



Children, Young People and
Education Committee

Perinatal mental health in Wales

October 2017



National Assembly for Wales
Children, Young People and Education Committee

The National Assembly for Wales is the democratically elected body that represents the interests of Wales and its people, makes laws for Wales, agrees Welsh taxes and holds the Welsh Government to account.

An electronic copy of this document can be found on the National Assembly's website:

www.assembly.wales/SeneddCYPE

Copies of this document can also be obtained in accessible formats including Braille, large print, audio or hard copy from:

Children, Young People and Education Committee
National Assembly for Wales
Cardiff Bay
CF99 1NA

Tel: **0300 200 6565**

Email: **SeneddCYPE@assembly.wales**

Twitter: **[@SeneddCYPE](https://twitter.com/SeneddCYPE)**

© National Assembly for Wales Commission Copyright 2017

The text of this document may be reproduced free of charge in any format or medium providing that it is reproduced accurately and not used in a misleading or derogatory context. The material must be acknowledged as copyright of the National Assembly for Wales Commission and the title of the document specified.

Children, Young People and
Education Committee

Perinatal mental health in Wales

October 2017



National Assembly for Wales
Children, Young People and Education Committee

Children, Young People and Education Committee

The Committee was established on 28 June 2016 to examine legislation and hold the Welsh Government to account by scrutinising its expenditure, administration and policy matters, encompassing (but not restricted to): the education, health and well-being of the children and young people of Wales, including their social care.

Current Committee membership:



Lynne Neagle AM (Chair)
Welsh Labour
Torfaen



Michelle Brown AM
UKIP Wales
North Wales



Hefin David AM
Welsh Labour
Caerphilly



John Griffiths AM
Welsh Labour
Newport East



Llyr Gruffydd AM
Plaid Cymru
North Wales



Darren Millar AM
Welsh Conservative
Clwyd West



Julie Morgan AM
Welsh Labour
Cardiff North



Mark Reckless AM
Welsh Conservative Group
South Wales East

The following Member was also a member of the Committee during this inquiry:



Mohammad Asghar AM
Welsh Conservative
South Wales East

Contents

Executive summary	7
Recommendations.....	9
01. Background.....	13
First 1,000 Days	13
Perinatal mental health	13
Our approach to this inquiry	14
02. Government strategy	16
Together for Mental Health.....	16
Funding	16
Implementation.....	17
Accountability	18
Our view.....	20
03. In-patient care	22
Provision of Mother and Baby Unit (MBU) support	22
Demand for MBU support.....	23
The appropriateness of non-MBU care for acute cases.....	27
Wider benefits of MBU care	29
Options for future MBU provision	29
Our view.....	32
04. Specialist community support.....	35
Provision of specialist community support	35
Psychological therapeutic support.....	37
National quality standards.....	39
Our view.....	41
05. Clinical pathway	42
All-Wales clinical care pathway	42
Referral and waiting times.....	43
Our view.....	45
06. Integration of perinatal mental health services	46
Antenatal education, pre-conception advice and general public awareness	46
Training and continuous professional development.....	48
Communication between professionals.....	51
Continuity of care	52
Third sector	53

Neonatal care	55
Bereavement support	56
Our view	57
07. Bonding and attachment	60
Interventions	61
Feeding	61
Medication	63
Our view	64
08. Health inequalities	66
Dual diagnosis and learning disabilities.....	67
Language and communication	68
Teenage pregnancy	68
Our view	69
Annex A – List of oral evidence sessions.....	70
Annex B – List of written evidence	72

Data produced in the infographic opposite are drawn from the following sources:

Written evidence PMH 06 – Public Health Wales

Written evidence PMH 15 – Royal College of General Practitioners Wales

The National Institute for Health and Care Excellence (NICE) (2015) Antenatal and postnatal mental health: clinical management and service guidance.

Royal College of Psychiatrists (2015) Perinatal mental health services: Recommendations for the provision of services for childbearing women

PERINATAL MENTAL HEALTH

Up to **1 in 5** women are affected by perinatal mental illness. There were **33,279 live births in Wales** in 2015 meaning between **3,328 and 6,656 new mothers** will have experienced a perinatal mental health issue.

12%

of women experience depression during pregnancy.

13%

of women experience anxiety during pregnancy.

15-20%

of women experience depression and anxiety in the first year after childbirth.

Postpartum psychosis affects between **1 and 2 in 1,000 women**.

50% of women who develop postpartum psychosis have **no history of previous mental illness**.

£8.1bn

Estimated long term cost of perinatal mental illness to society as a whole, for each year of births in the UK.

£1.2bn

Estimated cost of perinatal mental illness to the NHS, for each year of births in the UK.

Psychiatric disorder has been a **leading cause** of maternal mortality, contributing to **15%** of all **maternal deaths** in **pregnancy** and **6 months postpartum**.

Executive summary

Perinatal mental illness affects up to one in five mothers. With around 33,000 births a year in Wales, approximately 6,600 women encounter mental health issues caused or worsened by pregnancy or childbirth. Conditions including depression, anxiety, and psychosis sit along a spectrum of severity, with symptoms that range from being treatable at home through to those requiring highly specialist, in-patient care in hospital. At its worst, mental illness is a leading cause of maternal death.

Evidence highlights that where perinatal mental illness affects a mother, the likelihood that her child will experience behavioural, social or learning difficulties also increases. Furthermore, partners and wider family members can be affected during this period, both emotionally and economically, as they seek to support both the mother and child affected.

Our inquiry showed that while the Welsh Government's recent investment of £1.5 million in specialist community perinatal mental health services is to be welcomed as a significant step forward, further work remains to be done in relation to mental health support for pregnant and new mothers in Wales. Following the closure in 2013 of Wales's only Mother and Baby Unit - a ward which allowed women to be admitted with their babies for treatment - it is estimated that as many as 100 women a year with severe mental illness have been treated in an adult psychiatric unit, separated from their child, or have had to travel as far as Derby, London and Nottingham for in-patient treatment.

While we recognise that Wales's geography poses challenges for the provision of specialist MBU beds, we conclude that their absence in Wales is not acceptable and must be addressed by the Welsh Government as a matter of urgency. We are pleased the light we have shone on this issue is already bearing fruit, and welcome the budget agreement announced on 01 October 2017 which commits to developing specialist in-patient perinatal mental health support for new mothers and their babies in Wales. As south Wales has the birth rates required by the clinical standards to sustain a specialist MBU, we recommend that a unit is established along the M4 corridor and funded on a national basis to provide services for the whole of Wales. We recognise, however, that travelling to south Wales is unlikely to be suitable for populations elsewhere, particularly the north. As such, while we note that north Wales alone does not have the necessary birth rates to sustain a specialist MBU, we call on the Welsh Government to engage proactively with providers in England to discuss options for the creation of an MBU in north east Wales that could serve the populations of both sides of the border.

We welcome the development of specialist community perinatal mental health teams across Wales during the last 12 months and wish to put on record our thanks to the committed staff who are working hard to establish and deliver high quality services. We recognise the vital role they can play in seeking to intervene early and prevent the deterioration of mental illness in perinatal mothers, and their important contribution to managing conditions in the community, reducing the need for families to travel for care and alleviating demand on hospitals. However, the variation in service provision across Wales is not acceptable. Timely, high quality services should be an expectation and a right for all women who experience perinatal mental illness rather than a matter of luck. As such, we make a number of key recommendations including providing more funding for those areas of Wales struggling to deliver the necessary services, and prioritising the provision of psychological support for pregnant and postnatal women given the established link between perinatal ill health and a child's health and development. We welcome the work to develop an All-Wales Perinatal Care Pathway and call on the Welsh Government to ensure that it focuses on equitable and consistent outcomes for all women in Wales, regardless of their location.

Awareness of perinatal mental health remains poor among the public and health professionals. Frontline staff - including midwives and GPs - feel ill equipped to identify and treat maternal mental illness. We recommend, therefore, that the Welsh Government undertake a public awareness campaign to improve understanding of perinatal mental health conditions and their symptoms. We believe that this is crucial if we are to reduce the high levels of stigma and fear associated with discussing mental illness. We also call on the Welsh Government to work with the relevant professional bodies to ensure that perinatal mental health becomes a core part of the training and continuous professional development of all healthcare professionals likely to come into contact with pre- and post- natal women. Communication between professionals also needs to improve to ensure that vulnerable women are identified quickly and receive the continuity of care that allows them to feel more able to confide and speak about how they are feeling.

The role of the third sector in identifying gaps in service provision and filling them was clear. Without the charity sector many services would not exist. More needs to be done to provide funding for and awareness of these services so that the statutory and third sectors can join together to provide integrated, clinically- and cost-effective interventions. We received worrying evidence about the lack of statutory support for neonatal and bereaved parents, and the role the third sector has to play to try to fill this void. We call on the Welsh Government to address this as a matter of priority.

The importance of attachment and bonding for parents and their children was highlighted. Children with whom secure attachments are not established early in life can be at greater risk of a number of detrimental outcomes including poor physical and mental health, relationship problems, low educational attainment, emotional difficulties and conduct disorders. To help improve interventions to support bonding and attachment, we recommend that the Welsh Government explore whether the role of specialist health visitor in perinatal and infant health introduced recently in England could be beneficial in Wales. Linked to this, we acknowledge the many documented benefits of breastfeeding for both mother and baby. The evidence we received about a feeling of pressure to breastfeed potentially contributing to some mothers' mental illness did, however, lead us to recommend that further work be undertaken to consider the impact of feeding on perinatal mental health. We were also worried to hear about the mixed messages which exist in relation to the use of medication during the perinatal period and call on the Welsh Government to ensure that established standards, advice and guidance on psychological medication during pregnancy and breastfeeding are in place.

Finally, we consider the relationship between health inequalities and perinatal mental health. It is clear that the perinatal period offers a particular opportunity for safeguarding wellbeing in the long term. We believe that a more concerted effort to reach more vulnerable groups is required, not least those with a dual diagnosis of perinatal mental illness and substance misuse or learning difficulties.

We look forward to receiving a response to our report in the next six weeks and will continue to monitor throughout this Assembly how our recommendations are being implemented.

Recommendations

Recommendation 1. That the Welsh Government establish and provide national funding for a clinician-led managed clinical network (MCN). The MCN should be provided with the necessary resource including senior clinical and administrative time, and a training budget. This will enable it to provide national leadership, coordination and expertise for the further development of perinatal mental health services and workforce, including in relation to quality standards, care pathways, professional competencies and training resources. The MCN should maintain the multi-disciplinary approach displayed by the current Community of Practice to encourage and develop effective joint working and communication among all relevant professionals. Page 21

Recommendation 2. That the Welsh Government ensure one of the new MCN's first tasks is to agree and publish outcome-based performance measurements for perinatal mental health services. Once these are developed, the Welsh Government should collect and publish national and local data on the measures, with service provision, activity and improvement monitored by a named associated public body (e.g. Public Health Wales) so that further levers for improvement can be identified and implemented. Page 21

Recommendation 3. That the work requested by WHSSC to identify the level of demand for in-patient Mother and Baby Unit (MBU) services should be completed as a matter of urgency. We recommend that this work be finished during the 6-week window in which we would expect the Welsh Government to provide a response to this report and should be a core consideration when deciding how to allocate the funding for specialist in-patient perinatal mental health services announced as part of the 01 October budget agreement. Page 32

Recommendation 4. That the Welsh Government ensure, once the urgent work to establish the level of demand for MBU services is completed as requested by WHSSC, more robust data collection and monitoring methods are maintained across the perinatal mental health pathway in order to understand the ongoing level of need and demand for support and to provide a stronger evidence base for future service development. Page 33

Recommendation 5. That the new managed clinical network (see recommendation 1) prioritises the production of guidance for professionals and information for patients on the evidence-based benefits admission to an MBU can have for mothers, babies, and their families so that more informed decisions about treatment options can be taken. Page 33

Recommendation 6. That the Welsh Government, based on the evidence received, establish an MBU in south Wales, commissioned and funded on a national basis to provide all-Wales services, staffed adequately in terms of numbers and disciplines, and to act as a central hub of knowledge and evidence-based learning for perinatal mental health services in Wales. Page 33

Recommendation 7. That the Welsh Government, in light of the fact that an MBU in south Wales will not necessarily be suitable for mothers and families in mid and north Wales, engage as a matter of urgency with NHS England to discuss options for the creation of a centre in north east Wales that could serve the populations of both sides of the border. More certainty should also be established by

the Welsh Government in relation to the ability of the Welsh NHS to commission MBU beds in centres in England where those are deemed clinically necessary. Page 33

Recommendation 8. That the Welsh Government deliver a clear action plan to ensure that centres providing MBU beds, wherever they are located (in England or in Wales), are closely integrated with specialist community perinatal mental health teams and that these beds are managed, co-ordinated and funded on an all-Wales, national basis to ensure efficient use and equitable access, especially as they are often needed quickly in crisis situations. Page 33

Recommendation 9. That, on the basis of an ‘invest to save’ argument and following analysis of the forthcoming evaluation of services and Mind-NSPCC-NMHC research results, the Welsh Government provide additional funding to Health Boards to better address variation so that service development and quality improvement can be achieved by expanding existing teams. To enable all community perinatal mental health services to be brought up to the standard of the best, the mechanism adopted by the Welsh Government to allocate additional funding should have as its primary aim the need to address the disparity in provision between Health Boards in Wales. Page 41

