

Using the candidacy framework to conceptualize systems and gaps when developing infant mental health (IMH) services: A qualitative study

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Abstract

The development of infant mental health (IMH) services globally is still in its early stages. This qualitative study aims to understand the challenges of setting up IMH services and explores the views and experiences of 14 multi-disciplinary stakeholders who are part of the IMH implementation group in a large Scottish health board. Six major themes were identified through thematic analysis. This paper examines the most prominent theme “Systems” alongside the theme “Gaps in Current Service”. The theoretical framework of “candidacy” is found to be a valuable way to conceptualize the complex systemic layers of micro, meso, and macro factors that contribute to the challenges of setting up services. At the micro level, key themes included the view that services must be accessible, individualized, and involve families. At the meso level, in line with the aims of the service, multiagency integration, aspects of early intervention, and clear operating conditions were all seen as important. Finally, at the macro level, perhaps the biggest challenge perceived by stakeholders is delivering a service that is entirely infant-focused. These findings will help inform policy makers about factors considered by professionals to be vital in the establishment of IMH services in Scotland and across the globe.

KEYWORDS

candidacy, gaps, infant mental health, qualitative research, systems

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1 | INTRODUCTION

“How different the lives of infants in dire circumstances might be if these large and complex systems better appreciated and valued their experiences” (Zeanah, 2009:8).

Bronfenbrenner (1979) developed the ecological systems theory to conceptualize how all layers of the system play a role in human (infant) development. There is the potential to improve outcomes for children and their families during this sensitive period (Conel, 1975; Houtepen et al., 2018; Marryat & Frank, 2019), whether their difficulties are due to an underlying vulnerability in the child, or in the family system or wider social network. Despite abundant literature on the epidemiology and importance of infant mental health (IMH), little has been written internationally or in the United Kingdom (UK) in relation to IMH service development (Weaver et al., 2022).

There is increasing evidence to suggest that targeted parent-infant interventions, when delivered in a timely way, are cost effective treatments for primary and secondary prevention of poor infant mental health (Emde & Wise, 2003; Olds, 2006). The estimated prevalence of mental illness amongst infants is 10%–22%, similar to that of older children (Egger & Angold, 2006; Skovgaard, 2010; Wichstrøm et al., 2011). Despite this consistent finding, IMH services are not widely available across the world.

In the UK, health service management is devolved to the four nations. Each have made commitments to children’s mental health services: in England a commitment has been made to specialist provision being accessible to those aged 0–25; in Scotland a specific commitment has been made to develop IMH services; and an Infant Mental Health Strategy has been published in Northern Ireland (Hogg, 2019). A recent report from Wales (Bateson et al., 2021) which evidenced the level of need in three localities, has made recommendations about the development of services across the country.

Rare Jewels (Hogg, 2019) reported on the provision of specialized parent-infant teams across the UK and the policy context in each nation. At that time, 25 teams had been established in England with one each in Wales and Northern Ireland. Child and Adolescent Mental Health Services (CAMHS) in four of Scotland’s health boards were providing services to infants, and the commitment to the development of specialist IMH services was noted. Challenges to the commissioning of these services included a lack of clarity about who was accountable, limited resources often directed to later interventions with older children, and a perception that babies’ needs were often not identified, understood, or prioritized.

Key Findings

1. Using the lens of the candidacy framework this paper presents the findings of a qualitative research project which examined a group of professionals’ views about IMH services and why they are challenging to build and sustain.
2. This research demonstrates the clear view of professionals that IMH services must be infant-centered with integrated multiagency working to ensure that all babies have their mental health and wellbeing needs met.
3. This can be done by making sure that leaders and policy makers in Scotland and across the globe prioritize the development of IMH services which are accountable and accessible to those most in need.

Comparing the contributions of richer and poorer countries to knowledge about infancy, Tomlinson and Swartz (2003) remind us that over 90% of the world’s infants are born in low-income countries, which carry a disproportionate burden in terms of health and social problems. The World Health Organisation (WHO) (2018) reports that nearly 250 million children aged under five in low- and middle-income countries (LMICs) risk missing critical development milestones. The case is made for early years investment in terms of both health benefits and economic prosperity globally. Earlier WHO publications have addressed maternal mental health and child health and development in LMICs (2008) and the role of national action plans in reducing health inequities (2010). The former paper reports on a series of studies on maternal mental health problems in the perinatal period. These showed that:

1. The prevalence of maternal mental disorders is significantly higher in LMICs;
2. The impact on infants goes beyond delayed psychosocial development and also includes low birth weight, reduced breast-feeding, hampered growth, severe malnutrition, increased episodes of diarrhea and lower compliance with immunization schedules (WHO, 2008:7).

In this context, the survival of the infant often takes precedence over consideration of their emotional health and wellbeing. Burger et al., reporting on the relationship between maternal mental health and infant development in South Africa, argue that “children should not merely

survive but also thrive in order to develop their full potential” (2022:849). Lachman et al. reflect that “models of early development and IMH have often been developed for high-income settings, and sometimes carry under-examined assumptions about care and wellbeing” (2021: 836). The contextual challenges to IMH service development and delivery include social inequalities, the legacies of racism, dispossession and migration, the effects of diseases such as tuberculosis and HIV/AIDS, and interpersonal violence.

