disorders should be further strengthened by improving communications between these teams.

Nationwide research into prevalence and service needs should be carried out to formulate and influence policies.

Psychiatrists need to take a more active role in combating cultural beliefs and stigma among patients and their families by introducing maternal mental health literacy among the general public and advocating for policies to improve services for women in the perinatal period.

Conclusions

The timely detection and treatment of perinatal mental illnesses are of utmost importance. It is essential to educate policy makers and professionals regarding these and to develop innovative research and policies that are culturally sensitive, feasible as well as sustainable.

Author contributions

A.H. and K.A.L.A.K. both contributed to the literature survey and the writing of the manuscript.

Declaration of interest

None.

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THEMATIC PAPER

Perinatal mental health around the world: priorities for research and service development in Norway

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Despite the country's generous social welfare systems, perinatal mental health problems are prevalent in Norway. National guidelines recommend that health services identify women with perinatal mental conditions, but systematic screening and clear treatment pathways are not nationally endorsed, neither are recommendations for evaluating and treating possible parent–infant interaction difficulties of affected mothers. There are no subspecialties in perinatal psychiatry or psychology, hence healthcare personnel often lack expertise about perinatal mental health.

To safeguard the mental health of infants and parents, we need to establish systematic communication between primary healthcare professionals, as well as between primary- and secondary-level professionals.

Norway is a sparsely populated Nordic country with 5.7 million inhabitants. The larger cities have more concentrated populations, especially in the central-eastern area around Oslo (23% of the country's population). About 18% of inhabitants are immigrants, mostly from Europe. Non-Western immigrants are mainly Asian (33.5%) or

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African (14.0%). Norway also has an indigenous people: the Sami (around 1% of the population). Norway has the fourth-highest income per capita according to the World Bank. Nevertheless, despite large investments in health, several factors suggest an increasing prevalence of mental disorders.[1]

Norway's parental leave policies are generous. Parents have up to 52 weeks of paid parental leave before and after delivery, with at least 15 of these weeks reserved for the mother or the father. Currently, 71% of fathers make use of this opportunity.[2] If a new mother is too ill to take care of her infant, the father is entitled to take over her part of the leave.

Universal perinatal programmes are in place to safeguard the physical and mental health of the mother and child during pregnancy and after birth. All pregnant women are entitled to free maternity care from a midwife at a maternal and child health (MCH) centre or from their general practitioner (GP), and all costs related to delivery and hospital stay are covered. The period spent in the maternity ward has gradually been reduced from an average of 4.1 days in 1999 to 2.8 in 2017. Consequently, more of the responsibility for the early postnatal period has been transferred to municipalities. Within the first week postpartum, mothers should receive a home visit by a midwife or a public health nurse to ensure that mother and baby are healthy.[3] However, many municipalities do not have enough time and/or resources to follow up on postnatal women and newborns.[4] Midwives and public health nurses play an important role in identifying perinatal alcohol and drug misuse, domestic violence, sexual abuse and developmental problems in children, while the GP is responsible for diagnosis and treatment.

Perinatal mental health

Despite generous social welfare arrangements and a well-developed healthcare system, the prevalence of depressive symptoms among perinatal women in Norway does not differ from that in other high-income countries.[5] Studies among immigrants in Norway have shown similar results.[6] Suicide has been reported as the most common indirect cause of maternal deaths in Norway.[7] The level of perinatal illness among fathers remains unstudied.

The Norwegian guidelines for pregnancy care recommend that health services identify women with symptoms of perinatal mental health problems.[8] However, there is no directive for how this should be done nor what type of follow-up those identified should receive.[5] Screening women for depression in connection with pregnancy and the postpartum period was assessed by the Norwegian Council for Priority Setting in Health Care in 2013, with the conclusion that postnatal depression screening should not be introduced at a national level.[5] Despite this recommendation, approximately 50% of Norwegian midwives and primary health nurses use the Edinburgh Postnatal Depression Scale (EPDS) for exploring mental health issues in pregnant and postpartum women.[9]

The MCH centres offer both individual and group-based support for families, addressing difficulties with the child, the parental role and interaction problems. An increasing number of MCH centres have access to psychologists, which has strengthened the implementation of early prevention and treatment efforts for perinatal mental disorders. Unfortunately, many MCH centres do not employ psychologists, as this service is not mandatory.

The GP is central in providing first-line mental healthcare to perinatal women. The GP knows the woman and her family, her previous mental and medical problems, as well as her current social situation. GPs can provide supportive listening and basic psychotherapy and initiate and monitor psychotropic medication. Unfortunately, significant deficiencies exist in communication between MCH centres and GPs in many parts of Norway.[10] Perinatal women with substance use disorder, and their children, can receive treatment via interdisciplinary specialised drug prevention services for parents.[11] Pregnant women with a harmful addiction may, by law, be detained in treatment facilities without their consent to prevent harmful effects on their infants.

The GPs refer women with more serious perinatal mental health problems to a district psychiatric centre for acute evaluation, out-patient consultations or hospital admission. There are no separate referral pathways or services for perinatal women, but out-patient services should prioritise pregnant women and parents with infants and small children for treatment.[12] The maximum allowed waiting time can be up to 14 weeks after referral, and this may cause critical delays in treatment for new parents and children.

Perinatal women often meet doctors and therapists without special knowledge of perinatal mental health challenges, as there is no mandatory education or subspecialty in perinatal psychiatry or psychology. GPs may therefore receive conflicting advice from different specialists regarding psychotropic medication during pregnancy and lactation. Norwegian guidelines in obstetrics recently included an extra chapter focusing on how to handle pregnant women with psychiatric disorders.[13] Parents may need support in interacting with their children in addition to treatment for their own problems. However, there are no recommendations for evaluating or offering specific treatment regarding parents' bonding and interaction problems with infants when the mother is ill.

