Emphasize early, appropriate and evidence-based interventions in a tiered fashion for young children and families at risk.

Improve equity and quality in services for young children and their families

- Develop effective national strategies to address inequity in services for young children and their families.
- Ensure adequate resources for providing quality, individualized care in all services relating to young children and their families, including families that need extra support.
- Offer regular skills development, professional guidance and high-quality staff training on evidence-based practices within all systems that provide services to young children and their families.
- Ensure that surveillance and quality control systems perform with adequate frequency, rigour and authority.

Improve cross-sectoral collaboration for the benefit of the child and family

- Ensure systematic coordination and collaboration between prenatal care and infant and child healthcare.
- Establish systematic collaboration between infant and child healthcare and early childhood education and care.
- Ensure effective collaboration between specialized adult services and prenatal care, infant and child healthcare, social services and child protection services in the case of parental mental illness, alcohol and substance abuse, violence or other at-risk circumstances.
- Legally define the responsibilities of all relevant institutions regarding collaboration within and between systems that provide services to the youngest children and their families.

Advance research, knowledge and understanding about the first 1000 days of life

- Prioritize Nordic research pertaining to the first 1000 days of life, especially in areas identified as needing further research, and actively support research collaboration within the Nordic region.
- Encourage a special call within the Nordic countries for research on the effectiveness of psychosocial interventions and implementation that cover all levels in a stepped-care manner from promotion to treatment during the first 1000 days in life.
- Promote knowledge about infant mental health and the significance of the early years to parents and staff in healthcare, social services, child protection and early childhood education and care.

In sum, Nordic governments are encouraged to equally address to the following six areas:

- **Recognize** the importance of the first 1000 days of life for lifelong mental health and wellbeing.
- **Provide** comprehensive support for parents during children's first 1000 days of life.
- **Identify** and respond systematically to risk factors early in life.
- **Improve** equity and quality in services for young children and their families.
- **Strengthen** cross-sectoral collaboration for the benefit of young children and their families.
- **Advance** research, knowledge and understanding about the first 1000 days of life.



Conclusions

During the course of this three-year project, the Nordic countries have gathered their strength and expertise to achieve an overview of how they are managing to provide their children with a good start in life. The project has centered on collecting, examining, and disseminating the knowledge, experience and resources found within these countries to identify successful practices to share and learn from each other. Also, to define areas for further research and development and thus contribute to a growing knowledge base in the Nordic countries regarding infant and toddler mental health. The project has been successful in this regard with the publication of two extensive reports, in addition to the present report, containing a wide-reaching situation analysis and scientific review of existing interventions and assessment tools. The final aim is to support a development where all children in the Nordic countries receive the best start in life and this will depend on future political will and advocacy within the region.

In light of their strong welfare systems, public healthcare and education systems, the Nordic countries have every ability to provide optimal conditions for positive child development. However, for those of us working on this project for the last several years, it is evident that more can be done. There is a need for more systematic parental support during the critical early years, more consistent and individualized support for families at-risk, better access to evidence-based practices and improved cross-sectoral collaboration. In addition, the Nordic countries can do better in supporting truly child-friendly conditions in society where the needs of the youngest children are prioritized and early childhood education and care receives the focus and funding needed to promote excellence.

Good childhood conditions, particularly in the very first years of life, provide the foundation for mental health and wellbeing throughout the lifespan, and thus, the basis for vibrant and flourishing societies. This is not only an important public health issue but a critical issue for economic and social sustainability. We hope that the knowledge and insight achieved by this project will guide the Nordic countries towards a bright and socially sustainable future where the pivotal early years of human life receive the recognition and support they deserve.

Appendix: National workshops



Denmark

In Denmark, it was a prerequisite that the national workshops concentrated on measures that would be feasible within existing financial and organizational frameworks. As a result, the work was based on current thinking and initiatives in the area. It should also be noted that in Nordic contexts, the term "policy recommendations" refers to the outcome, but in a Danish context, it is considered to mean "points for further consideration". Below is a summary of the Danish national workshops and the discussions before, during and after them. The resulting proposals reflect the overall consensus from the workshops, along with contextual information based on the points for consideration prepared by participants in advance and statements from the Mentimeter (see below).

In collaboration with the National Agency of Education and Quality and the National Board of Social Services, the National Board of Health in Denmark reviewed the proposals to select the most important ones for each of the project's previously defined four themes. However, it should be noted that the proposals articulate perspectives that will require further research and discussion prior to implementation. This summary does not focus on specific tools, tests or methods, but instead refers to potential solutions that could inform subsequent considerations and development work. The possible points for consideration for further development have not been discussed at the political level.

Participants and procedure

Two national workshops in Denmark explored the four main themes defined in the Situation Analysis Report. The aim was to generate sufficient knowledge of the topics to facilitate work on potential development initiatives. Workshop 1 dealt with health promotion subjects, focusing on general work. Workshop 2 focused on risk factors and the most vulnerable groups. Participants were to be experts in pregnancy, early social and healthcare services and/or work in ECEC as researchers, practitioners or managers in relevant organizations. Invitations were issued to take part in either one or both workshops, although recipients were encouraged to make

it known if they thought it would be more relevant for them to attend the other workshop. Approximately one-third of the 35 participants took part in both workshops, which meant that some participants in Workshop 1 were able to further expound on their views in Workshop 2. To ensure the greatest possible output, approximately 20 experts were assigned to each workshop, subdivided into three breakout groups of 5–7 people.

Given the COVID-19 situation at the time, some consideration was given to whether the two workshops could be held physically. As the participants were spread across the country, there was a risk that they would have to cancel at short notice due to either local lockdowns or the need to self-isolate. As a result, the two workshops were held online despite the challenges to which this gives rise in terms of dynamic working. The online format also placed a limit on how long participants could reasonably be expected to remain engaged, so the events were shortened by an hour. Participants were asked to prepare by reading the Situation Analysis Report. They were also sent the following work-related questions based on the topics to be addressed during the workshop(s).

Questions for Workshop 1:

1. How can we, within the existing framework for prenatal care, better promote good mental health and wellbeing in families during pregnancy and in infancy/toddlerhood?
2. How can we promote attachment and healthy emotional development between infants/toddlers and their parents?
3. How can we promote mental health and wellbeing among the youngest children in ECEC? How can we improve cooperation between parents and professional actors?

Questions for Workshop 2:

1. How can we get better at identifying and reacting to early risk factors related to the mental health and wellbeing of infants and toddlers and their families, and how can we improve parental collaboration in this context?
2. How can we improve intersectoral collaboration in connection with early intervention, with a focus on mental health and wellbeing?

Participants were asked to briefly formulate in writing three points for consideration for each of the workshop's questions. This was designed to make the group work effective, allow everyone to be heard, and take advantage of the ability to share written input on the screen, like a kind of digital whiteboard, to spark discussion. The workshops were held on Microsoft Teams on May 31st and June 2nd 2021. They had similar structures and began with a general framework presentation before breakout groups spent an hour working on each question. The breakouts began with each participant sharing their prepared points for consideration on the screen via

PowerPoint. The floor was then opened up to discuss the question more broadly, with a view to reaching an agreement on the points for further consideration. Each group produced approximately five points for consideration/recommendations. The two workshops concluded with all of the participants gathering in Mentimeter (www.menti.com) to identify what they considered to be the most important outcome of the work done on each question. The participants' written responses could be seen by everyone on the screen in real time, forming a collective picture of the groups' efforts. The Mentimeter responses and the group summaries make up the outcome of the two workshops.

Follow-up work consisted of condensing the points for consideration/recommendations from the two workshops. Approximately 20 responses to each question were analyzed, compared, consolidated and in some cases rewritten to convey the most important aspects of the overall message. Project participants from the National Board of Social Services, the National Agency of Education and Quality and the Danish Health Authority then assessed the groups' contributions professionally in the light of the framework set for the workshops and in relation to ongoing work in the area.

Recommendations for action

1. Promoting mental health and wellbeing in prenatal care

In general, prenatal care in Denmark is of high quality. The Danish healthcare system develops all the time, as do people's needs and expectations of it. Participants in the national workshops expressed a desire to learn more about how the current recommendations are implemented and how to monitor them. They agreed in general on the need to make expectant mothers and their partners even better prepared for becoming parents, and that health visitors should make a prenatal visit to all pregnant women and their partners. The workshops also called for greater focus on involving fathers/partners, as they play a significant role in the parenting and the child's upbringing.