In this paper, we are reporting a study carried out in a high-income country where, in 2019, the government committed to funding the development of specialist IMH services. A recently published paper from Scotland found that socioeconomic and other factors were associated with risks to infant mental wellbeing and development (Galloway et al., 2022). There was a paradoxical picture of lower uptake of services in more deprived areas, yet relatively more affluent areas recorded a higher rate of use of perinatal mental health services, and more infants received “enhanced” health visitor services. The delivery plan for this program of work to develop IMH services recommended the use of a systems approach to ensure the right intervention is delivered at the right time (Scottish Government, 2021). While there may be specific challenges to accessing health services in LMICs, inequities in service access are of concern in all countries. The concept of “candidacy” (discussed below) as a means of understanding how patients access and interact with a service may be a helpful lens to use when considering IMH service development in any country.

The current paper explores the views and experiences of professionals with an interest in IMH and is part of a wider project which sought to understand the challenges of setting up IMH services. Findings related to perceived barriers and enablers are published elsewhere (Weaver et al., 2022).

1.1 | Theoretical framework

“Candidacy” was proposed by Dixon-Woods et al. (2006) as an explanatory model for understanding access to services and we used this framework (as refined by MacKenzie et al. (2012)) to explore how IMH services could be accessed and utilized. The candidacy concept suggests that an individual’s identification as a candidate for health services is structurally, culturally, organizationally, and professionally constructed. This allows for a deeper exploration of the issues associated with candidacy whilst also considering inequity in the uptake of healthcare service so that more appropriate recommendations can be made for practice, policy, and future research Dixon-Woods et al.

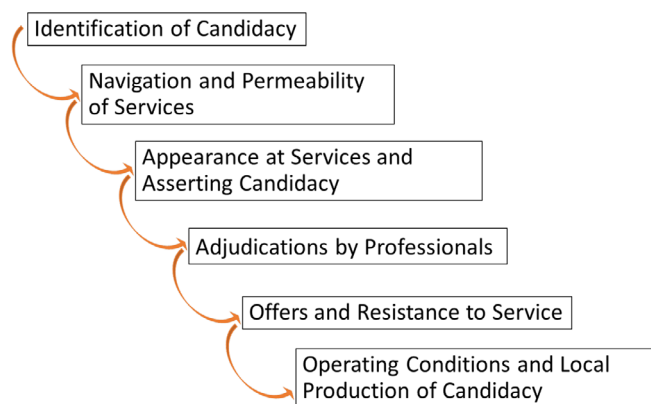


FIGURE 1 Modified candidacy framework used with permission from Dixon-Woods et al. (2006).

(2006). The framework proposes “over-lapping stages in the process of negotiating candidacy that are suggestive of a journey into and through services” (see Figure 1). Its application to IMH service uptake can be seen as both helpful and challenging. Our youngest citizens depend on others to access services, thus the concept depends on their parents, carers, and involved professionals understanding the purpose and value of intervention. It may be, for instance, that these adults do not realize that their infants are candidates for a service and/or have a right to access it (if, indeed, they are even aware of its existence).

2 | METHODS

2.1 | Study design

This qualitative study used semi-structured interviews with key stakeholders to address two over-arching questions:

“Why is it challenging to build IMH services, despite the fact that we know that the baby’s brain is developing so rapidly?” and

“How do the professional and personal childhood experience of stakeholders influence their views about new IMH services?”.

These questions seek to elicit stakeholders’ views on the importance of systemic factors which influence how the service works and how accessible it is. By mapping them on to “the candidacy journey,” we have sought to understand the pathway to services in more depth. These pathways have previously been found, in this geographical area, to favor those from less deprived communities where

the risk factors for developmental delay, mental disorder, and poor relationships in infancy are less than in deprived communities (Galloway et al., 2022). By mapping them on to “the candidacy journey”, infants’ access to services can be understood in more depth. The construct of candidacy has been used with increasing evidence in understanding the influences on access to mental healthcare particularly from the standpoint of a vulnerable candidate (Liberati et al., 2022).

We have found qualitative research with stakeholders, like this, to be an excellent way to build the partnerships needed to support service development (Turner-Halliday et al., 2018). Individuals were interviewed individually, then brought together in focus groups at a later stage to explore differing perspectives and the reasons for these, leading to the development of shared goals.

2.2 | Recruitment

Two National Health Service (NHS) health boards in Scotland received early funding to develop IMH services and care pathways. The multi-agency Infant Mental Health Stakeholder Group in one of these (comprised of 31 members) was purposively sampled to ensure that a range of participants was represented, including from health, education, social care, and the third sector. Those selected were invited by the Infant Mental Health Lead researcher (AM) to take part in preliminary interviews and were sent participant information sheets. Interviews took place via Microsoft Teams (by F.P., A.W., F.M.) using a semi-structured topic guide that was piloted with researchers interviewing each other. Each interview was conducted in pairs with one researcher acting as a “guider” following the topic guide whilst the other acted as an “enquirer”, exploring topics that were brought up and asking relevant follow-up questions. Interviews lasted between 46 and 60 min (mean length 54 min). These were audio-recorded, transcribed verbatim, and stored securely in an anonymized form. Thereafter, the initial findings informed an iterative process, which included purposive sampling of additional participants and thoughtful pairing of previous participants in focus group interviews. Participants took part in one to three interviews or focus groups of up to 2 h in length.

2.3 | Analysis

Data were initially analyzed thematically according to the methods of Braun and Clarke (2006). In phase 1, two transcripts were chosen at random and coded by six researchers (F.P., A.W., F.M., A.D., H.M., A.M.). Initial themes were

independently generated and combined into a table for phase 2. The three interviewers repeated this process for a further two purposefully selected transcripts which generated the initial coding frame. Decisions regarding themes or subthemes were resolved by discussion. In phase 3 data were collated into potential themes, identifying further codes from the remaining transcripts. In phase 4, the coding frame was reviewed once more and further refined by tasking each interviewer with the write up for two related themes.