Recommendation 10. That the Welsh Government ensure work underway on improving access to psychological therapies for perinatal women (and men where necessary) is prioritised given the established link between perinatal ill health and a child’s health and development. Priority should be given to ensuring pregnant and postnatal women with mental health problems have rapid and timely access to talking therapies or psychological services (at primary and secondary care level), with waiting times monitored and published. We request an update on progress in relation to improving access to psychological therapies for perinatal women (and men where necessary) within 12 months of this report’s publication. Page 41

Recommendation 11. That the Welsh Government ensure all Health Boards invest in signing up fully to the Royal College of Psychiatrists’ quality standards for perinatal mental health services in order to realise the benefits of peer review, shared learning and service benchmarking. Page 41

Recommendation 12. That the Welsh Government ensure that the new all-Wales clinical care pathway for perinatal mental health services requires consistency of outcomes (including referral windows and waiting times) but enables Health Boards to retain the level of flexibility around delivery methods necessary to manage and meet local need. The priority should be to develop and implement within the next 12 months an evidence-based, integrated all-Wales clinical care pathway (with some local differences). The pathway should help to deliver integrated services and incentivise early intervention and holistic approaches to care and recovery. Page 45

Recommendation 13. That the Welsh Government and Health Boards work together to raise awareness of perinatal mental health issues amongst the public and health professionals, particularly midwives. This should take the form of a public awareness campaign to improve understanding of the symptoms and risk factors associated with perinatal illness and should encourage the normalisation of discussion of emotional well-being in order to reduce stigma and fear of disclosure. Page 57

Recommendation 14. That the Welsh Government review information provided in standard pre- and post-natal packs given to women in Wales to ensure that it includes the necessary details about emotional well-being, perinatal mental health and where to seek help and support. Page 57

Recommendation 15. That the Welsh Government design and provide for all Health Boards a national framework for antenatal classes and require Health Boards to do more to encourage attendance. The framework should include conversations about emotional wellbeing and the realities of parenthood in order to break down the significant and damaging stigma surrounding perinatal mental illness. Page 58

Recommendation 16. That the Welsh Government work with the relevant bodies to ensure that perinatal mental health is included in the pre-registration training and continuous professional development (CPD) of all health professionals and clinicians who are likely to come across perinatal women. The Welsh Government should ensure coverage of perinatal mental health as a discrete topic within midwifery and health visiting education is improved and forms part of the pre-registration mental health nursing programme. The Royal College of General Practitioners' core curriculum for general practice training also needs to better equip GPs to deal with perinatal mental health problems. Page 58

Recommendation 17. That the Welsh Government undertake work to develop and deliver a workforce strategy/competency framework to build capacity and competency across the specialist workforce, looking to experience in England and Scotland's Managed Clinical Networks (MCNs) which take responsibility for training as part of their leadership and co-ordination role. Page 58

Recommendation 18. That the Welsh Government ensure every Health Board has a specialist perinatal mental health midwife in post to encourage better communication between professionals to enable women who are unwell to get the very best care and support they need. Page 58

Recommendation 19. That the Welsh Government ensure all Health Boards work towards a situation in which every woman has a continued relationship with either a midwife or health visitor. While meeting with the same individual may not be possible on all occasions, continuity of care should be an aspiration to which all Health Boards actively commit resources, with a named lead responsible for each woman's perinatal care. Page 59

Recommendation 20. That the Welsh Government work with Health Boards to ensure appropriate levels of third sector provision are properly funded, especially where referrals are being made to and from statutory services. A directory of third sector services should be made available to increase awareness of their availability and relevant third sector providers should be invited as a matter of course to attend training jointly with statutory services. Page 59

Recommendation 21. That the Welsh Government outline within six months of this report's publication how it expects the lack of psychological support for neonatal and bereaved parents to be addressed and standards to be met, and what steps it will take if compliance with the standards is not achieved. The third edition of the neonatal standards should be published as a matter of priority. Page 59

Recommendation 22. That the Welsh Government give consideration to developing a specialist health visitor in perinatal and infant health role in Wales to liaise with - and work in - a multidisciplinary way with CAMHS and infant mental health services, provide specialist support to mothers, fathers and their children, and provide specialist training and consultation to the wider health visiting and early years’ workforce, particularly with regard to issues relating to attachment and bonding. Page 64

Recommendation 23. We recognise the benefits of breastfeeding especially with regards to bonding and attachment and recommend that the Welsh Government commission work to look in further detail at the impact of feeding on perinatal mental health and translate this into guidance for professionals and the public. Page 65

Recommendation 24. That the Welsh Government ensure Health Boards have in place established standards, advice and guidance on psychological medication during pregnancy and breastfeeding, and ensure that they are implemented. Page 65

Recommendation 25. That the Welsh Government ensure all workforce planning for perinatal mental health service provision considers - and provides for - the Welsh language needs of the population. Page 69

Recommendation 26. That the Welsh Government require Health Boards to report on the extent to which their perinatal mental health teams are engaging - and undertaking joint work - with other services such as CAMHS, Community Addiction Units (CAUs) and primary and secondary care mental health teams. Page 69

Recommendation 27. That the Welsh Government undertake further work on the link between health inequalities and perinatal mental health, focusing in particular on the best mechanisms for the early identification and treatment of those populations in greatest need. Page 69

01. Background

First 1,000 Days

1. Researchers have identified the First 1,000 Days of a child's life - from pregnancy through to a child's second birthday - as a critical window of time that sets the stage for a person's intellectual development and lifelong health. It is a period of enormous potential, but also of enormous vulnerability. Using the term "First 1,000 Days" gives significance to the impact of the early years on children's development and well-being, in the same way as we recognise terms such as toddler, teenager and senior citizen.
2. In December 2016 we undertook a consultation on the First 1,000 Days. The aim of the consultation was to inform our consideration of the extent to which Welsh Government policies and programmes support the early parent role, before birth and during the first two years of a child's life, and how effective these are in supporting children's emotional and social capabilities and development.
3. Evidence submitted to the First 1,000 Days consultation suggested that a more detailed piece of work on perinatal mental health was necessary, particularly as poor parental (including perinatal) mental health can have a significant impact on children's health and development.¹ In March 2017, we decided to undertake a focused inquiry on this topic.

Perinatal mental health

4. The perinatal period begins at the start of pregnancy and runs until the end of the first year after a baby is born. Perinatal mental health is about the psychological and emotional health and well-being of pregnant women and their children, their partners and their families.
5. During pregnancy (also referred to as the "prenatal" or "antenatal" period) and after the birth of a child (often called the "postnatal" or "postpartum" period), women are at a higher risk of experiencing mental health problems. Perinatal mental health problems are defined by a spectrum of mental health issues, including anxiety, depression and postnatal psychotic disorders which have their onset during pregnancy or the first year after a baby's birth. This period is also a time when a range of mental health conditions that a woman may have previously experienced can return or worsen.²
6. It is estimated that perinatal mental ill health affects up to 20 per cent of women at some stage during their pregnancy or in the first year after childbirth.³ Depression and anxiety are the most common mental health problems during pregnancy, with around 12 per cent of women experiencing depression and 13 per cent experiencing anxiety (including conditions such as post-traumatic stress disorder, obsessive-compulsive disorder, generalised anxiety disorder, and tokophobia⁴) at some point. Many women will experience both. Depression and anxiety also affect 15-20 per cent of women in the first year after childbirth.⁵
7. A smaller number - between 1 and 2 in every 1,000 women having a baby - will experience psychotic episodes, or postpartum psychosis, which is classed as a serious mental illness. Postpartum

¹ Written evidence, *PMH 06 - Public Health Wales*.

² Written evidence, *PMH 06 - Public Health Wales*.

³ Written evidence, *PMH 23 - Mind Cymru*.

⁴ Tokophobia is an extreme fear of childbirth.

⁵ NICE (2015), Antenatal and postnatal mental health: clinical management and service guidance.

psychosis can happen to any woman, although the risk is higher in women with bipolar disorder or schizophrenia.⁶

8. While treatment is just as effective for women in the perinatal period as at other times, perinatal mental ill health is associated with a heightened need for prompt and effective care. This is because a mental health problem during the perinatal period not only has the potential to adversely affect the mother, but also has lasting consequences for the developing child. Linked to this, the separation of mother and infant can have serious effects on the mother infant relationship and be difficult to reverse.⁷

9. The risks from loss of bonding opportunities in the early days of an infant's life is well evidenced and can have a long term impact on mothers, babies and the wider family and result in longer recovery times for mental health problems.⁸ Furthermore, while the mental health charity Mind notes that only mothers can formally be diagnosed with a perinatal mental health problem, it points to studies which suggest that partners can also experience perinatal mental health problems, with around one in five men experiencing depression after becoming fathers.⁹

10. Perinatal mental illness is associated with maternal mortality, which is generally low in the UK. From 2009-2013, almost a quarter of women who died in the UK between six weeks and one year after pregnancy died from mental-health related causes, with 1 in 7 women dying by suicide.¹⁰

11. It is widely acknowledged that even if perinatal mental illness itself is not preventable, it is possible to prevent many of the negative effects of perinatal mental health illness on families and, with the right care and support, women can make a full recovery and have fulfilling family lives.¹¹

Our approach to this inquiry

12. At the outset of this inquiry we identified the following areas as those we were particularly keen to explore:

- The Welsh Government's approach to perinatal mental health, with a specific focus on accountability and the funding of perinatal mental health services covering prevention, detection and management of perinatal mental health problems (including whether resources are being used to the best effect).
- The pattern of in-patient care for mothers with severe mental illness who require admission to hospital across both specialist mother and baby units (designated mother and baby units in England) and other in-patient settings in Wales.
- The level of specialist community perinatal mental health provision that exists in each Health Board in Wales and whether services meet national standards.

⁶ Written evidence, *PMH 19 - Royal College of Psychiatrists*.

⁷ WHSC (2017), [Paper to Joint Committee: Tier 4 Specialist Perinatal Mental Health in Wales](#)

⁸ WHSC (2017), [Paper to Joint Committee: Tier 4 Specialist Perinatal Mental Health in Wales](#)

⁹ Mind (2016), [Understanding postnatal depression and perinatal mental health](#), page 11.

¹⁰ Maternal, Newborn and Infant Clinical Outcome Review Programme & MBRRACE-UK (2015) [Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK 2011- 13 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13](#).

¹¹ See, for example, written evidence *PMH 06 - Public Health Wales* and *PMH 27 - Action on Postpartum Psychosis*.

- The current clinical care pathway and whether current primary care services respond in a timely manner to meet the emotional well-being and mental health needs of mothers, fathers and the wider family during pregnancy and the first year of a baby's life.
- Consideration of how well perinatal mental healthcare is integrated, covering antenatal education and preconception advice, training for health professionals, equitable and timely access to psychological help for mild to moderate depression and anxiety disorders, and access to third sector and bereavement support.
- Whether services reflect the importance of supporting mothers to bond and develop healthy attachment with her baby during and after pregnancy, including breastfeeding support.
- The extent to which health inequalities can be addressed in developing future services.

13. To inform our work on this inquiry we used the evidence submitted as part of the First 1,000 Days consultation and supplemented that with a targeted call for written evidence and 11 oral evidence sessions. A list of those who gave oral evidence and responded to our targeted call for written evidence is included in Annex A. We would like to thank all of those who contributed to this process.

14. As part of our inquiry we were keen to hear from those with lived experience of perinatal mental illness. We held an event with stakeholders on 18 May 2017 to obtain the views of service users and health professionals. We are very grateful to the 25 people who came from across Wales to contribute to our discussion and who willingly shared their experiences with us.

02. Government strategy

Together for Mental Health

15. The Welsh Government's Together for Mental Health Delivery Plan 2016-2019 highlights the need for improved access to perinatal mental health services across Wales. One of its stated priorities is to ensure that "all children have the best possible start in life which is enabled by giving parents/care givers the support needed".¹²

16. To deliver that aim the Plan requires all Health Boards to have a community perinatal service in place, to ensure that educational and training programmes are provided across Wales to improve awareness and management of perinatal mental health problems, and for information and support to be offered to women during pre- and post-natal periods to support healthy attachment, drawing on Welsh Government programmes like Flying Start, Families First, Bump, Baby and Beyond, and third sector initiatives.

Funding

17. In June 2015, the Welsh Government announced £1.5 million per year of new funding to improve mental health outcomes for women with perinatal illnesses, their babies and families. The funding was to be used to establish community-based specialist perinatal services across every Health Board in Wales and would be allocated on the basis of the number of births rather than the existing level of service provision. The expectation was that community perinatal mental health services would be available in each Health Board by November 2016.¹³

18. Following the funding announcement, the Welsh Government explored the various community-based services currently in operation in Wales, met with stakeholders and considered the core components of a community-based service. All Health Boards were required to submit proposals that were collaborative and multi-disciplinary to ensure that services would fit the needs of local populations. Health Boards were asked to:

- consider what professional roles each team should comprise;
- give due regard to existing services; and
- consider how the improved services would be delivered equitably across the Health Board area (for example, in Flying Start areas, Health Boards were required to demonstrate appropriate linkages).

19. When asked whether Health Boards have sufficient staff and resources to deliver an effective and appropriate perinatal mental health service, the Cabinet Secretary for Health, Well-being and Sport, Vaughan Gething AM, told us:

"I think it's really important not just to see this as, 'Is the £1.5 million delivering the whole service?', because this is about pump-priming a service that did not exist in the same way beforehand, but about being part of how you plan your service for your whole community. So, it's part of a wider team. [...] It isn't simply to say, 'This is nothing to do with me; go into the specialist team.' You've still got responsibilities for the people you provide healthcare for. It's

¹² Welsh Government (2016), Together for Mental Health Delivery Plan 2016-2019, page 13.