The participants also underlined the importance of intersectoral cooperation, particularly when providing support to vulnerable families. Other points that they discussed were: the need for intersectoral cooperation to help identify the most vulnerable families; that vulnerable families should receive timely support; that the expectant parents should receive support related to all relevant challenges and needs; and the need to improve interaction and collaboration between the various actors in prenatal care.

Recommendations:

1. Continue the process of implementing the Danish Health Authority's existing recommendations for prenatal care in order to enhance the quality of universal services throughout the country. Follow up on the implementation by recording and monitoring progress.

2. Building on existing legislation, introduce closer systematic, intersectoral and interprofessional cooperation so that services and early interventions for vulnerable and high-risk pregnant women and families are coordinated.

- Establish systematic cooperation using shared tools and IT systems
- Ensure systematic methods for the transition from the maternity ward to municipalities.

3. Systematic detection of vulnerable or high-risk pregnancies and timely and correct level¹⁹ referral from the general practitioners (GPs) to both the prenatal care and health-visiting services of the level as soon as possible.

- Set up interdisciplinary procedures in local and regional authorities to target these issues early in the pregnancy.

4. If needed, supplement standard prenatal visits to expectant parents with appointments for psychosocial and/or medical services. Generally, this will take the form of GPs, midwives and social workers making appointments for health visits early in the pregnancy (GA 16–20 at levels 3 and 4, GA 26–32 at levels 1 and 2). Parents should also be made aware that they have the option to request a visit.

- Provide prenatal health visits for all expectant mothers and their partners
- Provide an option for health visitors to bring a social worker or midwife with them to prenatal appointments
- Focus more closely on early intervention/support/treatment for parents during pregnancy, to take advantage of the "open window" during the short prenatal period.

5. Focus systematically and separately on involving the father/partner, both to draw on their resources and identify possible challenges.

6. Provide interdisciplinary (midwife and health visitor) training in small groups for both parents on preparing to give birth and parenting.

- Offer guidance for parents on emotional contact, including regulating the child's and their own feelings. This is especially important for vulnerable

19. This refers to level 3 and 4 according to the Danish graded care.

groups, such as parents who may have been neglected as children.

- Promote and talk about physical wellbeing for parents as well as the child. Attachment begins during the pregnancy, and physical wellbeing is associated with early relationship building and prenatal attachment.
- Ensure that parents have realistic expectations for the early postnatal period.

7. Conduct systematic analyses of social networks early in the pregnancy in order to identify resources and encourage parents to make use of or build networks.

- Encourage midwives to ask about networks and options for social support
- Provide information about local network services – and if necessary, refer to these services to strengthen families' competences and opportunities.

8. Use validated research tools to perform a structured and systematic detection of risk factors for mental health issues during pregnancy.

- Check for issues such as abuse, mental health issues, domestic violence or other stressors.
- Ensure that relevant treatment is available for the risk factors that are explored.

9. Train relevant social work and healthcare professionals to work more closely together (in theory and practice).

- Develop understanding of other disciplines with which it may be relevant to enter into collaborations, as well as insight into the limits of the individual's professional knowledge
- Clarify the importance of systematic interdisciplinary collaboration.
- Maintain professionalism while improving interdisciplinary understanding, and establish a common linguistic frame of reference among professionals, e.g. through training together.

2. Promoting healthy emotional bonding and wellbeing in infant and toddler care

This topic primarily concerns universal psychoeducation services for parents, aimed at 1) improving understanding of interaction with the child; and 2) providing key psychological knowledge about infant and toddler development, as well as typical parenting challenges, with a view towards fostering a close relationship between parents and children. The emphasis is on better implementation of current recommendations, as well as developing better opportunities for working on the mental health of both parents and children. The discussions at the workshops also concerned the mother and the father/partner's mental health and their relationship with each other, as this is seen as crucial to the family's wellbeing and the ability to support and regulate the child's feelings. The importance of interdisciplinary and intersectoral coordination and collaboration was also stressed. Specialists work together to provide families with interdisciplinary support.

Recommendations:

1. Continue the process of implementing the Danish Health Authority's existing recommendations for prenatal care and health visits in order to enhance the quality of universal services throughout the country. Follow up on the implementation by recording and monitoring progress.

2. Provide guidance and support for both parents in small groups.

- Increase parents' knowledge of, e.g. infants' and toddlers' social and physical development, what can be expected in interaction with the child at specific ages, togetherness in the family, motor development, play, socialization, healthy food, sleeping habits and screen time, and the importance of a healthy partner relationship.
- Develop the skills of frontline staff in relation to parental attachment and healthy emotional development.

3. Increase focus on mental health in healthcare professionals' meetings with parents and children.

- Systematically focus on personal and psychosocial issues at preventive health examinations by GPs.

4. Further develop systematic methods and improve the quality of the work aimed at supporting good relationships between parents and children through better quality interdisciplinary collaboration and based on shared evidence-based methods and tools.

- Ensure consistency in screenings/research methods and examination (e.g.

for postnatal depression) of all expectant and new parents.

- Standardize tools for interdisciplinary collaboration.

5. Focus systematically and separately on involving the father/partner, both to draw on their resources and identify possible challenges.

6. Promote closer coordination between disciplines working with the same family in order to provide the family with better support and continuity.

3. Promoting mental health and wellbeing among the youngest children and their families in ECEC

The participants discussed the importance of supporting and developing a pedagogical learning environment of high quality through the Strengthened Pedagogical Curriculum. High-quality ECEC in relation to this project must, based on the common pedagogical curriculum, incorporate: 1) children's mental health, development and wellbeing; 2) work with interaction in communities of children, enhancing the competences of all children to contribute; 3) work with interaction in communities of parents; and 4) the relationship between parents, home life and the ECEC. Signs of poor mental health must be detected early and dealt with in close contact/cooperation with the parents, a prerequisite for which is good relationships between the children and adults involved and between the parents and the ECEC staff.

Closer cooperation with parents is crucial – particularly with regard to children and families in vulnerable situations – and must focus systematically on the transition between home and ECEC. The point of cooperation is to work towards shared goals. This requires treating parents as experts when it comes to both their own and their child's lives. Another prerequisite is knowledge of indicators of poor mental health, as well as knowledge concerning measures that can support good mental health. Interdisciplinary partnerships between social educators and healthcare professionals based on a common understanding of wellbeing would also help develop measures to promote wellbeing and mental health.

Recommendations:

1. Improve the quality of the pedagogical learning environment in ECEC by continuing the process of implementing current recommendations and guidelines in the strengthened pedagogical curriculum. High-quality ECEC has a significant impact on especially vulnerable children's wellbeing and upbringing.

- Enhance the evaluation process for the ongoing development of the pedagogical learning environments – especially for the benefit of children in vulnerable situations. Focus on ongoing skills enhancement for ECEC staff in children's wellbeing and development.

2. Make systematic efforts to improve professional caregivers' relationship skills in order to establish safe and developmental relationships with children at risk/in vulnerable situations, e.g. ensure staff work with each individual child so that they establish a secure attachment to at least one adult in their ECEC. This may require additional skills enhancement and paying greater attention to retaining staff so that there is stability in the personnel group.

3. Strengthen the cooperation with parents through competence development of the ECEC staff, systematic application of forms of dialogue that support good cooperation and a management focus on the organization of the cooperation with parents.

- Improve professional knowledge of and managerial focus on the importance of cooperation based on parent involvement, tailored to the needs of the child and the family.
- Hold interdisciplinary introductory meetings for parents, health visitors and ECEC staff.
- Allow sufficient time to build a trusting relationship between parents and ECEC staff.
- Provide a clear framework for parental collaboration.

4. Pay closer attention to transitions from home to ECEC and between institutions in a child's life. This will help develop important health-professional knowledge, e.g. via tripartite meetings involving health visitors, parents and ECEC staff. Where necessary, support must be provided for children at risk/children in vulnerable situations and their parents during these transitions.