Focus group interviews were also analyzed and coded independently (by S.H., A.D.N.). Themes were identified from Focus group 1 and put into a template which was used to code the remaining four focus groups. Audio recordings were listened to in order to determine if there were any particular areas of disagreement or heated debate.

The definition and naming of themes were agreed with the research team in Phase 5 and in the final stage the report was produced using the Candidacy framework to aid our understanding of the journey of infants accessing mental healthcare services.

2.4 | Reflexivity

The project was led by two female consultant child and adolescent psychiatrists who have carried out research in the field of IMH. A male child psychotherapist leading IMH Service development in a different health board provided an additional reflexive perspective. The data collection and analysis of individual interviews were carried out by two female specialist registrars in Child and Adolescent Psychiatry and a female medical student undertaking an intercalated BMedSci. The focus group interviews were separately analyzed by a different pair of female specialist registrars in Child and Adolescent Psychiatry and a female BMedSci medical student which provided triangulation of the data. An experienced female research associate was consulted in the design and analysis process. A senior male clinical lecturer was involved in the review and the write-up of the paper.

All researchers underwent a recorded interview at the early stages of the project to increase the researchers’ reflexivity and understanding about issues relating to the development of an IMH Service. The three interviewers had not met the stakeholders and were in the position of having little knowledge about IMH or the planned development of the local service. This facilitated genuine curiosity and appeared to facilitate participants being at ease in sharing their views. Researchers’ prior preconceptions were explored before each interview and the process was reviewed afterwards. Additionally, the wider research group met fortnightly to review findings and refine the

TABLE 1 Focus group composition.

| | Profession |
|---------------|---|
| Focus group 1 | CAMHS Psychiatrist Perinatal & IMH Project Manager |
| Focus group 2 | Children, Young People and Families Officer Family Nurse Practitioner (FNP) Supervisor |
| Focus group 3 | Early Learning Quality Officer Child Psychotherapist |
| Focus group 4 | Educational Psychologist Perinatal Psychiatrist |
| Focus group 5 | IMH Psychiatrist Health Visiting Service Improvement Coordinator |

methodology if necessary. This report was shared with the participants to confirm the analysis reasonably reflected their interviews.

3 | RESULTS

3.1 | Demographics

Of the 18 participants invited, 14 were interviewed and four did not respond to the email invites. A retired GP was later invited to participate since invited GPs were unable to take part due to service pressures. The exact role of each participant is omitted to maintain the confidentiality of stakeholders. The 14 participants were categorized into four sectors.

- Health: Three Psychiatrists from different subspecialties (Perinatal, Child, and Adolescent Mental Health services (CAMHS) and IMH); Counselling Psychologist; Health Visiting Service Improvement Coordinator; Child Psychotherapist; Midwife; Perinatal IMH Project Manager; Family Nurse Practitioner (FNP) Supervisor (consultant psychologist supervising family nurses); retired General Practitioner
- Social Services: Manager
- Education: Early Learning Quality Officer; Educational Psychologist
- Third Sector: Children, Young People and Families Officer
- Non-responders: Two Social workers, one GP, one Chief Nurse

Among the 14 participants, 10 attended both the individual and focus group interviews. Table 1 shows the pairing of the stakeholders into five focus groups.

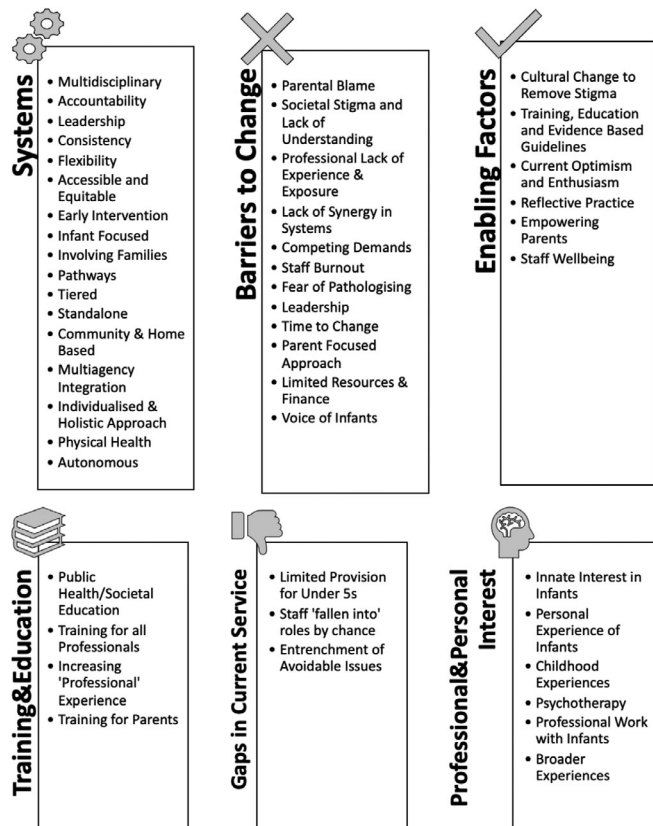


FIGURE 2 Overview of initial thematic analysis themes and subthemes used with permission from Weaver et al. (2022).

3.2 | Themes

The six main themes: Barriers to change, Enabling Factors, Systems, Gaps in Current Service, Training, and Education, and Professional and Personal Interest are shown in Figure 2 along with overlapping subthemes (Weaver et al., 2022). This paper explores the biggest theme Systems and its related theme Gaps in Current Service.