¹³ Written evidence, *PMH 21 - Welsh NHS Confederation*.

also about remembering that this isn't a service that just relies on £1.5 million, because the whole budget is nearly £7 billion, and so, actually, we need to think about how the whole service is deployed and not just this one part of it, albeit we recognise that there was a gap and that's what the money and the commitment is helping to deliver on."¹⁴

20. Following the conclusion of our evidence gathering, the Welsh Government announced as part of its budget agreement with Plaid Cymru for 2018-19 and 2019-20 a commitment that the Welsh NHS will develop specialist in-patient perinatal mental health support for new mothers and their babies in Wales.¹⁵ At the time of this report's publication, no further detail was available. Matters relating to specialist in-patient services are considered in more detail in chapter 03 of this report.

Implementation

21. Prior to the allocation of the new funding, only Cardiff and Vale University Health Board (CVUHB) and limited areas of Abertawe Bro Morgannwg University Health Board (ABMUHB) had some level of specialist perinatal mental health support available.¹⁶ Beyond those areas, the limited support available was provided by universal primary care professionals and/or community mental health teams who did not necessarily have specialised perinatal mental health training or experience.

22. The majority of those who provided evidence acknowledged that the injection of funds announced for specialist perinatal mental health services in 2015 has led to a considerable improvement in the ability of Health Boards to provide services for those in need relative to the pre-2015 period. Nevertheless, a number of witnesses concurred with the view expressed by the Royal College of Psychiatrists (RCPsych) that:

"...there has always been a shortfall of perinatal mental health services in Wales so we are working from a very low baseline. More investment is needed to meet the needs of those requiring treatment, to improve the availability of training in perinatal mental health to health professionals, and to address shortfalls in some areas across Wales."¹⁷

23. All Health Boards reported that they had successfully filled the majority of the posts within their newly created teams and all, bar Betsi Cadwaladr University Health Board (BCUHB), reported that they were operational. However, continued variation in provision of support across Health Boards was cited by the majority of witnesses as an ongoing issue. Giving evidence as the Welsh Representative of the Perinatal Faculty of the RCPsych, Dr Sue Smith, Consultant Psychiatrist, told us:

"...it's a really good start, but there's still a way to go, particularly in some of the health boards [...] because it was starting from different baselines, some were starting from scratch, and so they had to look around for the best ways to actually use that money in their particular service. It's different depending on the amount of rurality, the number of births, obviously, and the way that

¹⁴ Oral evidence, *Record of Proceedings [para 25]*, 12 July 2017.

¹⁵ Welsh Government, *Budget Agreement 2018-19 and 2019-20*, 01 October 2017.

¹⁶ Oral evidence, *Record of Proceedings [para 282]*, 24 May 2017.

¹⁷ Written evidence, *PMH 19 - Royal College of Psychiatrists*.

existing services are configured, and how much input there is, perhaps, in primary care and voluntary services.”¹⁸

24. At our stakeholder event, several participants said that the statutory provision for perinatal mental health services available is not sufficient. They explained that getting a referral into the service could be very difficult and that there was no clear pathway for accessing support. A phrase used repeatedly was “we had to fight to get the help we needed”.¹⁹

25. More detailed consideration of specialist community perinatal mental health services, including funding arrangements, is given in chapter 04 of this report.

Accountability

26. Public Health Wales (PHW) noted in its written evidence that its ‘1000 Lives Mental Health and Learning Disabilities Improvement Team’, led by its national clinical lead for perinatal mental health services, has supported the development of a National Steering Group and Perinatal Community of Practice.²⁰ We were told that the group must report progress to the Children and Adolescent Mental Health Services and Eating Disorders (CAMHS/ED) Planning Network Steering Group on a quarterly basis, which in turn facilitates the reporting of perinatal mental health service developments to the NHS Wales collaborative to inform the chief executives of the seven Health Boards in Wales.²¹ In terms of accountability to the Welsh Government, progress is reported through Integrated Medium Term Plans (IMTPs).

The All Wales Perinatal Mental Health Steering Group (AWPMHSG) and Community of Practice (CoP)

The AWPMHSG was established in 2016 to offer advice and information as well as support the development of all-Wales standards and pathways for the delivery of perinatal mental health services. Its membership includes those with lived experience of perinatal mental illness, third sector organisations such as the NSPCC and Mind Cymru, the National Centre for Mental Health, midwives, health visitors, obstetricians, psychiatrists and specialist perinatal practitioners. It convenes and reports quarterly.

The AWPMHSG is also responsible for championing and enabling the provision of perinatal mental health training, and facilitates much of this work via the All Wales Perinatal Community of Practice (CoP). The CoP’s aim is to improve and develop community services across Wales by sharing learning, resources and materials to develop effective, efficient, empowering and equitable services to women who need them and to promote pathways to ensure timely and appropriate access to care.²²

¹⁸ Oral evidence, *Record of Proceedings [paras 7-9]*, 28 June 2017.

¹⁹ **Note of stakeholder event held on 18 May 2017**, published 13 June 2017.

²⁰ Written evidence, *PMH 06 - Public Health Wales*.

²¹ Written evidence, *PMH 29 - Welsh Government*.

²² **Additional written evidence provided by the All Wales Perinatal Mental Health Steering Group on its work and remit**, published 12 July 2017.

Managed clinical network

27. Representatives from across the range of Health Boards,²³ academia,²⁴ third sector,²⁵ Royal Colleges,²⁶ and the Institute of Health Visiting²⁷ supported the development of the Community of Practice into a managed clinical network for perinatal mental health, akin to those in existence for other aspects of maternity care such as cardiac, liver, foeto maternal unit and neurology.²⁸

28. Professor Ian Jones, representing the Maternal Mental Health Alliance and co-Chair of the AWPMSHG, compared Wales's arrangement to the developing managed clinical network in England:

“...our community of practice here has some of the same aims, but hasn't got the resources that they have in England. I think that has caused some difficulties and some problems [...] I did argue with the Welsh Government when the money was given, that taking some money, top-slicing from all of the health board budgets and funding a network at that time, with proper time funded for it and having a senior clinician to lead—. Scotland have just done this, actually, and Roch Cantwell, who is a very senior clinician, has been given, I think, two and a half days a week and has been funded to lead that network, with admin time, with a training budget—those kinds of things. I think the community of practice as it is, is good; I think there are some good things it's done, but I don't think it's resourced properly at the moment to really be a managed clinical network in the way that it could be.”²⁹

29. Professor Jones explained that a managed clinical network could have more impact than the current Community of Practice on training:

“...training is an ideal example of what you could give that clinical network responsibility to work out, and a budget: ‘How are we going to train our professionals? What is it that we can buy in and buy into?’”³⁰

30. Dr Sue Smith, Consultant Psychiatrist and second co-Chair of the AWPMSHG, cited the potential influence a managed clinical network, with more “clout” than a Community of Practice, could have by insisting that Health Boards invest in signing up to RCPsych quality standards:

“...it sometimes feels that perhaps we [the Community of Practice] haven't got that much clout in terms of actually insisting that certain health boards do certain things. In that way, a managed clinical network would maybe have a lot more influence. We can only advise and maybe write letters saying, ‘The community practice advises this’, but individual health boards, when they've got lots of other priorities, are not necessarily going to take that over something else that they need to be addressing.”³¹

²³ Oral evidence, *Record of Proceedings* [paras 304, 460 and 463-464], 28 June and [paras 137 and 153], 6 July 2017.

²⁴ Oral evidence, *Record of Proceedings* [para 368], 24 May 2017.

²⁵ Oral evidence, *Record of Proceedings* [para 32], 24 May 2017.

²⁶ Oral evidence, *Record of Proceedings* [para 198], 24 May and [para 177], 28 June 2017.

²⁷ Written evidence, *PMH 24 - Institute of Health Visiting*.

²⁸ Written evidence, *PMH 10 - Betsi Cadwaladr UHB*.

²⁹ Oral evidence, *Record of Proceedings* [para 368], 24 May 2017.

³⁰ Oral evidence, *Record of Proceedings* [para 368], 24 May 2017.

³¹ Oral evidence, *Record of Proceedings* [para 304], 28 June 2017.

Performance measures

31. Commenting on performance measures more generally Rhiannon Hedge, Senior Policy and Campaigns Officer for Mind Cymru, told us:

“...something that’s missing from the ‘Together for Mental Health’ delivery plan’s focus on perinatal health is around the performance measures—they’re not at all outcomes focused. The performance measures in the perinatal section of the delivery plan are just that the services exist and that 10 per cent of new mothers are in contact with community perinatal support. There’s nothing in there around whether those services are delivering improved outcomes, or whether people’s mental health is improving and they’re better able to manage their own mental health.”³²

32. With respect to reporting arrangements, Joanna Jordan, Director of Mental Health within the Welsh Government’s NHS Governance and Corporate Services, told us that the Welsh Government has requested regular updates from Health Boards about their progress with their plans for community perinatal mental health services. This includes information on recruitment, numbers of referrals, and contact with patients. In addition, Health Boards are expected to report on perinatal services via their regular progress reports to the All-Wales Mental Health Partnership Board on “Together for Mental Health”.³³

33. On the topic of developing the Community of Practice into a managed clinical network Karen Jewell, the Welsh Government’s Nursing Officer for Maternity and Early Years, noted that - given the relative youth of the specialist community services - the Community of Practice was the best approach for the moment as it enabled the sharing of practice. The Cabinet Secretary endorsed her view that a managed clinical network is more about having specialist clinicians who meet and share practice later in the process:

“Karen Jewell: So, definitely, it would be something that we would be open to later on, and it may well develop into a managed clinical network, but, probably, at this moment in time, so that it’s open and inclusive, a community of practice is probably the best way to go.”³⁴

Our view

34. We welcome the recent focus on - and investment in - perinatal mental health services in Wales. Given the long term costs of perinatal mental illness detailed in the infographic at the beginning of our report, we believe a strong case can be made - on the basis of an “invest to save” argument - to allocate more money to perinatal mental health services. We discuss this in further detail later in this report.

35. The important role played to date by the AWPMHSG and Community of Practice was clearly articulated during the course of our inquiry. The cross-sector, multi-disciplinary approach they have taken to their work should be praised and maintained. We note the concerns raised during our inquiry

³² Oral evidence, *Record of Proceedings* [para 7], 24 May 2017.

³³ Oral evidence, *Record of Proceedings* [paras 63-63], 12 July 2017.

³⁴ Oral evidence, *Record of Proceedings* [para 170], 12 July 2017.

that the Community of Practice lacks the formal authority and resource associated with a managed clinical network and support calls for its status to be reviewed.

Recommendation 1. That the Welsh Government establish and provide national funding for a clinician-led managed clinical network (MCN). The MCN should be provided with the necessary resource including senior clinical and administrative time, and a training budget. This will enable it to provide national leadership, coordination and expertise for the further development of perinatal mental health services and workforce, including in relation to quality standards, care pathways, professional competencies and training resources. The MCN should maintain the multi-disciplinary approach displayed by the current Community of Practice to encourage and develop effective joint working and communication among all relevant professionals.

36. We also note the current lack of outcome-based performance measurement of perinatal mental health services in Wales. Measuring the volume of activity alone is not sufficient - more work needs to be done to ensure that the nature of the activity undertaken, including the quality and impact of services, is monitored.

Recommendation 2. That the Welsh Government ensure one of the new MCN's first tasks is to agree and publish outcome-based performance measurements for perinatal mental health services. Once these are developed, the Welsh Government should collect and publish national and local data on the measures, with service provision, activity and improvement monitored by a named associated public body (e.g. Public Health Wales) so that further levers for improvement can be identified and implemented.

03. In-patient care

37. NICE guidelines and guidance from the RCPsych recommend that women who need in-patient care for a mental health problem in late pregnancy or within 12 months of childbirth should normally be admitted to a specialist mother and baby unit, unless there are compelling reasons for not doing so.³⁵ While consideration will be given in the first instance to whether a woman's support needs can be addressed at home via community treatment, due to the need to care for a baby too, there is a lower threshold generally for admission to a mother and baby unit than to an acute ward.³⁶

38. Mother and baby units (MBUs) are specialist psychiatric wards in hospitals to which women with severe perinatal mental health issues can be admitted with their babies. MBUs provide treatment and support for women with perinatal mental health problems while also supporting them in developing parenting skills and bonding with their babies.

Provision of Mother and Baby Unit (MBU) support

39. Since 2013 there has not been an MBU in Wales. Women requiring in-patient care in Wales after giving birth either face admission to an adult psychiatric ward without their baby or treatment out of area at an MBU in England.³⁷ In some cases, attempts have also been made to manage at home mothers who would have benefited from admission to an MBU.³⁸

40. One of the most pressing issues raised in written and oral evidence was the lack of provision for in-patient services for mothers who need admission with their babies. Nearly all stakeholders who submitted evidence expressed significant concerns about gaps in acute care and the lack of an MBU in Wales. The Wales TUC described the situation as “appalling”³⁹ while the British Psychological Society said that in-patient care for mothers with severe mental health difficulties in Wales is “woefully inadequate”.⁴⁰

Why did the Cardiff Mother and Baby Unit close in 2013?