- When sharing information between health visitors and ECEC staff, both sides need to know why this particular information must be handed over as part of the pedagogical and healthcare work.

5. Improve interdisciplinary collaboration, e.g. through regular theme days involving health visitors and ECEC staff. The aim is to increase awareness of each other's professional competences and work, which requires access to discussions between

the professions, especially in areas with social problems (e.g. in collaboration with family-centered care, "wellbeing cafés/meetings", etc.).

- Ensure that ECEC staff have easy access to interdisciplinary discussions on specific as well as general issues in relation to mental health/poor mental health in children aged 1–5.

6. Examine the possibility of enhanced collaboration between municipal pedagogical-psychological counselling (PPR) services and ECEC focusing on the child's wellbeing, e.g. in connection with challenging cooperation with parents.

7. Expand the consultancy role played by health visitors in ECEC.

- Establish the health visitors' role as a sparring partner, with a view towards exchanging and developing knowledge among social and healthcare professionals, which requires that health visitors have insight into the common pedagogical foundation in the strengthened pedagogical curriculum.
- In practical terms, collaboration between childcare and health visitor/consultancy roles could take place at interdisciplinary meetings involving the health visitor service and ECEC.

8. Ensure systematic methods and quality in the learning environment aimed at supporting the child's wellbeing, learning, development and self-formation.

4. Identifying and responding to early risk factors among infants and toddlers and their families

The participants identified a clear need to strengthen the systematic identification of early indicators of poor mental health in both children and parents, or risk factors that can lead to poor mental health, so that appropriate action can be taken as early as possible. This involves looking at factors such as violence, abuse, illness, parenting skills and the parents' mental health, as well as the family's social network and situation. Attention should be paid to this from the pregnant woman's first visit to the health service and continue throughout everyday life at ECEC. This will require an interdisciplinary understanding of how to identify poor mental wellbeing and the tools used in this work. It will help if all of the professional disciplines use the same criteria for vulnerability and tools to address issues.

Finally, families and children with poor mental wellbeing must have access to follow-up services. This will also require that the different professionals involved know about the options available to promote the wellbeing of both families and children. The work should be based on the family's needs and on an understanding of the complexity of the potential interventions.



Finland

Participants and procedure

Three national workshops were conducted in Finland in May 2021. Each consisted of 11-17 participants along with facilitators and technicians. Participants differed for each workshop according to the topics to be discussed and included researchers, developers, managers and employees in the field of child and family services and early education, as well as public health nurses, midwives, doctors and psychologists from maternity and child health clinics and specialized healthcare facilities. Participants were asked to prepare for the workshop by reading relevant sections from the Situation Analysis Report. The workshops were held via the Teams platform in May 2021 and each lasted for four hours. The program was divided into three phases and concluded with a discussion session during which the group outlined proposals for future procedures. Facilitators and the staff at the Itla Children's Foundation later refined the draft proposal and sent it to the participants for comment. The workshop process was as follows:

- SWOT analysis
- Future vision and allocation of responsibilities
- Prioritization
- Concluding discussion on the proposed procedures.

Participants were divided into two breakout rooms to discuss the topic at hand. The work done by the breakout groups was documented via Google Jamboard's (<https://jamboard.google.com>) virtual whiteboard. The facilitator and a participant tasked with taking notes compiled the documentation. The breakout groups then returned to the main session to present their findings and take part in a more wide-ranging discussion.

Recommendations for action

1. Promoting good mental health and wellbeing in prenatal care

The SWOT analysis identified as strengths the solid basic education and training of staff in the antenatal services in Finland and the statutory and periodic health check-ups, because of the opportunities they provide to support the family during pregnancy. Other strengths mentioned were family coaching, support for early interaction between parent and child, screening for antenatal risks, the use of standardized forms, the fact that the antenatal services take into consideration both parents and the fact that the organizations provide low-threshold services. The workshop participants also saw the integrated work between the maternity and child health clinics (neuvola) as a positive development because it facilitates preventive visits, in which an emphasis on mental health is embedded. The SWOT analysis identified that the antenatal services do not currently place sufficient emphasis on the positive effects of good mental health for the child and for the family as a whole. Better utilization of evidence-based knowledge to support parenthood and more efficient coordination of the training for different interventions and practices are required. The participants concluded that the current perception is that staff are expected to coordinate the in-service training, whereas this is, in fact, a management responsibility. They also identified a need for more effective utilization of interdisciplinary services in the family centers and home services. In addition, they concluded that regional inequalities need to be taken into account.

As far as risk identification is concerned, the group mentioned the possibility of providing more health clinic visits, and also referred to the HAL outpatient clinics (narcotics, alcohol and drugs) , which provides ongoing services for families with substance-abuse problems. The latter was mentioned as a model that could inform the future development of the perinatal mental health service chain. The group identified weaknesses such as staff turnover in the antenatal services and restrictive operating parameters (e.g. the centralized appointment system) that do not support a close, ongoing relationship between the family and health professionals. In addition, the group found that the title "maternity clinic" suggests that its focus is not on the wellbeing of the whole family. Other weaknesses identified by the SWOT analysis concerned treatment for anxiety, lack of service chains, lack of training for doctors in the promotion of good mental health, and cooperation between different disciplines, which was perceived as inadequate in some sectors (e.g. between social services and health clinics), but also between organizations and other service providers.

In terms of themes, the group felt that development work should focus on sexual health, relationship issues and the making use of whatever support networks the family has. It also perceived the identification of violence and responses to it as inadequate, and hoped to see greater efforts in this area. They found that the instructions for identifying risks are not always clear, and identified as weaknesses the lack of coordination of the aforementioned knowledge and of training. In the SWOT analysis, the workshop participants also mentioned the shortage of competent staff, weak leadership and lack of resources as threats to knowledge and training. They also identified thematic threats related to a lack of trauma

awareness, limited availability of psychiatrists, difficulties in articulating mental health issues and incorporating them as part of routine work, and diminishing resources.

The group noted that the fragmentation of funding for the third sector was of particular concern, as were structural issues such as the low level of recognition for preventive work, and inadequately specific competences in child and family services at managerial level. The latter discussion revolved around the perception that it is important for managers to have the requisite competences in the field, and the group mentioned the recruitment of managers without such competences as a specific threat.

Recommendations:

1. Focus antenatal services on the importance of good mental health for the child's wellbeing and on how positive parenting and a good relationship between the parents are important for the child's wellbeing.
2. Provide specific instructions for health- and social care professionals on how to talk about and promote the importance of good mental health as a foundation for the child's wellbeing.
3. Further develop the content of the extensive health check-ups and enhance the potential of the family centers as a local service that provides support for families, e.g. by making them more multi-functional.
4. Help the local and regional authorities responsible for organizing antenatal services to introduce knowledge-management systems. In practical terms, this means selecting evidence-based interventions, training, implementation and follow-up work, which together form a seamless whole that guarantees the adoption of new methods in all sectors. In addition, establish interdisciplinary platforms for organizing specific training sessions for managers on issues related to antenatal mental health.
5. Develop national structures and competences that will collate comparable follow-up data on the evidence-based methods used in antenatal services. These competences should be available at both national and regional levels and support development work in the field.
6. Ensure that outpatient services have antenatal mental health services, in order to guarantee information flows between different parties (e.g. maternity hospital, maternity and child-health clinics, social work department), and facilitate consultation and coordination between the different sectors and levels. In addition, the regions and different organizations should work more closely together on research.

7. Improve documentation of the effectiveness of antenatal psychosocial work and communication about the importance of preventive work.
8. Further develop in-service training and competences with a focus on the wellbeing of staff. Systematize in-service training so that it enhances the competences of regional and local-authority staff, including their multicultural competences.
9. Establish a national (and digital) family-coaching bank that includes a digital support program for couples, which is available to all, to support parenthood and strengthen peer relations between parents.
10. Ensure that antenatal services take into account the impact of the COVID-19 pandemic. In the post-pandemic situation, for example, it is important to consider tackling waiting lists and associated resource shortages.

2. Promoting parenting skills and healthy parent-child relationships in infant and toddler care and other relevant systems.