3.3 | Systems

The seventeen subthemes within the theme “Systems” were organized into three levels (micro, meso, and macro) from the refined candidacy framework. These are described below and shown alongside “Gaps in Current Service” in Figure 3. This framework is used to map the complexities of systems and highlight the dynamic interaction of organizational factors that lie within and between each of the levels (Mackenzie et al., 2012). The micro level refers to the interaction between services and service candidates. The meso level refers to contextual and operating conditions within local and organizational structures.

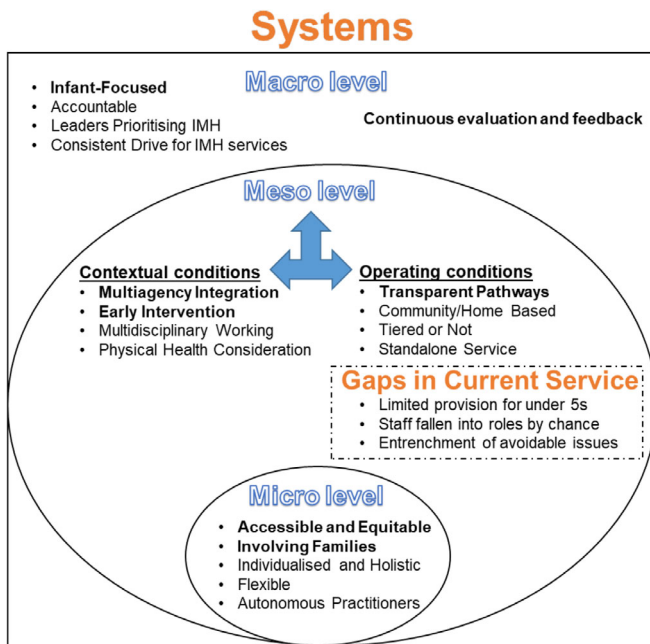


FIGURE 3 The subthemes within *Gaps in Current Service* incorporated within operating conditions at the meso level. Subthemes in bold were also found in focus groups—all levels (micro, meso, and macro) are related reciprocally to the other levels.

Macro level factors refer to structural and social relations and discourses found in national and political contexts.

3.3.1 | Micro level—Dynamic between services and service candidates

Accessible and equitable

There was a focus on the practical aspects of an IMH service with emphasis on it being flexible, timely, easy to access and universally accessible to all types of families. Lengthy waiting lists, narrow referral criteria or complex referral processes were identified as barriers to accessing services.

“Infant mental health service should be for everybody and there shouldn’t be criteria and if a parent is worried about their child’s infant mental health, they should have the right to be seen”—Psychiatrist.

Participants believed that accessibility should be improved through efforts to reach out to populations at risk and to families from a range of backgrounds, including the LGBTQ+ (Lesbian, Gay, Bisexual, and Transgender) community, families from ethnic minorities, older parents and also those not previously known to mental health services.

Involving families

Stakeholders shared the view that meeting the needs of the infant was important but the system around the child was also recognized to be vital. They talked in-depth about building relationships with parents or carers and trying to support them to make small lasting changes.

“Ultimately for me it is about working with parents, the families, because long-term they are the ones that are going to be doing this work”—Psychologist.

There was an emphasis on ensuring that the mental health and wellbeing of the primary carer was optimized alongside infant work. Several participants talked about prioritizing the building of secure attachment of infants and new parents. Some felt their roles varied from raising societal awareness of IMH to providing a “containing reciprocal relationship” with families or using formal “parent-infant psychotherapy” when necessary.

Individualized and holistic

Most participants viewed babies as inherently unique with their own set of “temperaments”. They supported individualized care plans for infants, with family support also being tailored to their specific needs. Stakeholders acknowledged that holistic care centered on the general wellbeing of an infant including the provision of basic practical supports to the carers.

“If we can just take the time to stop and listen, a parent will help us understand what they need and then we can work out how best to work with them”—Social Services Manager.

Flexible

Flexibility was emphasized by participants from health backgrounds. Service providers appreciate the need to go over and above in both understanding, reaching out and empowering families, particularly those with complex vulnerable needs.

“You cannot be too narrow minded when you work with babies and their parents, you need to be very flexible”—Psychiatrist.

Autonomous practitioners

Two participants thought that an IMH professional should be able to function autonomously with support from managers and colleagues who trusted and respected their independent assessment.

“Quite an autonomous role, you know you are the only practitioner that’s seeing that client in the home”—FNP Supervisor.

3.3.2 | Meso level

Meso level subthemes identified fell into two categories: Contextual conditions and operating conditions.

Contextual conditions

Multiagency integration. The subtheme of Multiagency Integration was linked to Early Intervention. Stakeholders talked about the need to work alongside front-line sectors to deliver psychological “first aid” and monitor for early signs of infant mental distress.

All participants identified integration of services as pivotal in the development of IMH services. This provides a multifaceted function in not only providing a comprehensive assessment for an infant but also supporting the infant’s wider network which improves the infant’s wellbeing and the relationship between families and service providers. Through partnership working, some participants appreciated the limitations of other services, and the importance of an extensive wider support network.

“Success of an infant mental health team will be in its relationships with those around about it, and in that collaborative working and that shared language of what we want to achieve and support in infants”—Psychiatrist.

Early intervention. Almost all participants identified that IMH services make a massive impact on the trajectory of an infant’s life by intervening early. They enthused about intervention in the antenatal period and how early signs of infant distress could be detected before severe complex disorders are cemented. This stage is recognized as a missed opportunity for many infants as well as a critical period for families when many are motivated to change for the benefit of their little ones.

“It is more hopeful to work in early intervention because you feel like it is making more of a difference. . . Also, you have got parents who are in the best position for them”

- Psychologist.