A number of reasons for the closure of the Cardiff MBU were cited in evidence to us, including:

- insufficient funding arrangements;⁴¹
- under-use of beds due to misunderstandings about who could access the unit and its relative geographic isolation from north, mid and west Wales;⁴²
- the unit's three beds rendering it too small to have a sufficient number and range of multi-disciplinary staff to develop the necessary level of expertise needed in an MBU;⁴³
- perinatal mental illness not attracting in 2013 the level of interest or acknowledgement it does today.⁴⁴

³⁵ See NICE (2015), [Antenatal and postnatal mental health: clinical management and service guidance](#) and Royal College of Psychiatrists in Wales (2015), [CR197 Perinatal Mental Health Services: Recommendations for the provision of services for childbearing women](#).

³⁶ Oral evidence, *Record of Proceedings* [para 62], 28 June 2017 and written evidence, *PMH 2 - Hywel Dda UHB*.

³⁷ Written evidence, *PMH 07 - Royal College of Nursing Wales*.

³⁸ Oral evidence, *Record of Proceedings* [para 63], 28 June 2017.

³⁹ Written evidence, *PMH 20 - The Wales TUC*.

⁴⁰ Written evidence, *PMH 17 - British Psychological Society*.

⁴¹ Oral evidence, *Record of Proceedings* [para 307], 24 May 2017 and [para 57], 28 June 2017.

⁴² Oral evidence, *Record of Proceedings* [paras 271, 274 and 307], 24 May 2017 and [para 57], 28 June 2017.

⁴³ Oral evidence, *Record of Proceedings* [para 60], 28 June 2017.

⁴⁴ Oral evidence, *Record of Proceedings* [para 271], 24 May 2017.

There was a consensus among witnesses that, in light of the epidemiological evidence, the unit's closure was not due to a lack of need as at least 50 to 80 women resident in Wales would require admission to an MBU on an annual basis.⁴⁵ We heard that, for the reasons listed above, from 2008-2013 the Cardiff MBU only had an average of 1.2 patients at any given time.⁴⁶

Reflecting on the unit's closure, Dr Sue Smith, a former member of staff, concluded "...what we should have done, rather than just closing, was to actually have a good look at what we need for the whole of Wales. If this is meant to be the unit for the whole of Wales, and it's not working like that, then why not?"⁴⁷

41. The Welsh Health Specialised Services Committee (WHSSC) explained that, in the absence of an MBU in Wales, it commissions and funds in-patient care at MBUs in out of area beds in England. We were told that all placements are funded on a "cost per case" basis from English providers designated to provide such services and that placements are subject to bed availability and the clinical acceptance of the patient's referral.⁴⁸

42. A number of witnesses, and those with lived experience who participated in our stakeholder event, reported difficulties finding in-patient beds at MBUs in England. References were made to the time spent by consultant psychiatrists ringing units around England to try to locate a bed,⁴⁹ with many unable to access provision when needed.⁵⁰

43. WHSSC representatives acknowledged the difficulties encountered when trying to find a bed in an MBU in England, noting that the process involved "extensive trawling with providers" and was often slower than they would like.⁵¹ They went on to state that locating an MBU bed was becoming "increasingly difficult" but, to date, they had always managed to find a bed where necessary.⁵²

Demand for MBU support

44. The Royal College of Midwives (RCMidwives) and Professor Ian Jones, Co-Chair of the AWPMSHG and Clinical Professor at the National Mental Health Centre, emphasised that the existence of high quality community perinatal mental health services does not remove the need for acute admission for the most severe cases of perinatal mental illness.⁵³ We were told that epidemiological evidence would suggest between 50 and 70 women would develop severe episodes of illness requiring highly specialised, perinatal psychiatry and nursing care in an expert in-patient MBU. The RCMidwives noted that WHSSC's numbers - suggesting fewer than five women have been admitted annually to MBUs - meant that between 45 and 65 women in need of MBU beds in Wales were not receiving that care, and questioned the acceptability of this situation.⁵⁴

45. Dr Jess Heron, Director of Action on Postpartum Psychosis, cited similar numbers in need of MBU admission for postpartum psychosis, adding that closer to 100 MBU beds would be needed each

⁴⁵ Oral evidence, *Record of Proceedings* [para 57], 28 June 2017.

⁴⁶ Oral evidence, *Record of Proceedings* [para 468], 28 June 2017.

⁴⁷ Oral evidence, *Record of Proceedings* [para 350], 28 June 2017.

⁴⁸ Written evidence, *PMH 18 - Welsh Health Specialised Services Committee*.

⁴⁹ Oral evidence, *Record of Proceedings* [para 497], 28 June 2017 and written evidence *PMH 12 - Cwm Taf UHB*.

⁵⁰ See **Note of stakeholder event held on 18 May 2017**, published 13 June 2017, oral evidence, *Record of Proceedings* [para 63], 28 June 2017 and written evidence *PMH 03 - Aneurin Bevan UHB*.

⁵¹ Oral evidence, *Record of Proceedings* [para 489], 28 June 2017.

⁵² Oral evidence, *Record of Proceedings* [para 490], 28 June 2017.

⁵³ Oral evidence, *Record of Proceedings* [para 100], 24 May 2017.

⁵⁴ Oral evidence, *Record of Proceedings* [para 275], 24 May 2017.

year for Welsh patients to address those acute cases of other perinatal mental illness requiring in-patient care.⁵⁵ Charlotte Harding, Founder and Chair of Perinatal Mental Health Cymru, gave examples of the other perinatal illnesses that were likely to require admission to an MBU in order to be treated successfully, including postnatal depression and anxiety, the latter of which she had suffered personally.⁵⁶

Lack of data

46. Despite the descriptions of need and demand given to us during our evidence gathering, WHSSC reported that the requests received for out of area placements in England for each of the last three years varied between six and 13, with actual placements running even lower than that.⁵⁷ Professor Ian Jones speaking on behalf of the Maternal Mental Health Alliance described these numbers as “the tip of a very big iceberg”, explaining:

“...much more often women are being admitted [...] in Wales, to general adult wards without their baby. The other thing, I think, to bear in mind with those numbers is that that doesn’t take account of those women who perhaps, ideally, because of the severity of their illness, should have been admitted, but because there’s no facility for them to be admitted with their baby, perhaps a more risky option is taken. The decision is for them to stay at home when perhaps the best option would be to be admitted.”⁵⁸

47. WHSSC representatives told us that they struggled to get information from Health Boards about the level of demand and need for MBU beds. They highlighted that the only “real, hard information” they receive is the requests for patients to access MBU services and noted that these have remained low. WHSSC representatives recognised that, due to the number of alternative services being accessed by women instead of MBU care, current levels of requests do not reflect the true demand. Nevertheless, they emphasised that in order to make a robust business case for MBU provision in Wales, further evidence of demand would be needed.⁵⁹

48. The lack of data on the true level of demand for in-patient perinatal mental health support was highlighted by the majority of those who gave evidence. A series of reasons for this “hidden” demand were given, including:

- women turning down placements in MBUs in England due to:
 - their distance from home and the associated impact on their families;⁶⁰
 - the level of uncertainty surrounding where a bed may become available;⁶¹
- the lack of data about the extent to which women are accessing in-patient adult psychiatric services from their local Health Board instead of an MBU bed;⁶²

⁵⁵ Oral evidence, *Record of Proceedings* [para 274], 6 July 2017.

⁵⁶ Oral evidence, *Record of Proceedings* [para 356], 6 July 2017.

⁵⁷ Oral evidence, *Record of Proceedings* [para 472], 28 June 2017.

⁵⁸ Oral evidence, *Record of Proceedings* [paras 305-306], 24 May 2017.

⁵⁹ Oral evidence, *Record of Proceedings* [paras 472-473 and 515-516], 28 June 2017.

⁶⁰ Oral evidence, *Record of Proceedings* [para 356], 28 June 2017 and [Note of stakeholder event held on 18 May 2017](#), published 13 June 2017.

⁶¹ Oral evidence, *Record of Proceedings* [para 75], 28 June 2017.

⁶² Oral evidence, *Record of Proceedings* [para 106], 6 July 2017.

- the lack of data about the extent to which women are being managed in the community as an alternative to being referred to a specialist MBU bed in England and/or an adult psychiatric ward;⁶³
- the lack of an MBU in Wales meaning that people were not aware that the option existed and so did not push for it;⁶⁴
- the stigma associated with mental health issues leading to the under-reporting of serious symptoms.⁶⁵

49. The Children’s Commissioner for Wales’s written evidence argued that the routine recording of information about the number of women with parenting roles entering adult in-patient mental health services could:

“... helpfully determine the need to re-establish a MBU in Wales; ensure the needs of the patient (as both an individual and a parent) are identified; and guarantee that the needs of their child/ren are also identified and addressed.”⁶⁶

50. WHSSC representatives told us that, in light of the difficulties establishing demand for MBU beds, the Community of Practice was now looking at how Health Boards can best collect data and information about outcomes from different placements, whether within adult psychiatric wards or MBUs.⁶⁷

51. The Cabinet Secretary for Health, Well-being and Sport emphasised that part of the purpose of investing £1.5 million per year in the creation of specialist community perinatal mental health teams was to establish a better understanding of how the level of need for very specialist perinatal treatment could be managed appropriately.⁶⁸ Nevertheless, he acknowledged that the establishment of the AWPMSHG subgroup on tier 4 services was in recognition of the need to review the most specialist end of the perinatal care pathway.⁶⁹ Both the Cabinet Secretary and his officials acknowledged the lack of data about demand for perinatal mental health services, noting its importance as a tool for assessing the level of need and the appropriate model of provision.⁷⁰

Distance versus specialism

52. Experienced practitioners and those with lived experience gave examples of women who would have benefited from access to an MBU refusing on the basis of distance and the impact being far from home would have on the mother, baby, partner and wider family.⁷¹

53. ABMUHB told us four ladies had been admitted with perinatal mental illness to acute psychiatric wards in their area since January 2017. They reported that three of the four women did not want enquiries about beds in English MBUs to be made because they would be too far from home.⁷² Dr Sue Smith speaking in her capacity as Consultant Psychiatrist at CVUHB noted that while she had

⁶³ Oral evidence, *Record of Proceedings* [paras 305-306], 24 May 2017.

⁶⁴ Oral evidence, *Record of Proceedings* [para 39], 24 May 2017 and written evidence *PMH 2 - Hywel Dda UHB*.

⁶⁵ Oral evidence, *Record of Proceedings* [para 62], 24 May 2017.

⁶⁶ Written evidence *PMH 05 - Children’s Commissioner for Wales*.

⁶⁷ Oral evidence, *Record of Proceedings* [para 533], 28 June 2017.

⁶⁸ Oral evidence, *Record of Proceedings* [para 110], 12 July 2017.

⁶⁹ Oral evidence, *Record of Proceedings* [para 100], 12 July 2017.

⁷⁰ Oral evidence, *Record of Proceedings* [paras 112-114], 12 July 2017.

⁷¹ **Note of stakeholder event held on 18 May 2017**, published 13 June 2017.

⁷² Oral evidence, *Record of Proceedings* [para 356], 28 June 2017.

made five referrals in the last year, at least another five women could have benefitted from a referral “but it’s hard to argue for the funding to [...] go miles away when we just about manage here”.⁷³

54. Dr Jane Fenton May of the Royal College of General Practitioners (RCGPs) highlighted the impact distance can have on the wider family:

“...if the mother is sent a long way away, [the family] are not able to support the mother and visit regularly [...] So, there are problems in the relationship for the whole family—the father and the extended family—because they can’t be a close family unit.”⁷⁴

55. As well as the emotional impact of distance on the wider family and partners, Aneurin Bevan University Health Board (ABUHB) and the RCPsych highlighted the financial impact paying for travel and accommodation had on them, adding to an already highly stressful situation.⁷⁵

56. However, a number of witnesses referred to the need for patients to be supported by healthcare professionals to make more informed decisions about how far they may need to travel in order to access the most specialist of services.⁷⁶ Professor Ian Jones of the Maternal Mental Health Alliance explained:

“...in other areas of medicine, when people are severely ill the understanding is that people may need to travel to receive the best and the specialist care [...] when we’re talking about the women—this one in 600 women—who need admission in the postpartum period, we’re talking about some of the most severe episodes of psychiatric illness that we see in mental health services [...] when we’re dealing with that level of severity and that need for specialist care, we do need to have that conversation with services and with the public, in order to deliver the specialist care that’s needed.”⁷⁷

57. Sally Wilson, a volunteer with Action for Postpartum Psychosis and someone with recent lived experience, told us:

“The closest mother and baby unit for myself was Manchester. I live in north Wales, so we had a long discussion about it. At the time I was probably too ill to realise that I needed to be in a mother and baby unit, but we didn’t want to break up the family and travel. So, that kind of not wanting to travel and stigma associated with travelling a few hundred miles away from the family home was a big thing for us [...] if we’d been given that information [about the benefit of treatment in an MBU] it would have been a more informed decision.”⁷⁸

58. Some witnesses highlighted concerns about the level of support available to women - particularly in the field of psychological therapies - once discharged from an MBU in England. It was

⁷³ Oral evidence, *Record of Proceedings* [para 366], 28 June 2017.

⁷⁴ Oral evidence, *Record of Proceedings* [para 232], 28 June 2017.

⁷⁵ Written evidence PMH 03 - Aneurin Bevan UHB and PMH 19 - Royal College of Psychiatrists

⁷⁶ Oral evidence, *Record of Proceedings* [paras 475 and 538], 28 June 2017 and [paras 309 and 321], 6 July 2017.

⁷⁷ Oral evidence, *Record of Proceedings* [para 308], 24 May 2017.