The SWOT analysis identified as a weakness the fact that these positive practical examples, in which encounters with families transcend cultural backgrounds, do not reflect the situation at national level. It is not always the case that both parents are involved in the meetings, parents living apart do not receive equal support and there is a lack of consistency in the service path for breastfeeding support, which leads to inequalities in terms of support for parent-child attachment and parenthood more generally. The SWOT analysis also identified loneliness and the fact that many families do not have large social networks as threats. The group noted that many families are struggling, even if they do not show it in public. Trust in society in general may also be weaker among families from non-Finnish cultural backgrounds. Professional skills are of great importance, particularly in encounters with families in which there are issues with violence or other problems. In practice, there has been inadequate progress in the long-term development and implementation of evidence-based interventions for healthcare and social professionals in this field.

In the plenary after the breakout groups, the participants all agreed on the need for discussion about basic issues such as how to conduct extensive health examinations that are unique features of the Finnish maternity and child healthcare system, best practice for documentation, how to use evidence-based interventions, how to support parent-child relationships, how to support breastfeeding, etc. Group-based support (family coaching and other groups) must be strengthened at national level in order to deliver support uniformly across the country and emphasize to families that participation in these groups is compulsory and requires commitment.

During the discussion, the group stressed that improving perinatal mental health

services is particularly important. Much could be done in this area, both during the pregnancy and immediately after birth, if the service paths for perinatal mental health were better organized.

Recommendations:

1. Develop extended health check-ups that also take fathers into account. Exploit the potential for health clinic visits for non-biological parents (e.g. social parents, the partners of the person giving birth).
2. Make greater use of digital services in the maternity and child health clinics, as a supplement to home visits.
3. Provide health- and social care professionals with easy access to documentation on the support needs of each family and the forms of support available to meet these needs. Make existing knowledge about interventions and their effectiveness readily available.
4. Develop service paths that ensure all parents receive the same level of support. Pay particular attention to equal support for non-cohabiting parents. Support the attachment relationship between the parent and the child, e.g. by supporting breastfeeding at the various transitional stages.
5. Improve processes at the family centers so that that they facilitate improved utilization and integration of the services (e.g. targeted family coaching).
6. Improve basic and further education and training for professional health- and social care staff to better account for the different families' psychosocial needs and improve their training in evidence-based interventions and their application.
7. Improve processes for applying research-based knowledge and using evidence-based interventions that promote psychosocial health at all levels of the system. In addition, develop new structures to guarantee the quality, use and maintenance of, for example, interventions and extensive health examinations.
8. Introduce a national parenting program aimed at ensuring that the implementation of the legislation and the recommendations regarding a support system for parents does ultimately improve the wellbeing of families in practice.

3. Identifying and responding early to risk factors among infants and toddlers and their families

The recommendations for action for this theme are based on SWOT analyses for the other themes.

Recommendations:

1. Ensure that perinatal mental disorders are identified efficiently, and that treatment and service paths are available in all services used by families expecting a child or families with a child under two years.
2. Develop health clinic services for families in need of extra psychosocial support, offering them additional visits to the clinic on top of the standard check-ups. The number of visits should be tailored to the family's specific needs. For some families, standard check-ups will suffice.
3. Improve information-gathering tools within the social sector in order to facilitate systematic and consistent risk identification and reporting regarding perinatal psychosocial support needs.
4. Clearly document the channels for consultation, the service paths and the division of responsibilities in the different services so that the health- and social care professionals are capable of responding to risk situations and feel confident in doing so.
5. Increase the scope of reflective work practices in all services provided for families expecting a child or with a child under two years, in order to boost staff confidence and willingness to tackle problems.
6. Enhance competences in dealing with violence and trauma (e.g. raising the topic, evaluation, support) in all services visited by families expecting a child or families with a child under two years.

4. Supporting mental wellbeing during parental leave and among the youngest children in daycare and preschool.

The SWOT analysis identified as strengths the length of universal parental leave, as well as universal and interdisciplinary early education. The group noted that the parental leave system allows parents to focus on the child, which includes enabling breastfeeding. They also noted that opportunities exist for the relevant services to make better use of development- and research-based knowledge. In addition, the group discussed the coverage of and regional equality in early education, and identified shortcomings in these areas. Parental leave does not always support employment, and the SWOT analysis identified this as a weakness in the system. They also discussed the education, training and competences of staff working in early education, from a number of angles. The participants mentioned that staff working in early education need training in specific situations, such as how to deal with different kinds of families (e.g. those with non-Finnish backgrounds) and family situations (e.g. divorce, bereavement, etc.), as well as topics related to nutrition and breastfeeding. They also identified as a weakness the ways in which early education staff provide information to the "remote parent", foster and biological parents or social parents, in order to ensure that they are all provided with the information they need. They noted that all parents, irrespective of background, should feel welcome in early education, and identified as a threat the lack of support for developing competences aimed at dealing with families from non-Finnish backgrounds. From the perspective of families, the discussion focused on what happens to breastfeeding if maternity leave comes to an end ahead of schedule and mothers return to work – especially if the workplace is not prepared for this eventuality. Declining birth rates and regional inequality were identified as threats to the availability of high-quality early education. The potential for Swedish-speaking or bilingual families obtaining a place for their child in a Swedish-language kindergarten near to their home has not been fully realized, despite Swedish being the second national language in Finland. This makes it difficult for the parents in Swedish-speaking families to return to work, and also means the child has fewer opportunities to improve their language skills/bilingualism, which in turn may limit their potential in school, networking, etc. The discussion also touched on the upcoming parental leave reform, as a result of which pre-determined quotas may lead to problems.

Recommendations:

1. Ensure sufficient and competent staffing in early education, e.g. by providing adequate basic education and training for staff, maintaining the attractiveness of the profession and facilitating commitment to the service.
2. Provide in-service training, which incorporates elements from different fields, for professionals working with children under two years.
3. Guarantee adequate in-service training for staff working in early education so that they are able to deal with all kinds of families (e.g. single-parent families, families with different cultural backgrounds, foster families where the child lives part-time with the biological family, families with a social parent or "remote parent", and families who want to continue breastfeeding even after the transition to early education). In addition, provide further in-service training on addressing inequalities stemming from the children's different backgrounds.
4. Ensure the wellbeing of the staff in early education by providing sufficient resources and in-service training to improve the competences of both employees and managers.
5. Support the transition from parental leave to early education, in both the early education system and workplace, by providing tangible support for both children and their parents. In addition, improve the Case Management within early education.
6. Develop a quality-assurance system that guarantees the same level of quality of early education by all providers in both the public and private sector, so that children enjoy equal opportunities when it comes to their psychosocial development.
7. Support ways of combining working life and parental leave in the forthcoming parental leave reform that promote children's psychosocial wellbeing and allow parents to combine their working and family, e.g. providing breaks to breastfeed and storage facilities for milk in the workplace and in early education units.
8. Set up and run a multi-disciplinary research and development project looking into the requirements for and effects of the support provided to parents of small children, and encourage interdisciplinary cooperation on the psychosocial wellbeing of children and their families.
9. Establish structures and processes that guarantee resources will be earmarked for the evaluation and further development of projects and research dealing with psychosocial support for children and their families. There is also a need for a process that facilitates the implementation of those psychosocial

interventions deemed effective by the evaluation process and roots them in early education and other services that support parenthood and the psychosocial wellbeing of children.

10. Provide support in early education that is tailored to the individual needs of the child.
-



Iceland

Participants and procedure

The Icelandic workshop was held at the end of February 2021. Professionals from prenatal care, infant and child healthcare, mental health services, child-protection services, academia, preschools and daycare services were invited to participate in an online workshop aimed at reviewing the results of The First 1000 Days in the Nordic Countries: A Situation Analysis, and to propose reforms. The workshop lasted one day and was divided into two sessions. The first consisted of a presentation of the First 1000 Days project, its goals, and the results so far. The second consisted of breakout groups in which proposals for further action in Iceland were discussed and formulated.

The participants were divided into four groups, based on their expertise. Each group dealt with one of the project's focus areas: 1) wellbeing during pregnancy and preparation for parenthood; 2) parenting skills and positive parent-child relationships; 3) identification and intervention for early risk factors; and 4) mental wellbeing among the youngest children in daycare and preschool.