Some participants wanted IMH support to begin before the birth by targeting expectant mothers at risk. The social services manager quoted the cost effectiveness of early intervention service.

“for every £1 . . . every £10 that we spend at that end. . . we save £9 later on’ . . . or something. . . so right down to financial terms apart from the emotional impact just making it better for children”—Social Services Manager.

Multidisciplinary working. There was significant crossover between Multiagency Integration and Multidisciplinary Working and stakeholders at times provided interchangeable descriptions. Participants from various backgrounds highlighted the need for the IMH service to be multidisciplinary so that the infant could be provided with a holistic care plan.

“It needs to be a multidisciplinary team, I think it needs to have representation from the psychology and health visitors and psychiatry and nursing, kind of all of the people that want to feed into that need to be round the table, but equally I think there needs to be really strong links with the services that are already existing and already seeing these infants but they don’t know what to look for”—Psychologist.

Many stakeholders reflected on the challenges of working together but acknowledged and were respectful towards the expertise brought in by colleagues from different backgrounds. Participants suggested a range of professionals to be included in the multidisciplinary team, with an emphasis on liaison with universal services like Social Work and Early Years Workers. Stakeholders from Health highlighted health visitors as a vital workforce.

Physical health considerations. This subtheme was highlighted by stakeholders from Health who considered the impact of physical health needs. The care of infants in terms of physical and mental health care is not well differentiated, hence parents and professionals may have differing views on the remit of infant mental health services. Psychiatrists reflected on their broad training experience in both physical and mental care needs which is advantageous when it comes to caring for infants.

“You don’t want to just look at the child from an infant mental health perspective because some children definitely have neurological or neurodevelopmental disorder or they have syndromes, you know genetic syndromes, organic syndromes”—Psychiatrist.

Operating Conditions

Transparent pathways. This subtheme was frequently interlinked with the subthemes Accessible and Equitable, Early Intervention and Multiagency Integration, and is revisited later in the *Gaps in Current Service*.

Several stakeholders had concerns about how referral pathways were laid out and recognized the need to educate and support all referrers in caring for infants’ mental health. Some envisioned clear signposting which would

give clarity to universal workers and parents leading to quicker access. There was concern about transitions from IMH services to Child and Adolescent Mental Health services (CAMHS).

“Whether it is something that CAMHS felt that they could manage or whether it was something that wasn’t their remit at all, and it would be something else that was needing to be done”—FNP Supervisor.

Community/home based. Health participants stressed that service delivery should take place at home if possible. Having specialist services within the community can improve accessibility for families and allow for a more holistic assessment.

“Seeing a child and a client in their own home environment is really crucial, you are going to observe a lot more about what’s going on in that family in the home rather than in a clinic”

- FNP Supervisor.

Tiered or not. Participants provided conflicting views on IMH services being tiered (i.e., organized from universal services in the “bottom tier” with more specialist services in the “top tier”). Most held the view that there should be a tiered approach because of limited resources.

“If you have only got a limited resource, in my mind... you’re only ever going to address the tip-of-the-iceberg, which is my starting point for mental health services anyway”

- Child Psychotherapist.

Some participants identified that specialist services needed closer links to frontline staff and thought that the infrastructure for universal services needed to be developed alongside specialist infant care.

“I think there needs to be a greater focus at the universal level”

- Early Learning Quality Officer.

One psychiatrist felt strongly that IMH services should not be a tiered service and a GP shared that the rejection of mental health referrals often related to specific criteria from tiered system approaches. Two others were unclear what a tiered approach was and were concerned that this might stigmatize service users.

“I think if they [parents] are worried about their baby, they have a right to have an answer now, not to go through such a lengthy journey, as most of these parents go through”

- Psychiatrist.

Standalone service. Some described the need for a standalone IMH service to help create awareness of infants’ mental health. This would allow better recognition at management level as the service develops and also encourage referrals to specialist services.

“Infant mental health needs to be an individual service, because it needs to be recognized in its own right” - Psychologist.

3.3.3 | Macro level—Structural and social relations and discourses

Infant-focused

Stakeholders commented that delivering infant-centered care was challenging as the infants’ needs are easily overshadowed by the challenges of the wider system. A psychologist highlighted the significance of responding to infants’ cues and ensuring professionals and families provide care in an infant-led manner. This was identified as a reason for the difficulties in identifying infants whose mental health was deteriorating.

“There’s probably something self-protective and people not wanting to go near it [an infant who is really unwell]. It is so emotive and painful to think about a wee baby in that level of distress”—Psychiatrist.

Accountable

Stakeholders were passionate about having quality IMH services across Scotland. They welcomed a national standard and aspired to have better services than other countries. They wanted the Scottish Government, policy makers and managers to be held accountable so that time and financial investment would be put into building services for infants in Scotland.

“When we are talking about senior leaders, I would use the word more ‘accountability’ because you know in the past, we’ve introduced things like key performance indicators that health boards were measured against... Why not be brave to introduce something that you can then be assured that

the organisation will have to report back on basically?"

- Service Improvement Coordinator.

Leaders prioritizing IMH

Participants reflected on their experience of leading and advocating for a service designed specifically for infants. They wished to see infants' needs prioritized at all levels to ensure continuous funding to deliver quality services and create an awareness that working with infants is a long-term commitment.

"I don't know if the leadership priorities had something to do with that, but I know that the pull and drain in CAMHS has been so significant that again the pre-5 population just goes down the priority list"—Service Improvement Coordinator.