⁷⁸ Oral evidence, *Record of Proceedings* [para 313], 6 July 2017.

commented that, on transfer back to Wales, specialist services previously accessible to women were no longer available due to the distance from the mother's home:

“When you're discharged, you'll be coming back to your community area, and the further that you are, then you're actually going to have to start again in terms of who's going to be able to follow that work up [...] if you've had support from someone and you've developed a relationship and you've developed trust and the doctor has helped you, you want to see that person again [...] But, if your mother and baby unit is over 90 miles away, that's not going to happen.”⁷⁹

The appropriateness of non-MBU care for acute cases

59. While the data about the number of women who access support in acute psychiatric wards was described as “non-existent for all practical purposes”,⁸⁰ evidence to our inquiry suggested that annually around 60-80 women with acute perinatal mental health issues resident in Wales would be treated in adult psychiatric wards or in the community.⁸¹

60. Among those who gave evidence there was clear consensus that adult psychiatric wards are not suitable settings to treat perinatal mothers, most obviously because such circumstances would necessitate the separation of a mother from her child. Such separation was described as “damaging” for both mother and infant,⁸² with “profound” implications at that moment and in future for general mental health,⁸³ and for bonding and attachment.⁸⁴ Dr Jess Heron from Action on Postpartum Psychosis spoke of the impact on the whole family of the separation of mother and baby soon after birth:

“It's a really important time in the development of a family. Partners are new dads as well, and it's a really important time for child development [...] we know that women suffer huge trauma from being separated from their baby at that time, even when they're severely psychiatrically ill. When you listen to women recollecting that time in their life, even many years later there's so much anger, trauma and guilt from that separation. We know that separation of mother and baby at this time is just wrong. We know that it's wrong for the mother and wrong for the baby's development.”⁸⁵

61. Another reason given for the unsuitability of admission to an adult psychiatric ward of a mother with perinatal mental illness was the fact that staff were unlikely to be sufficiently expert to care for the range of needs that a perinatal mother would have.⁸⁶ Charlotte Harding, a mother with lived experience of acute postnatal mental illness, told us:

⁷⁹ Oral evidence, *Record of Proceedings* [para 236], 6 July 2017.

⁸⁰ Oral evidence, *Record of Proceedings* [para 89], 6 July 2017.

⁸¹ Oral evidence, *Record of Proceedings* [para 305], 24 May 2017.

⁸² Oral evidence, *Record of Proceedings* [para 267], 24 May 2017 and [para 499], 28 June 2017.

⁸³ Oral evidence, *Record of Proceedings* [para 273], 24 May 2017.

⁸⁴ Oral evidence, *Record of Proceedings* [para 468], 28 June 2017 and written evidence *PMH 12 - Cwm Taf UHB*.

⁸⁵ Oral evidence, *Record of Proceedings* [para 306], 6 July 2017.

⁸⁶ Oral evidence, *Record of Proceedings* [para 53], 24 May 2017.

“... [a generic adult psychiatric ward] is not a place for a postpartum woman. Your body is different; you are lactating. It’s not a place where a mum who has just given birth should be.”⁸⁷

62. Dr Sue Smith, Consultant Psychiatrist, highlighted the superior rate of recovery in MBUs as compared with general adult acute wards:

“...women get better quicker when they go to mother and baby units. But it might not look like that, because perhaps their average length of stay seems to be a bit longer, but that’s because women stay on units until they’re better, whereas, on acute wards, with the best will in the world these days, people often get a bit better and then they go out on leave, that goes okay, so then they go home. We don’t do that for mother and baby units. We make sure women are properly able to not only be better themselves, but able to look after their babies. So, they may stay longer, but they get better quicker, in my opinion.”⁸⁸

63. Another option for a woman with acute perinatal mental health illness is to be cared for at home by a specialist community team. While it was noted that care at home was possible, witnesses warned that it was high risk due to the severe and often rapidly changing nature of perinatal mental ill health.⁸⁹ They emphasised that, where home treatment was being considered for managing acute perinatal mental illness, very skilled and confident practitioners would be required to perform the necessary risk assessments.⁹⁰ Dr Annemarie Schmidt, Consultant Psychiatrist at BCUHB warned:

“...if you’ve got home treatment going in once a day, the patient may seem fine in the morning but the situation is very different at night. I think you have to be very careful and very experienced.”⁹¹

64. Dr Jess Heron from Action on Postpartum Psychosis told us:

“These are some of the most severe psychiatric illnesses that psychiatrists ever see. They come on so quickly. They get some of the most severe illnesses. They get severe within hours and days rather than the gradual onset that happens at other times. Most women just could not be cared for safely at home by home treatment teams. Women, when they develop postpartum psychosis, their delusions can be so extreme, so frightening, that they’re just not really safe in the community. If we tried to do that, many more women and children would die.”⁹²

65. She went on to list the numerous reasons why, for most cases of acute perinatal mental ill health, MBU care was preferable to any other form:

“...we know from the Confidential Enquiry into Maternal and Child Health and the maternal deaths report that suicide rarely occurs to women have been

⁸⁷ Oral evidence, *Record of Proceedings [para 304]*, 6 July 2017.

⁸⁸ Oral evidence, *Record of Proceedings [para 66]*, 28 June 2017.

⁸⁹ Written evidence PH1 - *Four individual health practitioners*.

⁹⁰ Oral evidence, *Record of Proceedings [para 133]*, 6 July 2017.

⁹¹ Oral evidence, *Record of Proceedings [para 134]*, 6 July 2017.

⁹² Oral evidence, *Record of Proceedings [para 354]*, 6 July 2017.

admitted at some point to a mother and baby unit. From our own survey we found that women who were admitted to a mother and baby unit were more satisfied; they felt safer during their care; they felt better informed about their illness; they felt more confident in the staff; they felt more supported with their recovery; they felt more recovered on discharge; they felt more confident with their baby and as a mother; and they had a shorter time to full recovery. And when we looked at full recovery, if we compared women who went to a mother and baby unit and those who went to a general unit, 27 per cent of women who went to a mother and baby unit said that they didn't feel recovered at 12 months, compared to 55 per cent of those who went to a general unit, which was statistically significant. So, just from that research perspective, it [admission to an MBU] does make a big difference.”⁹³

Wider benefits of MBU care

66. In addition to the expert and specialist care provided by MBUs for perinatal mothers and their infants, and the suggestion that they lead to speedier recovery for women who have access to them, respondents cited a number of their wider benefits. These included the opportunity they provide as centres of learning, hubs of knowledge, and providers of capacity building for wider perinatal mental health services,⁹⁴ and the fact that their existence raises awareness of the services available for women and their babies, conveying an overarching message that perinatal mental health is supported.⁹⁵

67. The positive impact of MBUs on fathers was also emphasised:

“...it's much less stressful for dads to come in and see their partner being safely cared for in the right environment and feeling welcome, rather than having to come in to the chaotic situations that general adult wards are—”⁹⁶

Options for future MBU provision

68. During the course of our inquiry we explored what might be the best approach to providing in-patient perinatal mental health care for women in Wales. While there was unanimous agreement that centrally-funded MBU provision should be made for any woman requiring in-patient care during the perinatal period, those who contributed evidence emphasised that the answer to the question “how and where?” was complex and difficult, largely due to Wales's geography.⁹⁷ Dr Annemarie Schmidt, Consultant Psychiatrist at BCUHB, told us:

“I'm sure that south Wales needs a mother and baby unit, and they certainly have enough births to warrant that. In north Wales, we have approximately 7,500 births a year. That was the number in 2015. That doesn't qualify us, according to what the Royal College is saying—that you need 15,000 to 20,000 births to fill an eight-bedded unit to capacity. [...] we need to build links with

⁹³ Oral evidence, *Record of Proceedings* [paras 305], 6 July 2017.

⁹⁴ Oral evidence, *Record of Proceedings* [para 48], 24 May, [para 363], 28 June and [para 373], 6 July 2017.

⁹⁵ Oral evidence, *Record of Proceedings* [paras 39 and 43], 24 May 2017.

⁹⁶ Oral evidence, *Record of Proceedings* [paras 306], 6 July 2017.

⁹⁷ Oral evidence, *Record of Proceedings* [paras 234 and 354] 28 June 2017 and [paras 106 and 122], 6 July 2017.

the north-west, because anything that happens in south Wales is unlikely to benefit our patients in north Wales.”⁹⁸

69. While establishing an MBU somewhere along the “M4 corridor” in south Wales would therefore be feasible in terms of birth rate, we were told no other area in Wales would have the numbers necessary to sustain a specialist service according to NICE and RCPsych guidelines.⁹⁹ Dr Sarah Witcombe-Hayes, Senior Policy Researcher for the NSPCC, summarised the problem this causes:

“...having a single mother and baby unit in Wales would not necessarily mean that all women in Wales would have equal access, with some still having to travel very far away.”¹⁰⁰

70. There was consensus in evidence that, to serve populations living closer to centres in England than Cardiff, dialogue needed to continue with English providers to limit the distance patients would need to travel to access MBU facilities.¹⁰¹ WHSCC warned, however, that:

“...since specialist commissioning has become an NHS England single body representation, it has become more difficult for Wales to engage in discussions about those types of arrangements. In the past, for example, we would have been able to speak to the north-west specialist commissioners and talk about Chester, Wrexham—anywhere—and co-locating those services. But I think in the new arrangements, it becomes more difficult when NHS England tend to look at the English population as a whole. Their five-year strategic review, based on identifying a number of centres across England, was very much done in isolation, with no discussion.”¹⁰²

AWPMHSG sub-group on Tier 4 services

71. In acknowledgement of the need for a more appropriate arrangement for acute perinatal mental health care in Wales, a sub group of the AWPMHSG was established to consider the future configuration of in-patient perinatal mental health services (often referred to as “tier 4” services). The sub group included representation from all relevant disciplines as well as from the third sector, and service users. The sub group considered relevant evidence, undertook visits to MBUs across the UK and held a stakeholder event in February 2017.¹⁰³

72. On 25 July 2017 three shortlisted options were presented by the sub group to the WHSCC Joint Committee, which brings Health Boards together to plan specialised services for the population of Wales, for consideration.

Shortlisted options for future provision of Perinatal Mental Health Tier 4 Services

*Reproduced as presented to WHSCC on 25 July 2017*¹⁰⁴

Option 1: Use IPFR process through a secured contract

⁹⁸ Oral evidence, *Record of Proceedings* [paras 101-102], 6 July 2017.

⁹⁹ Oral evidence, *Record of Proceedings* [para 77], 28 June 2017.

¹⁰⁰ Oral evidence, *Record of Proceedings* [para 53], 24 May 2017.

¹⁰¹ Oral evidence, *Record of Proceedings* [para 307], 24 May 2017.

¹⁰² Oral evidence, *Record of Proceedings* [para 546], 28 June 2017.

¹⁰³ WHSCC (2017), *Paper to Joint Committee: Tier 4 Specialist Perinatal Mental Health in Wales*.

¹⁰⁴ WHSCC (2017), *Paper to Joint Committee: Tier 4 Specialist Perinatal Mental Health in Wales*.

This is an extension of the current model but a contract secured with a named provider in NHS England in the north and south. Continuing with the current process without a secured contract is not an option as the availability of beds is becoming increasingly difficult and this poses a significant risk to Health Boards. Given that NHS England are currently in the process of reviewing the provision to increase their mother and baby provision early engagement with them is essential but will inevitably require additional investment to ring fence beds for Welsh patients.

Option 2: A single regional Mother and Baby Unit established for Wales

Based on a minimum of 2 admissions per 1000 live births annually and the number of live births for the population of Wales (Stats Wales 2015 data) using 31,602 live births it is anticipated that there should be at least 60-65 admissions per year nationally. It has been estimated that based on 0.25 In-Patient Mother and Baby beds per 1000 live births Wales would require 8 Mother and Baby beds. Whilst the location of the unit is outside the remit of the group in line with NICE guidance (2007) the following points will need to be considered when developing the detailed business case:

- Provide facilities designed specifically for mothers and babies (typically with 6-12 beds).
- Be staffed by specialist perinatal mental health staff.
- Be staffed to provide appropriate care for babies.
- Have effective liaison with general medical and mental health services
- Have available the full range of therapeutic services.
- Be closely integrated with community-based mental health services to ensure continuity of care and minimum length of stay.

Option 3: A regional Mother and Baby Unit established for Wales in the south and services contracted in England for the north

Given the birth data for the population of mid and south Wales a 6 bedded mother and baby unit is established in the south. Whilst north Wales mothers could theoretically access these beds a contract would be secured with a NHS England provider in the north as an alternative to provide equity in terms of travel distances.

73. The sub group recommended that the Joint Committee agree that the three options proposed be taken forward for the development of a detailed business case (to include a financial option appraisal and location of service provision) and that a service specification in line with the final option should be developed. However, at its meeting on 25 July, the Joint Committee asked for further information before reaching a decision. At the time of writing no further information about the Joint Committee's decision was available.