The 6–8 participants in each group reviewed the results of the Situation Analysis report and drew on their knowledge and experience to map the main strengths, weaknesses, opportunities, and threats in Iceland (SWOT analysis) in relation to the group's focus area. They then drew up proposals for how to provide better support for children's and families' wellbeing during the early years.

In May 2021, an open consultation symposium was held for all interested parties in the country. The symposium was advertised on social media and invitations were sent to the main professional associations and institutions involved in the wellbeing of children and parents during pregnancy and early childhood. The project and the results of the national workshop were presented at the symposium and participants discussed the proposals recommended by the working groups.

Recommendations for action

Mental wellbeing during pregnancy and preparation for parenthood

1. Run preparatory courses for all expectant parents in prenatal care.
2. Encourage the Development Centre for Primary Healthcare in Iceland (DCPHI) to draw up a policy and methodology for working with mental health during pregnancy and the early years in primary healthcare services.
3. Increase the number of midwives in prenatal care so that each midwife attends to fewer families, each family spends more time with their midwife and the prenatal services can handle more tasks.
4. Facilitate discussion and improve the dissemination of information to expectant parents about mental health and wellbeing during pregnancy, and establish a formal procedure to ensure that all expectant parents receive such guidance and education during pregnancy.
5. Promote cultural communication and cultural skills among staff in prenatal care. Ensure that all information, courses, and instructions are available in the main languages spoken in Iceland.
6. Increase the number of specialized professionals within DCPHI who have expertise in mental health issues relating to expectant parents, new parents, and infants, as well as expertise in the affairs of parents of non-Icelandic origin.
7. Promote professional knowledge and skills among midwives, e.g. offer compulsory courses on how to care for expectant parents who are experiencing psychological distress and identify the need for further support and services, offer regular professional guidance to midwives from mental health staff, and ensure that parental support is part of both basic and continuing midwifery education.
8. Promote continuity and co-operation between prenatal and infant and child healthcare, and explore options for integrating them into a single, unified system.
9. Encourage closer interdisciplinary collaboration and greater trust between healthcare staff, e.g., with joint planning days, collaborative projects, and courses on interdisciplinary collaboration.
10. Encourage research into the first 1000 days of life, prenatal care, and the efficacy of interventions.

Parenting skills and positive parent-child relationships

1. Improve professional knowledge and skills among primary care staff to foster coordination and ensure that most issues can be resolved in primary services without referrals to other services.
2. Provide more professional training and resources (e.g. time) to ensure that healthcare staff are able to attend properly to the needs of each family, give information and guidance, and offer positive interventions, e.g. relaxation and other resources. Establish a professional toolkit of positive approaches that help parents to nurture their own mental wellbeing.
3. Implement coordinated screening in prenatal care and infant and child healthcare for all major risk factors among both parents, using evidence-based assessment tools. Provide specific training for midwives and nurses in the use of screening tools and subsequent responses, e.g. how to initiate discussions with parents on difficult issues.
4. Devise courses on parenting skills, online educational material, and digital solutions to reach young parents. Establish parent groups based on parents' needs and wants, e.g. joint parent groups or separate mother and father groups.
5. Implement practical solutions to eliminate waiting lists for specific services.
6. Disseminate standardized education materials and information to parents in infant and child healthcare about infant mental health, the parenting role, the effects of toxic stress, etc.
7. Introduce more interdisciplinary collaboration within and between institutions. Make better and more direct use of teamwork, and enhance collaboration with other systems, e.g. preschools and social services.
8. Improve services and support for vulnerable groups on their own terms, e.g. disabled parents, parents of non-Icelandic origin, young parents, etc.
9. Establish 'family houses' or family centers in the local community, where all basic services are combined under one roof and the emphasis is on interdisciplinary, family-oriented, low-threshold services.

Identifying and responding to early risk factors among children and families

1. Pass new legislation on the integration of services for children's wellbeing²⁰, introduce regulations that clarify the responsibilities of all relevant institutions, and ensure funding, professional follow-up, and support for systematic implementation throughout the country.
2. Link prenatal care and infant and child healthcare to facilitate exchanges of information and ensure continuity in all services for children and parents, from pregnancy and through the early years.
3. Improve screening in prenatal care and infant and child healthcare so that it covers all major risks factors for both parents. Translate and culturally adapt recognized assessment tools to screen for risk factors such as alcohol and drug abuse, violence, and relationship difficulties. Based on the screening outcomes, flag risk factors in the digital records system to ensure that appropriate action is taken.
4. Set up a working group to draw up proposals for the establishment of family centers or 'family houses', similar to those in many of the other Nordic countries, which combine all basic services for children and families under a single roof, e.g. prenatal care and infant and child healthcare, school services, school healthcare, social services and family counselling.
5. Establish a shelter or home for families or expectant parents in vulnerable circumstances, taking inspiration from Danish family outpatient clinics, with defined procedures and responsibility for long-term, interdisciplinary follow-up for children at risk, e.g. due to alcohol or drug use by their parents.
6. Establish formal links and collaborations between infant and child healthcare and preschools.
7. Improve the definition of procedures and responsibilities for notifying child-protection services in prenatal care, infant and child healthcare and preschools.
8. Define the follow-up of new legal changes regarding children whose parents struggle with serious mental illness or substance abuse, and implement systematic supervision for these issues within all institutions that care for children and parents.
9. Conduct a needs and barriers analysis regarding the elimination of internal and external waiting lists in services for children and families, and draw up a clear and realistic long-term plan, complete with earmarked resources, to overcome that problem.

20. In the time since the Icelandic national workshop was held, the proposed bill on the integration of services for children's wellbeing has been passed as new legislation in the Icelandic parliament. The law dictates structural reforms to promote systematic collaboration between sectors that provide services to children and families, such as healthcare, social services, education and child welfare services.

Promotion of mental wellbeing among the youngest children in preschool and daycare

1. Review and update laws and regulations concerning daycare and preschool activities for the youngest children with a focus on their wellbeing, e.g. set age-related criteria for the maximum number of children per staff member, define a minimum requirement for the size and characteristics of outdoor and indoor spaces, set requirements for the education and continuing education of daycare and preschool staff, and make home daycare part of the remit of the Ministry of Education and Culture.
2. Launch initiatives designed to create truly child-friendly communities, e.g. shorten the working day for children and parents, extend parental leave to 18 months, ensure the provision of placement in preschool or daycare at the end of parental leave for those who want them, and increase subsidies for parents.
3. Evaluate the feasibility of offering payments to parents who wish to stay at home for longer – full- or part-time – with their children following the end of parental leave.
4. Set up family centres as an interdisciplinary forum for healthcare, social services, child-protection services, disability issues, and school and daycare issues.
5. Support preschool teachers and daycare staff who have the education, sensitivity and motivation to work with the needs of young children, e.g. by offering higher wages, making the working environment more attractive and introducing measures to reduce workload, e.g. by defining a maximum number of children per staff member and offering more flexible choices for how long children stay in preschool and daycare each day.
6. Draw up a national curriculum for children aged under two or make it an official requirement that all preschools that admit children under the age of two draw up a school curriculum for this age group.
7. Promote the creation of environments that nurture the development, playfulness, and wellbeing of young children, both outdoors and indoors, in preschool and home daycare.
8. Organize home daycare services following the example of Denmark, e.g. so that daycare staff are employed by local authorities and work under the guidance of preschool teachers, in accordance with the established curriculum for the youngest children.

Summary of recommendations:

1. Improve co-ordination and collaboration in prenatal care and infant and child healthcare

- Establish better links between prenatal care and infant and child healthcare to ensure continuity in services from pregnancy throughout the early years, facilitate exchanges of information and ensure that systematic work is conducted with families in risk groups before and after birth.

2. Improve parental support and preparation for parenthood

- Run courses on preparation for parenthood, both online, via the national online hub Heilsuvera.is, and via local courses that focus on changes in parents' wellbeing and behaviour following the birth of a child, including the relationship between the parents, the developmental, mental health and emotional needs of young children, positive parent-child relationships, the effects of harmful stress and childhood trauma, etc.
- Establish pilot projects on special parent groups in prenatal care and infant and child healthcare as an additional service to improve parents' social networks and provide platforms for professional and peer support.
- Include low-threshold parent and family counselling in primary healthcare or social services to which parents can turn when needed.
- Make better use of technology to reach parents, e.g. via online courses, digital educational materials, videos and podcasts.