Consistent drive for IMH

Some stakeholders recognized that developing mental health services for infants is a lengthy process requiring a consistent approach. There were reflections on the challenges of funding which is often time limited. Stakeholders were considering ways to ensure that the service was sustained in the future.

"What we need now is a constant, we need a workforce that is completely saturated in the whole evidence base around infant mental health"—Service Improvement Coordinator.

3.3.4 | Gaps in current service

Alongside the theme of *Systems*, all participants recognized that there were *Gaps in Current Service*. Three subthemes were identified. These are considered meso levels factors as they describe Operational Conditions influencing service provision.

Limited provision for under 5s

Many stakeholders spoke of the gap in mental health services for children under the age of 5, and opportunities for work with infants being limited.

"There is a definite gap there and it is just because there's never really been a service dedicated to it, it just gets dealt with in other services, probably not as well as what it would be if there was a dedicated service"—FNP Supervisor.

The consequence of a gap in service for infants has resulted in CAMHS workers lacking both the confidence and the competence to assess very young children and universal staff feeling frustrated by repeated rejection of referrals. Some participants highlighted that a proportion of children and families were missed by services while passionate professionals had struggles in finding jobs to work with under 5s.

Staff fallen into roles by chance

Participants from different sectors talked about feeling fortunate to have had colleagues who encouraged them to work in a service for infants. Some had exposure to IMH services during their training while others became familiar with them through their links to the new service.

"I was really lucky that I had a kind of psychologically informed midwife (colleague) who was really keen to get somebody in that could support families and therefore support the infants"—Psychologist.

Some participants reflected on their broad training background which had provided them a holistic and longitudinal lens which helped contribute to the shaping of IMH services.

Entrenchment of avoidable issues

Participants spoke about the difficulties in providing IMH care being related to an entrenchment of avoidable issues. Infants struggle to get access to services as they do not have a voice, and not many services are available. They depend on their parents or carers to access services and parental shame and stigma may prevent this. Some participants described "a vicious cycle" related to difficulty in accessing services and then failure of engagement with families who may withdraw from services which could be helpful for the infant.

"The big problem with infants is that if the problem is not approached and is not dealt with when it happens, it becomes more chronic and then becomes entrenched and then you have the 3, 4-year-old with some entrenched chronic behavioural dysfunctions, which become disordered, it is more difficult then, intervention then is more difficult"

- Psychiatrist.

In addition, there may be complex intergenerational issues that repeat themselves. This may be related to genetic heritability and parents' own experience of being

parented. The effect of parental mental health issues further intensifies the risks for the developing infant.

“It is a cycle thing through their family, so they’ve maybe not had a positive experience themselves when they have a young baby and an infant, and that cycle isn’t broken because they then don’t know how to parent either”—Children, Young People and Families Officer.

Themes from focus groups

Nine themes were identified in the separate analysis of focus groups. Of these, only one theme—*Continuous feedback and evaluation*—was not included in the initial thematic analysis (see Figure 2) of the individual interviews. Six of these themes (Infant-Focused, Multiagency Integration, Early Intervention, Transparent Pathways, Accessible and Equitable, and Involving Families) triangulated with the subthemes found under *Systems* in the individual interviews (see bold subthemes in Figure 3). Societal Stigma and Lack of Understanding was highlighted within the theme of *Barriers to Change* as reported by Weaver et al. (2022). Knowledge of Parents/Professionals/Society were covered under the theme *Training and Education*.

Additional theme: Continuous feedback and evaluation

In at least two focus groups, the importance of allowing feedback and reflection to direct the evolution of this new service, learning over time, was highlighted.

“I think a lot of it will be very much, it will evolve and will all kind of, you know, need to go with it, but probably effective communication as it’s going on and evaluations of how it’s going”—FNP Supervisor.

“I think it’s going to be a huge evolution just to see you know, you get feedback, you test it, and then you try again with something else”—Psychiatrist.

4 | DISCUSSION

The findings of this qualitative paper suggest that the main challenges to building IMH services are systemic factors, many of which are related to *Gaps in Current Service*.

Most participants were confident in sharing their vision of how IMH services should be developed while others, even those with little formal training in IMH, felt able to advocate for families they had worked with. Some reflected on how they had proactively sought out training in IMH

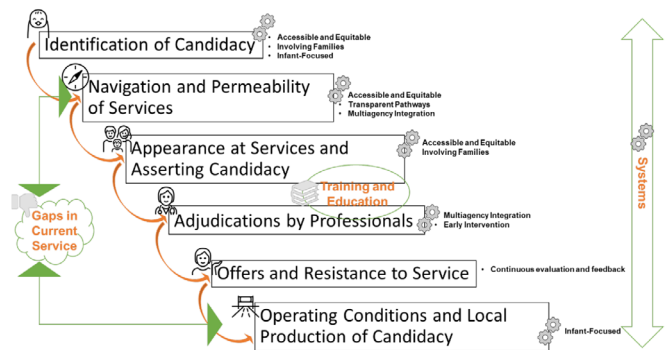


FIGURE 4 The complex relationship between the nine themes identified in focus group interviews incorporated within the candidacy framework.

following personal experiences. Despite being a heterogeneous group of professionals, almost all described a passion for working with infants. They described hope and a desire for the system to work for and around infants in a committed manner. Participants described similar themes even though their training background differed. Some focused on prioritizing funding, while others requested more training opportunities, and a wish for society’s attitudes towards IMH to be addressed. These hopes were further accentuated in the focus groups. Despite at times having differing professional perspectives and priorities, the focus groups exemplified the multidisciplinary, collaborative work that is required in order to achieve a successful IMH system.