74. The Cabinet Secretary noted that he would not be drawn on a particular model of acute care before the views of the Joint Committee had been presented to him. However, in relation to the possible number and location of an MBU, he commented:

“..one unit in Cardiff: I'd be surprised if that was the answer, because that didn't work previously, and, as I've said in the Chamber, Cardiff is a long way

from St David's and, actually, it can be a long way from Merthyr, frankly, let alone anywhere else."¹⁰⁵

75. Responding to questions about the extent to which England's perinatal transformation programme and the development of Welsh services could lead to complementary provision on both sides of the border, the Cabinet Secretary noted that NHS Wales was keen to have that conversation.¹⁰⁶

76. On 01 October 2017 the Welsh Government announced its commitment to developing specialist in-patient perinatal mental health support for new mothers and their babies in Wales as part of its budget agreement with Plaid Cymru for 2018-19 and 2019-20.¹⁰⁷

Our view

77. Based on the evidence received during the course of our inquiry we believe that the provision of in-patient care to mothers with severe cases of perinatal mental illness is wholly inadequate. While we accept that the most specialist of services will sometimes require patients to travel, the current uncertainty of arrangements with England is unacceptable and dialogue needs to take place between service providers in England and Wales to enable a strong cross-border commissioning relationship to develop. However, to minimise the distances women and their families need to travel to access the care they need, specialist in-patient provision needs to be developed within Wales. We therefore welcome the Welsh Government's announcement of its commitment to develop specialist in-patient perinatal mental health support in Wales and are grateful to all those who helped us shine a light on this issue over the last six months.

78. Evidence to our inquiry showed that general adult psychiatric wards were not sufficiently specialist to care for mothers during the perinatal period and should not be the only option available. Unless there is a clear clinical need, we do not believe that mothers should find themselves separated from their babies when they are being treated for perinatal mental illness. The long-term bonding and attachment issues, significant and lasting trauma to already unwell mothers, and the distress caused to their partners/wider families which can arise from such arrangements should not be tolerated in a modern health care service.

79. We acknowledge that inadequate data means we do not have a clear picture of demand for services, but there is clear epidemiological evidence that a minimum of 60-80 MBU beds a year would be needed for patients resident in Wales. As such, it is not acceptable that a maximum of 13 requests for referrals to MBU beds have been made annually in each of the last three years.

Recommendation 3. That the work requested by WHSSC to identify the level of demand for in-patient Mother and Baby Unit (MBU) services should be completed as a matter of urgency. We recommend that this work be finished during the 6-week window in which we would expect the Welsh Government to provide a response to this report and should be a core consideration when deciding how to allocate the funding for specialist in-patient perinatal mental health services announced as part of the 01 October budget agreement.

¹⁰⁵ Oral evidence, *Record of Proceedings* [para 122], 12 July 2017.

¹⁰⁶ Oral evidence, *Record of Proceedings* [paras 126 and 128], 12 July 2017.

¹⁰⁷ Welsh Government, *Budget Agreement 2018-19 and 2019-20*, 01 October 2017.

Recommendation 4. That the Welsh Government ensure, once the urgent work to establish the level of demand for MBU services is completed as requested by WHSSC, more robust data collection and monitoring methods are maintained across the perinatal mental health pathway in order to understand the ongoing level of need and demand for support and to provide a stronger evidence base for future service development.

Recommendation 5. That the new managed clinical network (see recommendation 1) prioritises the production of guidance for professionals and information for patients on the evidence-based benefits admission to an MBU can have for mothers, babies, and their families so that more informed decisions about treatment options can be taken.

80. We welcome the work undertaken recently to scope options for future in-patient MBU services for Welsh patients. Due to the relatively small number of beds required in MBUs that deliver multi-professional, highly-skilled care, we believe it would be sensible for bed usage to be coordinated at a national level and provided on a regional / all-Wales basis. Nevertheless, we acknowledge the difficulties associated with Wales's geography in terms of the location of any MBU within its borders and recognise that, while the birth rate in south Wales would sustain a unit somewhere along the M4 corridor, this would not solve issues in north Wales and would still require a proportion of women and families to travel some distance from mid and west Wales to access in-patient services. Provision must be made for additional beds beyond south Wales to be available to women resident elsewhere in the country.

81. We note that the WHSSC Joint Committee is still considering options for the provision of in-patient perinatal mental health services for Welsh residents. We emphasise the need for this decision to be made as soon as possible to prevent future mothers requiring MBU care from suffering the distress currently being caused to those not receiving such treatment. We further note that the final decision on the location of any MBU is not the responsibility of the WHSSC Joint Committee and emphasise the importance of the Welsh Government taking a decision on this as a matter of urgency.

Recommendation 6. That the Welsh Government, based on the evidence received, establish an MBU in south Wales, commissioned and funded on a national basis to provide all-Wales services, staffed adequately in terms of numbers and disciplines, and to act as a central hub of knowledge and evidence-based learning for perinatal mental health services in Wales.

Recommendation 7. That the Welsh Government, in light of the fact that an MBU in south Wales will not necessarily be suitable for mothers and families in mid and north Wales, engage as a matter of urgency with NHS England to discuss options for the creation of a centre in north east Wales that could serve the populations of both sides of the border. More certainty should also be established by the Welsh Government in relation to the ability of the Welsh NHS to commission MBU beds in centres in England where those are deemed clinically necessary.

Recommendation 8. That the Welsh Government deliver a clear action plan to ensure that centres providing MBU beds, wherever they are located (in England or in Wales), are closely integrated with specialist community perinatal mental health teams and that these beds are managed, co-ordinated and funded on an all-Wales, national basis to ensure efficient use and equitable access, especially as they are often needed quickly in crisis situations.

82. Due to the likely ongoing patient flows, and the potential for the development of a centre in north east Wales to help support both the populations of Wales and north west England, a copy of this report will be shared with NHS England and its MBU providers, the UK Department of Health, and the House of Commons Health and Welsh Affairs Select Committee to raise awareness of these cross-border issues.

04. Specialist community support

83. According to the Welsh NHS Confederation:

“Delivering care in the community not only alleviates demand on hospitals, but also allows for smaller multi-disciplinary teams to integrate their approaches, thereby enabling them to establish more personal relationships with patients and encouraging greater patient involvement in the treatment process.”¹⁰⁸

84. As noted in chapter 02, the recurrent £1.5 million announced by the Welsh Government in 2015 was to be used to establish community based specialist perinatal mental health services across every Health Board in Wales. The expectation was that integrated, multi-disciplinary perinatal mental health services tailored to the needs of respective localities and reflective of existing services would be available in each Health Board by November 2016.

Provision of specialist community support

85. Evidence presented to us during our inquiry shows that while a core perinatal service now exists in all Health Boards, variation remains in the nature of care provided by those services. The RCPsych described this variation as “unacceptable”, and attributed it to the fact that funding was distributed on the basis of birth rate as opposed to the existing level of service.¹⁰⁹ PHW stated:

“Whilst all health boards in Wales have or are in the process of developing their community perinatal mental health services, there remains variation across areas and this will need to be addressed by health boards to ensure equity of access and parity of provision.”¹¹⁰

86. On one end of the scale is CVUHB - given the services that existed there prior to the injection of funding in 2015 it has been able to grow its specialist provision to the point of meeting the RCPsych’s Quality Network Standards. In contrast, BCUHB which, prior to the allocation of recurrent funding, had no perinatal mental health service at all, will not be operational until November 2017 due to the need to design and recruit to a service from scratch. Other Health Boards were reported as sitting between these two ends of the spectrum. Powys Teaching Health Board (PTHB), given its geography and relatively low birth rate, is somewhat of an “outlier”. Its Chief Executive explained:

“...when funding is calculated on a population basis, we get quite a small amount. It’s very hard to then provide a specialist service that you may see in other health boards, because that person would be almost forever in their car. So, what we’ve learnt through experience is we need to invest in the generalist and community service and help to upskill and support them in order that, actually, these services are far more accessible locally. So, that’s where we’ve spent the reasonably small amount of money and tried to build upon midwives, practice, health visitors and colleagues from mental health, as well as the community psychiatric nurses and the psychiatrists in the service.”¹¹¹

¹⁰⁸ Written evidence, *PMH 21 - Welsh NHS Confederation*.

¹⁰⁹ Written evidence, *PMH 19 - Royal College of Psychiatrists*.

¹¹⁰ Written evidence, *PMH 06 - Public Health Wales*.

¹¹¹ Oral evidence, *Record of Proceedings [para 14]*, 6 July 2017.

87. When asked about the extent to which women in Wales were receiving the specialist treatment they needed for perinatal mental ill health, Professor Ian Jones of the Maternal Mental Health Alliance told us:

“There’s still a lottery in what services you get, with some services. I think Cardiff and Vale’s community service, as an example, is a very excellently staffed and delivered service, now. But in other parts of Wales where they were staffing from nothing, it’s more difficult.”¹¹²

88. Responding to questions about whether each Health Board had the capacity to provide for the needs of perinatal mental health patients, Dr Sue Smith, Consultant Psychiatrist, said:

“I would probably say ‘not yet’. Some have more so than others [...] I think we know where we’re trying to go, but we’re not there yet in all of Wales, definitely.”¹¹³

89. The British Psychological Society reported that some Health Boards (for example PTHB) had devoted a significant proportion of their resource to prevention and early intervention, but noted that it would be imperative that perinatal mental health services in each Health Board continued to expand their work on the treatment and management of perinatal mental health problems as well. In contrast, other witnesses - including those representing CVUHB - noted that the initial investment had been focused on delivery of care to those with more severe needs and that further work was needed to expand services towards early intervention and preventive end of the spectrum of community care.¹¹⁴

90. Participants in our stakeholder event who had lived experience highlighted the variation among (and in some cases within) Health Boards’ community perinatal mental health services. Some said that their experience of accessing services and the quality of care was very dependent on individual practitioners and clinicians as opposed to the existence of an effective system of support.¹¹⁵

Case study: the importance of specialist community perinatal mental health services

Stephen attended our stakeholder event in May 2017 to tell us about the loss of his daughter, Shanice, three years ago. After developing severe anxiety during pregnancy Shanice, who was 22 years old and eight months pregnant, committed suicide. At her inquest in 2016, her long history of depression which began with the birth of her first child in 2010 was reported. The inquest also heard that four days before his daughter died, Stephen was at a meeting in which Shanice told her social worker she had suicidal thoughts. The Coroner concluded that there were considerable shortcomings in the provision of support to young women like Shanice and called for the establishment of a specialist team in north Wales to help expectant mothers with mental health problems.¹¹⁶

Following monthly updates from BCUHB the Coroner was satisfied that he did not need to publish a Regulation 28 Report, a report which he has a legal power and duty to write following an inquest if it appears there is a risk of other deaths occurring in similar circumstances. However, he concluded that more work, resource and personnel would be required if robust services were to be established and

¹¹² Oral evidence, *Record of Proceedings* [para 285], 24 May 2017.

¹¹³ Oral evidence, *Record of Proceedings* [para 44], 28 June 2017.

¹¹⁴ Oral evidence, *Record of Proceedings* [para 273], 28 June 2017.

¹¹⁵ **Note of stakeholder event held on 18 May 2017**, published 13 June 2017.

¹¹⁶ BBC News online, **Shanice Priestley inquest: Pregnant mother’s suicide**, 10 June 2016

maintained.¹¹⁷ In September 2017, BCUHB confirmed that its specialist community perinatal mental health team had now been established.¹¹⁸

91. Karen Jewell, the Welsh Government’s Nursing Officer for Maternity and Early Years, acknowledged the variation in specialist perinatal teams across Health Boards and explained that this was due to local need:

“Each team has looked locally at what’s already available and then looked at what they require within that perinatal team to actually fit the need of the service and the demographic.”¹¹⁹

92. The Cabinet Secretary for Health, Wellbeing and Sport stated that one of the challenges about the service in all its aspects is establishing where variation is really about meeting local need and local circumstance. He referred to the Welsh Government’s intention to undertake work to evaluate the community perinatal mental health service in Wales and its importance in establishing how effective the staff mix has been, how many referrals have been made, and what sort of experience service users and service providers have had as a consequence of the introduction of specialist perinatal community services to which universal services can refer.¹²⁰

Psychological therapeutic support

93. Both the NICE guidelines and RCPsych’s Quality Network Standards for specialist perinatal mental health services (discussed in more detail in the next section of this chapter) highlight the need to have available a full range of therapeutic services, such as cognitive behavioural or talking therapies. Improving access to psychological therapies is an objective of the Welsh Government’s Together for Mental Health Delivery plan 2016-19. Some witnesses emphasised the particular importance of therapeutic support during the perinatal period due to some of the restrictions placed on the use of medication during this period (medication is discussed further in chapter 07).¹²¹

94. PHW noted in its written evidence that a 2013 review commissioned by the Welsh Government on access to and delivery of general psychological therapies across Wales highlighted variations in access and service quality and the absence of an agreed minimum data set for psychological therapies across Health Boards. PHW also pointed to monitoring data which suggests varied performance in meeting the waiting times target of 80% adherence to up to 28 days waiting time for assessment and treatment. This includes psychological therapies and is not specific to the perinatal period.¹²²

95. In its written evidence, the British Psychological Society stated that the ability of specialist perinatal mental health teams to meet the NICE guidelines on a waiting times target for assessment (2 weeks from referral) and treatment (4 weeks from referral) for psychological therapies in the perinatal period was compromised in Wales due to a lack of resource.¹²³

¹¹⁷ Letter to the Chair of the CYPE Committee from HM Senior Coroner for North Wales (East and Central), 18 August 2017

¹¹⁸ Letter to the Clerk of the CYPE Committee from BCUHB, 17 September 2017

¹¹⁹ Oral evidence, *Record of Proceedings* [para 16], 12 July 2017.

¹²⁰ Oral evidence, *Record of Proceedings* [para 18], 12 July 2017.

¹²¹ Oral evidence, *Record of Proceedings* [paras 339-347], 24 May 2017.

¹²² Written evidence, *PMH 06 - Public Health Wales*.