3. Systematically work towards a child-friendly society

- Raise awareness and increase knowledge of the significance of the first years of life.
- Increase respect for the importance of the parenting role.
- Extend parental leave.
- Define the responsibilities of the government, local authorities, and the business community when it comes to prioritizing the interests of children.
- Support measures that will enable parents and children to spend more time together during the early years, e.g. statutory shorter working week for parents of young children.
- Reduce the number of hours per day that children spend in preschools and daycare.

4. Include both parents in prenatal care and infant and child healthcare

- Reorganize prenatal care and infant and child healthcare care so that both parents are fully included in the service, and due attention is paid to non-birthing parents.
- Ensure that enough time is spent in conversations with both parents about

the changes that lie ahead, including in terms of their relationship (irrespective of whether they are a couple or not), etc.

5. Improve basic services for expectant and new parents

- Assess how many families it is desirable and realistic for each midwife and nurse to take care of in prenatal care and infant and child healthcare, and establish professional standards for this that healthcare institutions are required to follow.
- Place greater emphasis on courses, career development and guidance for healthcare staff, so they are able to deal with most issues in basic services, rather than having to refer parents and children to other services.
- Promote knowledge about infant mental health among healthcare professionals working with children and parents.
- Improve multidisciplinary collaboration, coordinated working procedures and trust between different professions, through initiatives such as joint planning days, collaborative projects, and courses for staff, so that diverse professional skills and knowledge benefit children and parents.

6. More targeted screening for risk factors during pregnancy and the early years

- Review screening procedures for risk factors in prenatal care and infant and child healthcare so that they include defined and tiered post-screening procedures and cover all major risk factors for both parents.
- Translate and localize evidence-based assessment tools to screen for alcohol and drug use, violence, relationship difficulties and parent-child bonding.
- Flag risk factors in digital records systems to ensure appropriate follow-up action, based on screening results and in accordance with clinical guidelines.

7. Improve services for vulnerable and marginalized groups

- Ensure that all information and educational materials for parents (on both the primary healthcare provider's website and the online hub Heilsuvera.is) are translated into the main languages spoken in the country.
- Offer courses for healthcare professionals on cultural skills and social determinants of health. Ensure that both professionals and representatives of marginalized groups are involved in the development of these courses.
- Inspired by the family outpatient clinics for vulnerable parents in Denmark, launch a service with defined procedures and responsibilities for long-term follow-up for children at risk, e.g. due to the parents' mental health problems or alcohol and drug use.
- Set up a shelter or home for expectant and new parents in vulnerable circumstances due to serious mental health or substance-related problems.

8. Increase intersectoral collaboration for the benefit of children and parents

- Pass new legislation on the integration of services for children's wellbeing, and draw up a clear implementation plan with earmarked resources, professional support and systematic follow-up throughout the country. Define the practical responsibilities for all institutions and service systems. With this in mind, map existing systems so that there are no gray areas, unclear processes or uncertainties about procedures and follow-up.
- Implement procedures for all institutions regarding new legal changes pertaining to children whose parents struggle with serious mental illness or substance abuse, and within each institution, define the role of responsible agents with the authority and resources to follow up on these matters.
- Evaluate the options for establishing formal co-operation between preschools and infant and child healthcare.
- Look into the possibility of establishing family houses or other low-threshold, interdisciplinary services in local communities that provide support, education, training, and counselling for parents under one roof.

9. Enhance efficiency and quality in services for young children and parents

- Conduct a needs and barriers analysis of the potential for eliminating internal and external waiting lists in service systems for children and families, and draw up a realistic, long-term plan with earmarked resources to overcome the barriers identified.
- Provide more funding, manpower and resources to all systems that care for young children and parents in order to recruit more professionals and reduce staff turnover and workload.
- Strengthen family mental health teams and further develop interdisciplinary mental health teams in the healthcare system so that they also reach children and are accessible throughout the country.

10. Improve the dissemination of information, recording of information and quality control

- Establish clearer working and follow-up procedures to ensure that records from home midwifery services are delivered to infant and child healthcare services.
- Enhance monitoring of adherence to clinical guidelines and best practices in the care of young children and their parents.
- Update clinical guidelines for prenatal care more frequently.
- Make better use of digital records systems to ensure follow-up and quality of service, e.g. checking off that parents have received certain information, that certain risk factors have been screened for, and the results have been followed up on as per standard procedures, etc.
- Provide healthcare professionals with greater access to information about clients within and between different systems when it is deemed necessary

to support the wellbeing of children and parents.

- Increase the number of internal and external evaluations and the amount of support for professional work in preschools and daycare.





Norway

Participants and procedure

The Norwegian workshop was held on June 4th 2021. It brought together a broad spectrum of representatives from the public health sector associated with pregnancy, prenatal care and small children aged 0–2. Many of the participants represented professional institutions and disciplines. Practitioners from relevant sectors were present but unfortunately not as many as expected. During the workshop, seven interdisciplinary groups, each consisting of 3–6 participants, were asked to come up with five tangible solutions to their given topic. Worksheets were structured around the given topics, with questions ranging from how to solve specific challenges to more general ones about the topic itself. The summary of the Norwegian workshop is based on group worksheets and analysis of the discussions and solutions designed to present a unified voice on the different topics discussed during the workshop.

Recommendations for action

The following general themes surfaced during the workshop as areas for consideration:

- **Take greater account of the perspective of both parents in perinatal care**

Having children is, for the majority of families, a joint effort involving both parents. However, today, the non-pregnant partner is not actively involved in perinatal care. We suggest that if partners are given the option to engage in conversations about their own upbringing and mental health, they will be more amenable to coaching that will prepare them for parenthood.

The group viewed it as paramount that the partner is placed on an equal footing with the mother, by including them in the information sent out by child health centers, endorsing their legal right to parental leave, employing more men in clinics, and promoting new research on the partner's role in perinatal mental health.

- **Ensure greater professional competence and agency**

There is a general need to enhance the competences of healthcare professionals in areas such as discussing mental health during pregnancy, as well as their ability to engage with peers from other disciplines. This is an issue in daily work in the field, as well as in education and training programs. Three key themes need to be addressed. The first is that the various healthcare services should strive to retain staff and nurture their competences, because at present unfavorable working conditions and contracts often lead them to move on to other jobs. As a result, their positions are often filled by less qualified individuals, which negatively affects the service. The second theme is that staff are unaware of the competences in other institutions and services, as well as in the families themselves. This means that the services are unable to take advantage of these competences, which ultimately affects service provision in general. This is especially apparent when patients and users are referred from one service/healthcare professional to another, as these referrals often overlook certain professions and institutions. Midwives and nurse practitioners specifically do not have the right to refer patients to all specialized services, which affects their ability to specialize through their work after completing their graduate programs.

- **Better models for cooperation between institutions**

There is pressing concern about silo-thinking within and between institutions, which prevents vulnerable children from receiving the help they need at an early stage. At local authority level, better arenas for cooperation between these institutions are needed, as multiple actors are involved – from the social welfare services, kindergartens, schools, child health centers, physiotherapy, child welfare agencies, etc. In general, a reassessment is needed of who is responsible for sharing knowledge about the different professions involved.

The following recommendations for action were proposed for the project's main themes:

Promoting mental health and wellbeing in prenatal care

1. Establish an interdisciplinary, validated mapping tool for mental health during pregnancy for both parents

There is a need for a validated tool that is adapted for its users, i.e. the parents of children aged 0–2 that will help address mental health-related challenges for the whole family. This tool will be based on a model for interdisciplinary cooperation during and after pregnancy. We believe that if families know that a team of healthcare professionals is available to assist them, they will be more willing to pose questions and ask for help.

2. Set up a registry to assure the quality of “early conversations”

As part of the quality assurance of health services, the group called for the setting up of a registry of the actions taken by other health professionals. The registry would also make it possible to identify risks and provide information about which tools have been used and to what effect. It would also systematically reveal challenges faced and shortcomings in the services offered to pregnant parents and those with children aged 0–2.