4.1 | Candidacy as a helpful concept in understanding service development

There are challenges inherent in using the concept of candidacy in relation to infants. Nonetheless, as IMH services do not treat the infant in isolation and seek to improve early relationships, it can be seen as a useful way to examine and address systemic processes (Osofsky & Fitzgerald, 2000). The model supports the understanding of the recursive and reflexive relationship between influencing factors operating at different levels and has been used to understand influences in accessing mental health services (Liberati et al., 2022).

Figure 4 illustrates the complex relationship of the themes identified in focus group interviews. The six themes coded under *Systems* in the individual interviews are shown to infiltrate all parts of candidacy whereas the *Gaps in Current Service* negatively impact on the navigation and permeability of services as well as the operating conditions and local production of candidacy. *Training and Education* informs professional judgement about whether IMH services are offered and therefore impacts on the

families of service users as they appear at services and assert candidacy.

4.1.1 | Identification of candidacy

Stakeholders spoke about the importance of ensuring that IMH services were provided in an accessible and equitable way. Infants (the term derives from the Latin “unable to speak”) are entirely dependent on the system around them and reliant on others to identify whether they are a candidate for specialist services. In our previous paper, *Societal Stigma* and *Lack of Understanding* were identified as major perceived barriers to service development (Weaver et al., 2022). Given that there is limited general understanding of IMH and a fear of parental blame, professionals may refer fewer families with “multiple difficulties, some of which will be difficult to mitigate” (Galloway et al., 2022). As stated earlier, the concept of candidacy in relation to IMH services depends on infants’ parents, carers and involved professionals understanding the purpose and value of intervention. In challenging socioeconomic circumstances, such a referral may not be seen as the main priority.

Participants identified that the involvement of families in care-planning and the co-production of services supports accessibility as does the delivery of individualized, flexible and holistic infant-centered care. Some of these facilitators have also been described in relation to the development of perinatal mental healthcare services in which women are encouraged to have choice about their care, which is appropriate, woman-centered and flexible (Webb et al., 2021).

4.1.2 | Navigation and permeability of services

Challenges in the navigation and permeability of services described at the time of the study reflected the fact that IMH services were not widely available in the UK. Some participants reported feeling exasperated in the context of limited provision for under 5s and described how this can lead to “a vicious cycle” in which complex intergenerational issues cannot be addressed. This was reiterated in the focus group interviews and was a source of disagreement between stakeholders with participants expressing their frustration that the proposed age range of the IMH service (conception to aged 3 years) may lead to a gap in services for children aged 3–5.

Referrals to specialist services are often made by general practitioners. This may be further complicated, or possibly helped, by the involvement of other universal service

providers (Hogg, 2019). In Scotland, *Getting It Right For Every Child* (2022) is the Scottish Government’s commitment to provide all children, young people and their families with the right support at the right time. Health visitors are identified in that framework as the key professionals involved with under-fives and are often best placed to make specialist referrals. It is helpful to have to have clear referral pathways in order to make navigating the journey in and out of services less challenging.

Most participants envisaged a tiered IMH system with a standalone specialist service. This is the framework for CAMHS in the UK National Health Service (Durkan et al., 2016). Tiered services may lead to universal service providers feeling distanced from a specialist service. These service “gap” issues between primary care and specialist services have been highlighted by Appleton (2000) who described a move to increase the amount of support specialist CAMHS offer primary care colleagues. Similar concerns were shared by participants who worried about IMH services being overstretched and only those with the most severe and complex disorders being seen. This generated extensive discussion in the focus groups and there was a strong sense of agreement amongst participants that existing structures and skillsets should be maximized, and that a new IMH service must link in with current services. Having long waiting times for specialist IMH services would not be helpful for patients and might deter referrals from universal services. Furthermore, in terms of infant brain development, rapid access is paramount and specialist services may need to address any lack of synergy by maintaining good working relationships with universal services to ensure IMH care reaches all infants in a timely manner.

4.1.3 | Appearance at services and asserting candidacy

Stigma can make it more challenging for families experiencing adversity to formulate and articulate their concerns in order to access services. For families experiencing structural inequalities, and current and past adversities including abuse, mental health or addiction problems, an added challenge for them in attending services is that they may feel judged or blamed (Galloway et al., 2022; Hogg, 2019; Webb et al., 2021). Some participants believed that IMH services were best provided in infants’ own homes. A third sector officer emphasized the practical supports that could help families to engage, including preparing them for who they would meet.

Professionals from a range of agencies should be able to promote infants’ rights to a service and thus help assert candidacy. In addition to midwives, health visitors and

family nurses, in Scotland, other specialist community professionals caring for infants include Early Years workers, social workers and community pediatricians. These may represent a vital untapped mental health workforce who could support candidates to attend specialist services. The training and background of these professionals varies and linking them into an effective and efficient system would require careful alignment and support.

4.1.4 | Adjudications by professionals

The value of practitioners working autonomously, but also able to seek advice, was emphasized. Professionals working in specialist IMH services require a high level of training and clinical expertise to make decisions and deliver early intervention. Training will be explored in a separate paper. From a systems perspective, it is important for professionals to develop a shared language when working together. The need for multiagency integration, early intervention, multidisciplinary working and consideration of physical health needs were seen as important contextual conditions which should underpin this model. This is in line with suggestions in the Rare Jewels report (Hogg, 2019) that parent-infant teams need to be complementary to other services that exist in local areas including health visiting, family nurses and specialist perinatal mental health services. The Care Quality Commission (2018) reported that, in local adult health care and social care systems in England, ineffective coordination of services resulted in the provision of fragmented care. This message will be important for IMH services globally as they develop.