¹²³ Written evidence, *PMH 17 - British Psychological Society*.

96. Several participants in our stakeholder event reported that waiting times for some psychological therapies were around 6 months and told us that they had paid privately for treatment because waiting times were too long or services were not available in their areas.¹²⁴ The RCGPs' evidence also referred to the variation in the availability of psychological therapies, noting that the waiting list can be up to six months.¹²⁵

97. During oral evidence PTHB stated it had "a long way to go" before the level of psychological therapy that they would wish to provide would be available.¹²⁶ While its provision of online cognitive behaviour therapy (CBT) was deemed effective for milder perinatal mental health issues, Dr Dwywnwen Myers, Clinical Psychologist representing the British Psychological Society, believed that such an approach would not be sufficient for the moderate to severe end of the perinatal mental health spectrum.¹²⁷

98. Dr Annemarie Schmidt, Consultant Psychiatrist at BCUHB, noted that while the new specialist team in BCUHB included 0.5 of a psychologist, she suspected they would very quickly struggle to provide individual therapy. This, she said, would likely be further exacerbated by the average waiting time in north Wales of 19 months for general individual psychological therapy (the shortest being 7 months in Wrexham and the longest being 33 months in the western end of the Board's area).¹²⁸

99. The British Psychological Society reported that Hywel Dda University Health Board (HDdUHB) is unable to provide one-to-one therapeutic work within the perinatal service, providing group work instead; ABMUHB's provision was reported as being limited to Bridgend only.¹²⁹ Cwm Taf University Health Board's (CTUHB) written evidence noted that it has access to one session per week of a clinical psychologist's time and, whilst it forms an important part of its service, funding restrictions limit the availability of psychological intervention.¹³⁰ ABUHB noted that within its perinatal team only brief interventions can be offered due to limited capacity, meaning the needs of those requiring longer term interventions may be only partially met. They went on to note that this can mean women are referred to secondary care Adult Mental Health services but acknowledged that there are long waits for psychological interventions in many of these services.¹³¹

100. A mother who suffered postnatal depression told us that being unable to attend face-to-face groups with a baby was a barrier to accessing such services.¹³² ABUHB noted that a lack of funding to offer a crèche facility as part of group interventions means many mothers who do not have childcare are unable to attend.¹³³

101. Dr Sue Smith, Consultant Psychiatrist at CVUHB, acknowledged that, even with the biggest and most established perinatal mental health team in Wales, the provision of psychological therapies

¹²⁴ [Note of stakeholder event held on 18 May 2017](#), published 13 June 2017.

¹²⁵ Oral evidence, *Record of Proceedings [para 214]*, 28 June 2017.

¹²⁶ Oral evidence, *Record of Proceedings [para 71]*, 6 July 2017.

¹²⁷ Oral evidence, *Record of Proceedings [para 209]*, 6 July 2017.

¹²⁸ Oral evidence, *Record of Proceedings [para 85]*, 6 July 2017.

¹²⁹ Oral evidence, *Record of Proceedings [para 199]*, 6 July 2017.

¹³⁰ Written evidence, *PMH 12 - Cwm Taf University Health Board*.

¹³¹ [Additional written evidence supplied by Aneurin Bevan University Health Board on psychological therapy provision](#), published 20 September 2017.

¹³² Written evidence, *PMH 11 - Individual response*.

¹³³ [Additional written evidence supplied by Aneurin Bevan University Health Board on psychological therapy provision](#), published 20 September 2017.

within her area “falls short” of what her team would like and noted that would be the case for other teams too.¹³⁴

102. PHW’s written evidence stated that an improvement strategy for psychological therapies in Wales has been initiated by the Welsh Government and that the Welsh National Psychological Therapies Management (WNPTM) Committee has developed detailed guidance for the provision of evidence based psychological therapies in Wales. It noted that its purpose is to assist in building effective, equitable and accessible psychological therapy services in Wales and that the WNPTM Committee will be supporting implementation, including workforce development and data collection.

103. Responding to concerns about access to psychological therapies, the Cabinet Secretary wrote:

“Access to psychological therapies for women with perinatal mental health illnesses is available in both primary and secondary mental health care. Work is underway to develop national standard measurements for access to more specialist psychological therapies through the Welsh Information Standards Board (WISB). Health boards will be expected to report on their waiting times from December 2017. We are now exploring the ability to use this data source to measure access for women with perinatal mental health problems with the AWPMHSG and the Community of Practice.”¹³⁵

National quality standards

104. A range of guidance is available outlining best practice in the provision of perinatal mental health services. NICE has published clinical and service guidelines for antenatal and postnatal mental health, which promotes early detection and good management of mental health problems.¹³⁶ The RCPsych’s Quality Network for Perinatal Mental Health Services has also issued standards in relation to both community perinatal mental health services and mother and baby units.¹³⁷

105. We were told that while each of the Health Boards would be working towards the national standards outlined by the Quality Network of the RCPsych, only CVUHB and ABUHB were currently fully signed up.¹³⁸ Dr Sue Smith, Consultant Psychiatrist, explained that there are three levels within the standards:

- Level 1: basic standards that everyone should be meeting;
- Level 2: services Health Boards really should have and should be definitely striving towards;
- Level 3: services some Health Boards will have but which cannot be expected from all.¹³⁹

106. Dr Smith also explained that there is a financial implication to signing up, with Health Boards having to pay approximately £3000 per year (or £7000 per three years) to the RCPsych to access the peer review that is necessary to review local services against the standards which can sometimes

¹³⁴ Oral evidence, *Record of Proceedings [paras 157-161]*, 28 June 2017.

¹³⁵ Correspondence from the Cabinet Secretary for Health, Well-being and Sport following 12 July oral evidence session, 1 August 2017.

¹³⁶ NICE (2015), Antenatal and postnatal mental health: clinical management and service guidance

¹³⁷ Oral evidence, *Record of Proceedings [para 119]*, 28 June 2017. More information on the RCP’s Quality Network for Perinatal Mental Health is also available online.

¹³⁸ Oral evidence, *Record of Proceedings [para 119]*, 28 June 2017.

¹³⁹ Oral evidence, *Record of Proceedings [para 119]*, 28 June 2017.

prove to be a barrier.¹⁴⁰ Professor Ian Jones of the Maternal Mental Health Alliance told us that in his experience, such investment is a “fantastically cost-effective way of really benchmarking yourself against the standards that are set by the services, the peers, around the country”.¹⁴¹

107. Anita-Louise Rees, Team Manager for Perinatal Mental Health Services at ABMUHB, noted that there were ongoing discussions as part of the AWPMSHG’s work about what perinatal mental health services in Wales should adopt as their standards for measuring quality of service, and what Health Boards should be aspiring to and achieving.¹⁴² She said:

“We’ve got the quality network, the royal college standards, for what the service should look like in terms of numbers and what we should be aiming to provide. I think there’s some general consensus that across Wales that seems reasonable. But I think we’re still in the development and planning stage at an all-Wales level, and I think we’re looking to try and take some direction, really, around what the agreed data collection sets would be and how are we going to measure our outcomes as services, both clinically and activity capacity demand-wise.”¹⁴³

108. A number of those who commented on the provision of psychological therapies stated that quality standards were not being met currently and that they “are quite difficult to meet”.¹⁴⁴ Dr Annemarie Schmidt, Consultant Psychiatrist at BCUHB, told us that her Health Board would struggle to reach the quality network standard in terms of provision of psychological therapy for those affected by perinatal mental illness.¹⁴⁵

109. One of the stated responsibilities of the AWPMSHG is to support the development of all Wales standards and pathways for the delivery of services.¹⁴⁶ Sarah Fox, Professional Policy Advisor for the RCMidwives emphasised:

“It will be really helpful to all, I think—most importantly the service users—to have a clear, all-Wales target of what is appropriate and what can be achieved.”¹⁴⁷

110. The Cabinet Secretary told us:

“...all Health Boards have agreed that they do want to work towards the standards. There are obviously different levels of standards, and what we would expect is that health boards would work up through those standards [...] Public Health Wales are looking with the community of practice at the moment at what the pathways look like and then what some of the measurable outcomes could be at the end.”¹⁴⁸

¹⁴⁰ Oral evidence, *Record of Proceedings [para 304]*, 28 June 2017.

¹⁴¹ Oral evidence, *Record of Proceedings [para 293]*, 24 May 2017.

¹⁴² Oral evidence, *Record of Proceedings [para 281]*, 28 June 2017.

¹⁴³ Oral evidence, *Record of Proceedings [para 282]*, 28 June 2017.

¹⁴⁴ Oral evidence, *Record of Proceedings [para 157]* 28 June 2017.

¹⁴⁵ Oral evidence, *Record of Proceedings [para 85]*, 6 July 2017.

¹⁴⁶ **Note provided by the All Wales Perinatal Mental Health Steering Group on its work and remit**, published 12 July 2017.

¹⁴⁷ Oral evidence, *Record of Proceedings [para 159]*, 24 May 2017.

¹⁴⁸ Oral evidence, *Record of Proceedings [paras 71 and 75]*, 12 July 2017.

Our view

111. We recognise that specialist community perinatal health teams have only been in place for a short amount of time and welcome the progress made to date. However, based on the evidence we received, we believe that services in Wales do not currently meet the needs of women at risk of, or experiencing, perinatal mental illness in an equitable or comprehensive way. We are particularly concerned about the worrying evidence we received illustrating the lack of psychological support across Health Boards in Wales to support women with perinatal mental illness. Nevertheless, we note and welcome the fact that all Health Boards are now working towards achieving the quality standards for perinatal mental health services set out by the Royal College of Psychiatrists.

Recommendation 9. That, on the basis of an ‘invest to save’ argument and following analysis of the forthcoming evaluation of services and Mind-NSPCC-NMHC research results, the Welsh Government provide additional funding to Health Boards to better address variation so that service development and quality improvement can be achieved by expanding existing teams. To enable all community perinatal mental health services to be brought up to the standard of the best, the mechanism adopted by the Welsh Government to allocate additional funding should have as its primary aim the need to address the disparity in provision between Health Boards in Wales.

Recommendation 10. That the Welsh Government ensure work underway on improving access to psychological therapies for perinatal women (and men where necessary) is prioritised given the established link between perinatal ill health and a child’s health and development. Priority should be given to ensuring pregnant and postnatal women with mental health problems have rapid and timely access to talking therapies or psychological services (at primary and secondary care level), with waiting times monitored and published. We request an update on progress in relation to improving access to psychological therapies for perinatal women (and men where necessary) within 12 months of this report’s publication.

Recommendation 11. That the Welsh Government ensure all Health Boards invest in signing up fully to the Royal College of Psychiatrists’ quality standards for perinatal mental health services in order to realise the benefits of peer review, shared learning and service benchmarking.

05. Clinical pathway

All-Wales clinical care pathway

112. A “clinical care pathway” is an approach for health professionals to use when managing the care of patients with particular health conditions, setting out the different steps to be taken at various stages. As noted by PHW:

“Clear, transparent evidence based pathways are essential for the prevention, early identification and treatment of perinatal mental health issues. To ensure that all women are supported by services that are proportionate to their level of need pathways need to be integrated, running across service boundaries. This requires all staff in contact with mothers, fathers and the wider family during pregnancy and the first years of a baby’s life to be aware of perinatal and parental mental health problems [...] The majority of perinatal mental health issues experienced by mothers are classed as mild to moderate. To ensure these women get effective support pathways should run across the spectrum of need from mild to severe.”¹⁴⁹

113. The RCPsych noted that the Health Boards’ clinical care pathways did not meet all patients’ needs in a timely manner in Wales,¹⁵⁰ but emphasised - along with many others who gave evidence - that work was underway to identify and address the specific issues and to develop a unified pathway.¹⁵¹ This work is being led by a task and finish group of the AWPMSHG.¹⁵²

114. While much hope is being placed in the development and implementation of an all-Wales clinical care pathway, some warned that it should not be viewed as a silver bullet. Helen Rogers, Director of the RCMidwives in Wales, cautioned:

“A pathway is only as good as those people who are working with the pathway, and if there aren’t clear referral routes, if there isn’t the capacity for midwives and others to refer, if they’re not properly trained, if they don’t have communication and good professional respect, then the pathway is just a piece of paper. It’s as much about the people who are delivering that pathway as the pathway itself.”¹⁵³

Case study: the impact of not having a clear clinical pathway

Sally, a mother from North West Wales, gave evidence to us in July 2017. Two years earlier, prior to the establishment of specialist community perinatal services, she had suffered severe mental illness after giving birth. She was discharged from an adult psychiatric unit to community home treatment - although an MBU bed in Manchester was discussed as an option, she and her family did not want to travel that far, and very little information was provided to them about the proven benefits of such treatment. In the absence of a clear care pathway and a lack of awareness among health professionals

¹⁴⁹ Written evidence, *PMH 06 - Public Health Wales*.

¹⁵⁰ Written evidence, *PMH 19 - Royal College of Psychiatrists*.

¹⁵¹ See, for example, oral evidence from the Royal College of Midwives, *Record of Proceedings [para 121]*, 24 May 2017 and Abertawe Bro Morgannwg UHB, *Record of Proceedings [para 284]*, 28 June 2017.

¹⁵² Oral evidence, *Record of Proceedings [para 112]*, 28 June 2017

¹⁵³ Oral evidence, *Record of Proceedings [para 129]*, 24 May 2017.

of available services, Sally's recovery only began after a third sector organisation, Action on Postpartum Psychosis (APP), became involved and signposted her to specialist perinatal psychiatric support.