3. Focus on the youngest children within national guidelines and research

Greater focus is needed on the mental health of toddlers, infants and their caregivers. We believe this will help to prevent domestic abuse, as stated in the KRIPOS report²¹. A lot of work has been done on this issue, although not in the form of randomized controlled trials. We call for further studies and research, closer cooperation between service providers and actors, and the development of a common language for use by the different professionals in this field.

Promoting healthy emotional bonding and wellbeing in infant and toddler care

1. Equal access to services throughout Norway

It is difficult for smaller municipalities to build up sufficiently varied staff resources and competences. We therefore suggest that these smaller municipalities work across geographical borders to combine their services and streamline their usage of digital tools and systems. These digital solutions should not be introduced at the expense of the physical interactions that are part of the current services, but should be used to enhance skills and make peer training more readily accessible.

2. A competence center or database of knowledge and expertise

The group thinks that there is a need for a knowledge base concerning toddlers and infants that is readily accessible to healthcare professionals and includes an overview of the different services in each region. This will help meet the demand for access to a broad spectrum of expertise during a busy working day and provide answers to the challenges identified in the “Svikt og svik” report²².

21. Alvorlig vold mot barn. Politiet, KRIPOS 2019: [alvorlig-vold-mot-barn.pdf](https://www.politiet.no/medie/nyheter/2019/09/20190910-alvorlig-vold-mot-barn.pdf) ([politiet.no](https://www.politiet.no))

22. Svikt og svik — Gjennomgang av saker hvor barn har vært utsatt for vold, seksuelle overgrep og omsorgssvikt. Utredning fra et utvalg oppnevnt ved kongelig resolusjon 13. november 2015. NOU 2017: 12 - [regjeringen.no](https://www.regjeringen.no)

3. Models that ensure good transitions, treatment and follow-up of families

It is necessary for the healthcare professionals that there is a greater correlation between the services and the solutions at every level, and it is essential that all relevant parties are aware of this need. We suggest that a greater degree of user involvement is required in the development of services for both parents and their children. We also see the necessity for greater continuity in the healthcare personnel that families encounter, which will help them develop strong attachments over time and improve the employees' ability to monitor the family's health and development.

4. National screening for mothers and their partners

Mapping the mental health of both parents at an early stage will facilitate prevention of various problems. We would also like to see clear, in-depth national guidelines and advisors capable of explaining which methods and solutions are available and recommended. One example of this would be a shift in emphasis in evidence-based national screening, from a method one can use to a method one should use. Knowledge-based services should be available to both the local authorities and the specialist healthcare providers.

Identifying and responding to early risk factors among infants and toddlers and their families

1. Establish a mandatory "infant and toddler" unit within BUP

A mandatory "infant and toddler" unit at BUP would facilitate the provision of services to pregnant women and their families and the parents of young children, as well as coaching for other services accessed by families. While such units exist, they are not available throughout the country, and some are being closed. They are an important resource because they help to map the needs of parents and contribute to the existing intervention apparatus by offering specialized competences to parents in need.

2. Report to the Storting (Stortingsmelding)

The purpose of the report is to draw up a national psychiatric and mental health plan and guidelines and to secure the requisite resources. This will result in holistic services, continuity and improvements to the mental health of families. It will also make it easier to map and evaluate the measures taken and to identify gaps in the healthcare system in general. In turn, this will give healthcare professionals a better understanding and overview of the services offered, and ultimately improve communication with parents and their experience of these services.

3. Mental health and follow-up work with parents

The healthcare services do not allocate sufficient time for meetings with new and expecting parents, as a result of which they are often referred to other staff groups. This is part of the wider issue that parents have to visit multiple services, and the time this takes for them and the staff involved. This is especially problematic in the area of mental health and illustrates the need for a better coordination between local authorities and specialist healthcare services. Better coordination would enable more frequent usage of national evidence-based screening, in particular aimed at identifying depression in parents.

4. Consolidate the 1000 Days project

The 1000 Days project needs to be consolidated by making it more available and

easier to access and by raising awareness of it among healthcare personnel and families. Specifically, the group suggested the following:

- Information campaigns for parents, healthcare professionals and the services aimed at parents
- Call for research funding to map the effects of 1000 Days
- A single telephone number, app or webpage ("one way in") for parents to get in touch with the service and to be directed to the appropriate staff or unit
- A 1,000 Days team in every local authority, as part of a broader attempt to establish multi-council efforts to reduce regional variations in quality and accessibility. The team will also provide a competence boost for smaller local authorities in particular – not as a substitute for current frontline services, but as a support unit that can ensure cooperation between the different services for families in need.

Supporting mental health among the youngest children in kindergarten

1. Better transition from home to kindergarten

Helping children adapt to kindergarten can significantly enhance their experience of it. This also has a long-term effect, as positive transitions at an early stage help to shape our attitude toward change later in life. In addition, cooperation between the kindergarten and the parents is likely to improve if sufficient resources are allocated to the adaptation process.

The prerequisites for a good adaptation should begin long before the child starts in kindergarten – ideally from the moment they are offered a place. Parents and children could be invited to visit the kindergarten in advance, during the parental leave period. In this way, the children can meet the staff and get accustomed to the new setting. Tied to this topic is the fact it is important to not generalize between one- and two-year-old.

2. Good cooperation between parents

Good cooperation between parents is essential if their child is to find their time in the kindergarten fulfilling. It also makes it a lot easier for the parents to discuss matters together and with the kindergarten staff if any doubts or issues arise.

This requires that kindergarten staff are actively involved in setting boundaries and providing arenas, and ensuring that all parents, regardless of social status or cultural background, can participate and voice their concerns. While there has been some research into parents' perspectives on life in kindergarten and cooperation with staff, more is required.

3. Improved knowledge about signs and risk factors

Enhancing the competences of kindergarten staff to take action when they notice signs of distress among children means that early intervention is more likely. This could prevent unfortunate types of development in children and stop issues from escalating and becoming more serious.



Sweden

Participants and procedure

The Public Health Agency of Sweden, in consultation with the project's external reference group, identified relevant organizations and invited key representatives to take part in the workshops. A total of 35 representatives were recruited from professional networks in the relevant arenas (maternal healthcare, child healthcare, preschool), government agencies, adjacent research fields and Sweden's national system for knowledge steering. As a starting point for discussion, all of the participants were asked to read the aforementioned Situation Analysis report, which identifies strengths and challenges in the Nordic countries. They were also given the opportunity to listen to an online presentation of the results of the project's second report on scientific reviews, which describes the scientific quality of psychosocial interventions and tests. One of the authors of the report presented the findings. At the start of each workshop, the Public Health Agency of Sweden's facilitator summarized the main results.

The Public Health Agency of Sweden chose to use the form of SWOT analysis recommended by the project working group for workshops. Another choice was to hold four workshops, one for each project area. At the end of each workshop, the group was invited to offer and prioritize proposals for action.

The workshops were held online, via Zoom, each one lasting around four hours. Between eight and ten people took part in each one. The workshops were led by a facilitator from the Public Health Agency of Sweden and an assistant who took notes to document the outcomes. The notes have been circulated to participants for comment. Participants were also invited to comment on which actions they considered most important, and which would be easy or difficult to change. Based on this feedback, the Public Health Agency of Sweden has continued to work on the documentation, focusing on how best to ensure equal access to support, and has compiled ten proposals for each area that are deemed important for implementing change.