Mothers do not usually bring their infants with them when admitted to hospital, owing to limited facilities or because of objections from their partners. Mother–baby units are not required by national policy, but a small mother–baby in-patient unit at Orkdal District Psychiatric

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Centre in mid-Norway has treated women with postpartum depression since 2017. The unit allows cooperation between adult, child and adolescent psychiatry and community health services. In Norway, the father of the child is encouraged to take an active part in caring for the baby from the start. This may reduce the need for mother–baby units in Norway.

Networking

For the past 20 years, Norwegian researchers have contributed to a range of quantitative and qualitative studies within the field of perinatal mental health. In 2013, Norwegian researchers were central in the establishment of the Nordic branch of the International Marcé Society for Perinatal Mental Health, a forum for inspiration and cooperation among perinatal clinicians, researchers and consumers. In 2017, the consumer-driven organisation *Landsforeningen 1001 dager* (1001 days) was established, dedicated to helping families struggling with perinatal mental health issues. The organisation has spurred political lobbying, provided information to perinatal women and the public through media, and been a driving force for further cooperation among perinatal health professionals in Norway. Such alliances of professionals, politicians and people with lived experiences may result in better research, service development and improved mental health for perinatal women, their infants and families.

Recommendations for service development and research

Our main conclusion regarding the status of perinatal mental health in Norway is that it is unclear who owns the responsibility when one of the parents has a mental health problem. The lack of specialised services and ill-defined referral pathways often hinder efficient treatment for severe perinatal mental disorders. Therefore, systematic cooperation among primary-level health professionals, but also between levels, is necessary for effective communication regarding parents' mental health in order to identify vulnerable families in the perinatal period.

We recommend developing national programmes for the systematic disclosure of or screening for perinatal mental health problems, alcohol and drug misuse, domestic violence and sexual abuse for both parents. Furthermore, the MCH centres should establish routines to identify problematic parent–infant interactions and early signs of infant mental health problems (e.g. regulation difficulties or social withdrawal). We recommend establishing low-threshold psychological interventions, delivered by public health nurses or psychologists, in primary healthcare for women identified with a perinatal mental health problem. Family–child and parent–child interaction support should also be easily available. This systematic disclosure/screening and the treatment pathway must be part of the mandatory health service from each municipality, to ensure stable funding.

Establishing local perinatal liaison services may be a solution to facilitate rapid communication between primary healthcare providers and specialists in adult and child psychiatry/psychology, obstetrics and neonatology. This may be organised through dedicated specialists in the acute ambulatory teams at district psychiatric centres. For vulnerable families, where one of the parents has a mental illness, interdisciplinary family teams may be a way of organising mental healthcare for the whole family. Issues related to perinatal mental health should be included in the continuing education of specialists in psychiatry and psychology.

We need more service research regarding how to improve the identification of perinatal mental disorders and how to organise mental healthcare and referrals during this period. We also need to evaluate what is accessible and appropriate evidence-based treatment for parents and children in the perinatal period and whether mother–baby units are feasible in Norway.

Data availability

Data availability is not applicable to this article as no new data were created or analysed in this study.

Author contributions

M.S.H. and S.K.D. drafted the manuscript, C.E.A.W. revised the content critically and made suggestions for further content. M.E.-G. critically revised the manuscript and drafted major revisions. M.S.H. and then S.K.D. incorporated the suggested changes from all co-authors and the external reviewers into the final manuscript. All authors agreed on the accountability of the content and approved the final manuscript.

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Declaration of interest

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GLOBAL ECHOES

A White doctor recalls mental hospital practice in apartheid South Africa

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The article offers a personal memoir of a psychiatric registrar's impressions of daily life while working in a South African mental hospital during the apartheid era in the late 1960s. From the perspective of a trainee psychiatrist, he recalls admission procedures, ward management, patient assessment, and medical and nursing care, including electroconvulsive therapy administration, at that time.

More than 50 years ago I was a registrar in psychiatry at Witwatersrand University Medical School in Johannesburg, South Africa. As part of the training I worked for 6 months at Sterkfontein Mental Hospital near the town of Krugersdorp and it was there that I recorded the following impressions, which I hope will be of interest to readers as a glimpse into the past and an awareness of ground still to be covered. The year is 1968.

Admission

Every few days a police van draws up outside the Admission ward in the 'Non-European' section of this large mental hospital, and disgorges its passengers. The people who climb uncertainly out of the van have all been committed to the hospital under the Mental Disorders Act. Some are pitifully neglected, malnourished and filthy. Most of them file unobtrusively into the ward, but one or two parade the bizarre behaviour that has brought them to their latest destination and have to be firmly steered into the custody of waiting nurses.

A common story is that they have been picked up as vagrants or that they have been involved in some violent incident in one of the sprawling townships that lie on the outskirts of the White residential areas. In a society where eccentric behaviour is more likely to attract a police van than an ambulance, these disturbers are moved to a police station, which then serves as a convenient half-way house out of the community.

They are kept in cells until they can be examined by a district surgeon, who decides whether or not they should be committed. The examination consists of a brief interview to establish whether there are legally acceptable criteria for the committal and to conduct a perfunctory physical check to rule out any somatic illness which might require urgent medical attention. The condition of some of the individuals who arrive at the hospital is sometimes strangely at odds with the routine health clearance entered on their medical certificates.

Most of the new arrivals are too wrapped up in their illness to know what is happening to them. Some think that they have simply been transferred to another jail. Inside the ward they are subjected to a handing-over ritual in which the police officer formally divests himself of

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