4.1.5 | Offers and resistance to service

Some insights gathered in a related part of this study are relevant here (Weaver et al., 2022). Barriers to change identified included feelings of parental blame, societal stigma and lack of understanding. This would be best explored in interviews with service users' families. In the focus group interviews, stakeholders were alert to families' fears that service providers might recommend that their child be removed from their care. Building trust with families is vital to avoiding non- or disengagement (Mason et al., 2020). The entrenchment of avoidable issues in which there may be a family script of being mistrusting of health-care services is important to recognize. Similarly, parents may find it hard to recognize that their infant is ill due to their own unresolved trauma (Fraiberg et al., 1975). These factors contribute to the resistance to engagement with services in a helpful manner. The additional theme

of continuous evaluation and feedback was recognized by stakeholders when interviewed in groups to be an important part of service development. Norton (2021) recognized that there is a paucity of literature on the theme of co-production in relation to Child and Adolescent Mental Health Services.

4.1.6 | Operating conditions and local production of candidacy

The *Gaps in Current Service* described here have the potential to be addressed in this final step of the candidacy journey. Historically there has been limited provision for under 5s both in this health board and in the UK more generally (Hogg, 2019). Participants also described the "entrenchment of avoidable issues" as a challenge linked to the prior absence of services. These reflections conveyed a feeling of being daunted by the enormity of the task inherent in ensuring that intervention is offered early and that intergenerational issues are addressed. Professionals may have "fallen into" their roles by chance but were nonetheless passionate about service development and optimistic about working together. This is in keeping with a major enabling factor described in our previous paper which was participants' Current Optimism and Enthusiasm about the development of IMH services (Weaver et al., 2022).

The need for leaders to continue to support IMH service development and ensure accountability is critical. There is evidence that IMH services are a cost-effective early intervention but the peaks and troughs of interest have hindered their development (Love & McFadyen, 2020; Durkan et al., 2021). A consistent drive for the development of IMH systems operating at all levels which are infant-focused and supported by a specialist team of practitioners is crucial.

4.2 | Strengths and limitations

This study was carried out during the early stages of IMH service planning prior to its opening. We did not interview potential service users but instead focused on a purposefully sampled group of professional stakeholders. This group had personally invested in the development of the IMH service and this may be viewed as a limitation. A further study examining the views of General Practitioners in areas of deprivation has been completed and a study examining the views of service users is planned. The infant's own voice may be difficult to capture. Attempts to do this will be augmented by the views of parents, carers and involved professionals which will also be of value.

Professionals interviewed did refer to their perceptions of the experiences of infants and their families and in this respect the views of the third sector officer provided some insight into the perceived challenges.

Most participants were from the health sector which was not surprising given that this study aimed to support the development of a mental health service. Nevertheless, the views from participants in education, social services and third sector are also included as they are equally important. Many of them were leaders or managers of teams, with some having experience of working in Europe or different mental health departments. The diverse range of professionals interviewed individually and the triangulation of data from the focus groups interviews are strengths of the research.

The participants were predominantly white women, which may be a reflection of a higher female workforce interested in IMH services and the demographics of the area in which the research was conducted. Future research should aim to collect the views of a wider and more diverse group of professionals and carers.

Although this study was carried out in one area of Scotland it is likely that some of the themes identified will be relevant in other parts of the United Kingdom and other countries around the world. Literature on the IMH service development in LMIC countries is limited but Toran et al. highlighted five critical issues when examining the IMH system in Malaysia (2011). Some of these key elements including policy, resources, personnel training, cultural sensitivity and early screening have similar strands to the main themes identified in this paper; suggesting the findings are relevant to not just high- and middle-income countries.

4.3 | Clinical implications

Using the lens of the candidacy framework this paper presents the findings of a qualitative research project which examined a group of professionals' views about IMH services and why they are challenging to build and sustain. The complex interplay of systemic factors which impact on the development and implementation of the service is described.

The comments of participants resonated strongly with the themes articulated in *Rare Jewels* (Hogg, 2019). These included the need for "focused and determined leadership" with clear accountability and governance. They have been grouped here into macro, meso, and micro levels and suggestions have been made about actions which would ensure that any services being developed are sustainable and accessible. National and local governments have a clear role at a strategic level, and operationally should not

only provide sufficient resources but also monitor access and effectiveness.

Patients' journeys into services are helpfully broken down into a series of steps (Figure 1). Consideration of what happens at each of these stages has the potential to improve the access of those most in need of services. We have seen that many things may interfere with referral and engagement, including professionals' understanding of the importance of early relationships and public perceptions about IMH. Our findings shed some light on these and we propose that professional education is accompanied by public health initiatives such as that embodied in the 1001 Days campaign (1001days.org.uk). In addition, local services must ensure that their services are delivered equitably and reach those in most need. This will depend on good respectful relationships with local referrers with whom a shared language is developed to ensure clear communication.

The factors identified here are likely to be relevant globally including in LMIC countries where IMH service development is in its infancy (WHO, 2018). Alongside the perceived barriers and enablers identified previously (Weaver et al., 2022), this research demonstrates the clear view of professionals that IMH services must be infant-centered with integrated multiagency working to ensure that all babies have their mental health and wellbeing needs met. This can be done by making sure that leaders prioritize the development of IMH services which are accountable and accessible to those most in need.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

For data protection, each participant was given a study ID, and a document tracking this system was kept separately, in a password-secured file. Transcripts were stored in a password-protected space and can be made available if deemed appropriate and retains confidentiality for participants. The data that support the findings of this study are available from the corresponding author upon reasonable request.

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