Recommendations for action

Promoting good mental health and wellbeing of pregnant women in maternal healthcare

1. Draw up binding national guidelines for interventions and activities that aim to promote mental wellbeing and prevent mental health problems in maternal healthcare during pregnancy and after giving birth.
2. Define a mission statement for the parent not giving birth as part of the binding national guidelines for mental wellbeing during pregnancy and after giving birth.
3. Launch web-based methodological guidance for health- and social care professionals based on the guidelines for mental wellbeing during pregnancy and after giving birth and on similar principles as other web-based knowledge resources in Sweden, such as the National Handbook for Child Health Services.
4. Develop a national web-based knowledge resource for health- and social care professionals on how to run parent groups about equal parenting, which are accessible to all, evidence-based and can be adapted to meet the different needs of each parent.
5. Generate knowledge about and increase the use of family centers as places for inter-sectoral collaboration where staff from maternal healthcare, child health and social services and other actors work together for the wellbeing of the future child.
6. Set up a national working group on the subject "maternal healthcare" as part of the National Program Area for Women's Diseases in Sweden's national system for knowledge steering in healthcare.
7. Develop and improve the types of collaboration that work well in maternal healthcare centers, and between maternal healthcare centers and actors in areas such as adult psychiatry, primary care (primary healthcare centers) and infant and child healthcare centers. Clarify the referral paths between maternal healthcare and other actors, specifically in cases when the woman is diagnosed with a psychiatric disorder during the pregnancy.
8. Give midwives in maternal healthcare centers access to training and further training in how to run parent groups on equal parenting, as well as identifying and managing mental health issues in pregnant women.
9. Ensure that the midwife has access to consult a doctor when needed, for optimal prenatal care.
10. Make time and space for work focusing on the mental wellbeing of the unborn child, the mother and her partner during pregnancy. Regulate the number of

pregnant women a single midwife is allowed to look after.

Promoting good parent child relationships in infant and child healthcare

1. Design a national health program for children from birth onwards that regulates the services that should be offered to every child.
2. Develop a national program for universal parenting groups, with specific focus on improving parent-child relationships, which also include skills training for health- and social care professionals. The program should be available to all IHC centers.
3. Increase the number and regularity of training programs in how to run parent groups for all IHC staff.
4. Devise training programs for IHC staff covering the field of early regulatory difficulties in children, early symptoms of developmental issues, parent-child interaction, emotional attachment and how to run groups.
5. Make permanent the extended home-visiting programs in the initial period after childbirth, and focus home visits on breastfeeding, the early parent-child relation and involving both parents.
6. Evaluate and introduce evidence-based forms of systematic screening to assess families' life situations, lifestyles, infant's social and emotional capacity, childparent interaction, and risk factors such as exposure to alcohol and substance abuse, violence and mental distress.
7. Conduct and disseminate the results of research on the importance of family centers for the promotion of good mental health in children and study the feasibility of setting up family centers (in all regions, and at least one in each local authority).
8. Evaluate options for introducing a structured method of assessing parent-child interaction, and the child's social and emotional capacity.
9. Introduce a ceiling on the number of users at each IHC center, based on the Care Needs Index (CNI), in order to make sure that there is time and space to function as a full IHC and that sufficient working hours are available to the staff.
10. Ensure that families in all regions have access to specialized infant care teams and treatment clinics that specialize in early parent-child interaction.

Identifying and responding to early risk factors in the first 1000 days

1. Draw up national guidelines for identifying and following up on the most common risk factors (e.g., alcohol and substance abuse, violence and mental health issues).
2. Devise systematic routines for following up on the most common risk factors (e.g. alcohol and substance abuse, violence and mental health issues) and for documenting infants' socio-emotional development.
3. Issue a call for specific research aimed at developing methods to improve mental health and promote wellbeing among children aged 0–2 years. Make use of the results in the scientific review report for the project "The First 1000 Days in the Nordic Countries".
4. Set up regional centers of excellence to provide extended support for families with problems (e.g. parents with alcohol and substance abuse problems, violence and mental health issues). The centers' remit may include knowledge dissemination, implementation, follow-up and evaluation.
5. Establish a functioning care chain for children aged 0–2 years, in which there are clear referral routes for preventive measures and enhanced support in all relevant care sectors.
6. Further develop collaboration between the prenatal team and the infant and child healthcare team, as well as child and adult psychiatry and other actors.
7. Develop and expand the family center's capacity to function as a low-threshold activity.
8. Develop and expand the home-visiting program as another form of lowthreshold activity.
9. Improve protection systems for infants (0–2 years) who have been exposed to violence and place greater emphasis on their rights.
10. Regulate access to psychosocial support in preschool for children in this age group in order to promote good health, and implement preventive measures. Specialists should work together with preschool staff on these issues.

Supporting the mental wellbeing of children aged 1–2 years in preschool

1. Bring together examples of good practices on intersectoral collaboration between preschool and other main actors regarding early interventions to promote mental wellbeing in children aged 1–2 years.
2. Develop interdisciplinary dialogue on intersectoral collaboration between main

actors (state, regions, municipalities), in order to identify current needs and create the conditions for the promotion of mental wellbeing in children aged 1–2 years.

3. Develop a national knowledge base for preschool staff that includes training in infant mental health and attachment and an evidence-based program promoting infant wellbeing and attachment in the preschool environment.
4. Create conditions for preschool to reduce the number of children in groups of children for this age. Regulate (via guidelines) the size of groups for children at this age and disseminate good examples of how the size of the groups has been reduced in practice.
5. Regulate how intersectoral collaboration on health-promoting activities between preschool and other main actors shall be organized for children aged 1–2 years.
6. Initiate skills development for preschool staff aimed at identifying children with special needs, focusing on early detection, the promotion of emotional attachment and ways of providing needs-based support.
7. Regulate that preschool staff have access to support from Special Education, speech therapists and psychologists and support from specialists in the staff's health-promoting and preventive work, and in work with referrals to healthcare and consultation with parents/guardians.
8. Adapt preschool facilities for children with multiple disabilities. Introduce care and intervention programs for these children.
9. Establish a national supervision system for preschool that covers both local authority preschool and independent ones and is equivalent to the supervision system for schools.
10. Regulate the state's design of the education system for preschool teachers so that it is dimensioned to supply all parts of the country with authorized staff.

References

- Danielsdóttir, S. & Ingudóttir, J. (2020). *The First 1000 Days in the Nordic Countries: A Situation Analysis*. Copenhagen: Nordic Council of Ministers.
- Martinussen, M. & Kurki, M. (Eds.) (2021). *The First 1000 Days in the Nordic Countries. Psychosocial Interventions and Psychological Tests: A Review of the Evidence*. Copenhagen: Nordic Council of Ministers.
- Britto, P.R., Lye, S.J., Proulx, K., Yousafzai, A.K., Mathews, S.G. et al. (2017). Nurturing care: promoting early childhood development. *Lancet*, 389, 91–102.
- Stewart-Brown, S.L. & McMillan, A.S. (2010). *Home and community based parenting support programmes and interventions: report of Workpackage 2 of the DataPrev project*. Coventry: Warwick Medical School.
- Black, M.M., Walker, S.P., Fernald, L.C.H., Andersen, C.T. et al. (2016). Early childhood development coming of age: science through the life course. *Lancet*, 389, 77–90.
- Shonkoff, J.P. & Phillips, D.A. (2000). From neurons to neighborhoods: The science of early childhood development. *National Research Council and Institute of Medicine Committee on Integrating the Science of Early Childhood Development*. Washington, D.C.: National Academies Press.
- Herrman, H. & Jané-Llopis, E. (2012). The Status of Mental Health Promotion. *Public Health Reviews*, 34, 1–21.
- Herrman, H. & Jané-Llopis, E. (2012). The Status of Mental Health Promotion. *Public Health Reviews*, 34, 1–21.
- Graça, M. (2017). Good early development — the right of every child. *Lancet*, 389, 13–14.
- Lo, S., Das, P. & Horton, R. (2017). A good start in life will ensure a sustainable future for all. *Lancet*, 389, 8–9.
- Barros, A.J.D. & Ewerling, F. (2016). Early childhood development: a new challenge for the SDG era. *Lancet Global Health*, 4, e873–e874.
- Daelmans, N., Darmstadt, G.L., Lombardi, J., Black, M.M., Britto, P.R., Lye, S. et al. (2017). Early childhood development: the foundation of sustainable development. *Lancet*, 389, 9–11.
- Sundhedsstyrelsen (2017). *Danskernes sundhed. Den nationale sundhedsprofil 2017*. Copenhagen: Sundhedsstyrelsen.
- Anna Rósa Arnardóttir (2016). *Mental health among youth in Iceland*. Stockholm: Nordic Centre for Welfare and Social Issues.
- Mona Sommer (2017). *Mental health among youth in Norway*. Stockholm: Nordic Centre for Welfare and Social Issues.
- Bremberg, S. (2015). Mental health problems are rising more in Swedish adolescents than in other Nordic countries and the Netherlands. *Acta Paediatrica*, 104. DOI: 10.1111/apa.13075.