115. A number of witnesses also emphasised the importance of retaining some level of flexibility within a national pathway. Carol Shillabeer, Chief Executive of PTHB told us that whilst it is very helpful to have national approaches and consistency, the focus needs to be consistency of outcome, with a level of flexibility in terms of how that outcome is delivered to meet the varying needs of different localities.¹⁵⁴ Dr Sue Smith, Consultant Psychiatrist, concurred that issues of rurality and varying need mean it is difficult to have one consistent pathway that everyone has to follow. She explained:

“One of the task and finish groups is looking at a standard pathway, but just hitting problems—that would work in that place, but that wouldn't work there. So there's got to be, perhaps, one, but with quite a bit of flexibility written in, really.”¹⁵⁵

116. Sarah Fox of the RCMidwives said:

“Each health board has their own individual pathways, and that means that midwives within health boards will know for their own individual health boards what that referral pathway is. That can cause challenges when you're talking about cross-boundary working, and some midwives will have women from different health board geographical areas. I know that there's some work towards all-Wales care pathway, and I think that we should see that as a very positive move, because that, I think, will help individual clinicians to be absolutely clear on what is available for all women and prevent the potential of having different levels of service provision dependent on where you live and which health board you are receiving care from.”¹⁵⁶

Referral and waiting times

117. Referrals to specialist community perinatal mental health teams are made via primary care, including GPs, midwives and health visitors. Dr Sue Smith, speaking on behalf of the Royal College of Psychiatrists, told us that, strictly speaking, referral from universal to specialist services would take place in the case of a woman who could not be managed in primary care because she had significant symptoms of mental illness that would need a secondary service. Dr Smith emphasised, however, that in the case of perinatal mental health, the threshold for referral is lower due to the fact that mental health issues in perinatal women can “reach much more significance”.¹⁵⁷

118. Written evidence from the Welsh NHS Confederation stated that the “general trend across Health Boards is that referrals are accepted within 4-5 weeks, but priority will likely be given to patients who show symptoms of serious perinatal health conditions, such as post-traumatic stress disorder (PTSD), schizophrenia or signs of suicidal ideation”.¹⁵⁸ This was echoed by representatives of ABMUHB, BCUHB, and CVUHB, all of whom noted that mild to moderate cases would be seen by the

¹⁵⁴ Oral evidence, *Record of Proceedings* [para 61], 6 July 2017.

¹⁵⁵ Oral evidence, *Record of Proceedings* [para 112], 28 June 2017.

¹⁵⁶ Oral evidence, *Record of Proceedings* [para 121], 24 May 2017.

¹⁵⁷ Oral evidence, *Record of Proceedings* [para 35], 28 June 2017.

¹⁵⁸ Written evidence, *PMH 21 - Welsh NHS Confederation*.

specialist perinatal team within approximately 28 days, but those with urgent needs would have contact with the crisis team or emergency community mental health team within a day, with specialist perinatal linking in as soon as possible.¹⁵⁹

119. The RCMidwives warned of the need to manage the level of referrals to the specialist service:

“...in terms of the investment in the health boards, in the specialist perinatal mental health service referral capacity, it currently meets the demand. But these are in their infancy and we know, where a new service has been set up and where previously there has been no, or virtually no, areas to refer women to, that that can build and that can snowball, and it may be that there is potential that it’s almost a victim of its own success and that demand does increase year on year. So, I think we need to be very forward thinking in how we support the service to move on and ensure that as many women as possible are supported to not need referrals.”¹⁶⁰

120. They recommended that the way to mitigate the risk of demand for specialist support outstripping supply was to ensure that part of the specialist teams’ resources is targeted at capacity building within universal primary care services in order to enable them to manage cases effectively:

“...what I think would be optimal is if there were more training to enable midwives to support the specialist perinatal mental health services in their care of women with identified issues, because there will be some women who perhaps wouldn’t need referral to a specialist service, if a level of care could be provided by the midwife. And there will be some women who do need a referral, but that referral will be more effective if the midwife is able to support the care that that woman is receiving through that specialist service. I think midwives currently aren’t receiving training in that area.”¹⁶¹

121. CTUHB noted that, within six months of its perinatal mental health service’s establishment, it had to reduce its referral window from one year postnatally to one month because of limited capacity to deal with the overwhelming demand.¹⁶²

122. Representatives of the Institute of Health Visiting concluded:

“...for access for mothers across Wales, there’s not consistency at the moment. But people are working towards that, so that when the pathways are established—and ideally, an all-Wales pathway is the way forward—there should be no doubt about where mothers go, when and how, and the appropriateness of the referral.”¹⁶³

123. The Cabinet Secretary confirmed that he expected an overarching national pathway to be introduced:

¹⁵⁹ Oral evidence, *Record of Proceedings* [paras 338 and 340], 28 June 2017 and *Record of Proceedings* [para 27], 6 July 2017.

¹⁶⁰ Oral evidence, *Record of Proceedings* [para 135], 24 May 2017.

¹⁶¹ Oral evidence, *Record of Proceedings* [para 224], 24 May 2017.

¹⁶² Written evidence, *PMH 12 - Cwm Taf UHB*.

¹⁶³ Oral evidence, *Record of Proceedings* [para 122], 24 May 2017.

“This really is about giving ourselves the best possible prospects to understand who is at risk, how we help that person, how we help them to make their own choices, and how we then have the right support available. I do think the all-Wales pathway will be helpful in us doing that, as well as then understanding what exists on a local level, which will differ [...] some service models will be different, and entirely appropriately different as well—Powys being the most obvious example—but to understand how all of those things make sense with a national pathway and then have local healthcare professionals make choices with women and their families.”¹⁶⁴

124. The Cabinet Secretary also emphasised the importance of looking beyond Wales’s borders when considering the care pathway for those with perinatal mental health issues.¹⁶⁵

Our view

125. We welcome the work underway to develop an all-Wales clinical care pathway for perinatal mental health services, but acknowledge that a pathway is only as good as the staff who underpin it. We explore key issues relating to staff in the next chapter.

126. We acknowledge that a level of flexibility in service design is necessary to tailor provision to meet the variety of needs and geographical demands of Wales’s urban and rural areas. Nevertheless, the all-Wales clinical care pathway should aspire towards consistency of outcomes for women across Wales. Timely, high quality services should be an expectation and a right for all women who experience perinatal mental illness rather than a matter of luck.

127. We note the concerns raised in our inquiry that, following the introduction of the new perinatal mental health service, there is a significant risk that they will be overwhelmed with referrals. We were worried to hear of examples of Health Boards having to reduce their windows for postnatal referral, including CTHUB who reported having to reduce the referral window from one year to one month postnatally only six months after the new service was established. The extent to which this forces those for whom specialist perinatal mental health support would be beneficial into more general mental health services was unclear and is an area that needs further consideration.

Recommendation 12. That the Welsh Government ensure that the new all-Wales clinical care pathway for perinatal mental health services requires consistency of outcomes (including referral windows and waiting times) but enables Health Boards to retain the level of flexibility around delivery methods necessary to manage and meet local need. The priority should be to develop and implement within the next 12 months an evidence-based, integrated all-Wales clinical care pathway (with some local differences). The pathway should help to deliver integrated services and incentivise early intervention and holistic approaches to care and recovery.

¹⁶⁴ Oral evidence, *Record of Proceedings* [para 82], 12 July 2017.

¹⁶⁵ Oral evidence, *Record of Proceedings* [para 81], 12 July 2017.

06. Integration of perinatal mental health services

Antenatal education, pre-conception advice and general public awareness

128. The Welsh Government's Together for Mental Health Delivery Plan outlines a desire to see women being offered good information and support when planning and during a pregnancy (as well as through birth and postnatally). Despite this, the British Psychological Society stated that perinatal mental health is not routinely covered in antenatal classes and much variation exists in pre-conception advice.¹⁶⁶ Those with lived experience who participated in our stakeholder event called for more discussion about perinatal mental health conditions such as postnatal depression, anxiety and birth trauma in antenatal classes.¹⁶⁷

129. Sarah Fox speaking on behalf of the RCMidwives told us there is no clear format for each antenatal class. She reported anecdotal evidence that perinatal mental health is touched upon in classes but the level of depth would depend on the individual class leader.¹⁶⁸ Ms Fox went on to warn against placing too much emphasis on antenatal classes, noting that fewer than 20 per cent of all pregnant women go to them and that some of those most at risk of developing perinatal mental illness are in the demographic least likely to attend. This, she argued, illustrated the importance of the routine enquiry undertaken by midwives during antenatal care, care which virtually all women will receive.¹⁶⁹

130. The NICE clinical guideline on antenatal and postnatal mental health states that a pregnant woman should be asked about her emotional well-being at her booking appointment, and during the early postnatal period. The clinical guideline states that healthcare professionals - namely, midwives - should also ask about a woman's mental well-being with each subsequent contact, with the guideline suggesting standardised questions to use to identify possible depression or anxiety.¹⁷⁰

131. According to the Royal College of Obstetricians and Gynaecologists (RCOG), large variations exist across the UK in the extent to which primary care services adhere to this aspect of the NICE guideline. The RCOG's **Maternal Mental Health - Women's Voices** report (February 2017) surveyed 2323 women with lived experience of perinatal mental illness across the UK in 2016, 56 of whom were Welsh (3 per cent of the total number of respondents). Of the Welsh respondents, 26 per cent reported that they were not asked about their mental wellbeing by any healthcare professional during or after their pregnancy; this compared with a UK average of 15 per cent.¹⁷¹

132. In contrast, PHW reported that maternal mental health is discussed routinely during pregnancy but acknowledged that the focus tended to be on identifying those with a diagnosis of a serious mental health problem rather than establishing general well-being.¹⁷²

133. Evidence submitted by four health professionals emphasised the need for antenatal education to shift the balance away from an emphasis on the physical aspects of pregnancy and childbirth towards consideration of emotional well-being. They also highlighted the need for antenatal education to be evidence based, and criticised what they described as the current "one size fits all"

¹⁶⁶ Written evidence, PMH 17 - British Psychological Society.

¹⁶⁷ **Note of stakeholder event held on 18 May 2017**, published 13 June 2017.

¹⁶⁸ Oral evidence, *Record of Proceedings [para 151]*, 24 May 2017.

¹⁶⁹ Oral evidence, *Record of Proceedings [para 155]*, 24 May 2017.

¹⁷⁰ NICE (2015), **Antenatal and postnatal mental health: clinical management and service guidance**.

¹⁷¹ Written evidence, PMH 09 - Royal College of Obstetricians and Gynaecologists.

¹⁷² Written evidence, PMH 06 - Public Health Wales.

approach.¹⁷³ Dr Jess Heron of Action on Postpartum Psychosis concurred, noting that general preventative strategies designed to improve well-being and address mild to moderate perinatal mental illness are unlikely to have any impact on postpartum psychosis. She argued that special pre-conception advice was essential for those at high risk (e.g. women with a previous episode of postpartum psychosis or a history of bipolar disorder), but acknowledged that half of all cases would develop in women with no history of mental illness.¹⁷⁴

134. A consultation response from a mother with lived experience called for better information for parents who already had children. She explained:

“In my experience there can be an assumption that you need less support and information as you have had a baby before. For me, my second pregnancy meant I felt more nervous and anxious as I had more realistic expectations around giving birth and the realities having a newborn. My second pregnancy also brought back negative memories of my first birth.”¹⁷⁵

135. The majority of stakeholders emphasised the importance of de-stigmatising and normalising mothers’ experiences of perinatal mental illness, to encourage mothers and their families to seek support as early as possible. PHW argued that a change in culture was needed to enable people to talk about their emotional well-being openly in order to normalise such discussions.¹⁷⁶ Health Boards agreed, noting that the colocation and alignment of perinatal mental health support and services with others could help reduce the stigma felt by women and their families.¹⁷⁷

136. When asked about the challenges associated with identifying perinatal mental health issues, organisations from across the spectrum of Royal Colleges, the Institute of Health Visiting, the third sector, and Health Boards listed the following:

- the high level of non-disclosure of perinatal mental health issues among pre- and post-natal women and their families due to the considerable stigma associated with mental illness and a fear among families that their baby might be taken away if they admit their difficulties;¹⁷⁸
- a lack of knowledge and confidence among front line health care professionals in recognising signs and symptoms in the earliest stages;¹⁷⁹
- inconsistency of contact with a lead health professional;¹⁸⁰
- the lack of contact GPs have under the midwife-led management of pre- and post-natal women, and the practical impact this has on their ability to identify and/or share information about their overall mental health.¹⁸¹

¹⁷³ Written evidence, *PMH 1 - Four individual health practitioners*.

¹⁷⁴ Written evidence, *PMH 27 - Action on Postpartum Psychosis*.

¹⁷⁵ Written evidence, *PMH 11 - Individual response*.

¹⁷⁶ Written evidence, *PMH 06 - Public Health Wales*.

¹⁷⁷ Written evidence, *PMH 02 - Hywel Dda UHB and PMH 21 - Welsh NHS Confederation*.

¹⁷⁸ Written evidence, *PMH 15 - Royal College of General Practitioners and PMH 23 - Mind*.

¹⁷⁹ Oral evidence, *Record of Proceedings [para 128]*, 24 May 2017.

¹⁸⁰ Oral evidence, *Record of Proceedings [para 309]*, 28 June 2017.

¹⁸¹ Oral evidence *Record of Proceedings [para 186]*, 28 June 2017.

137. A number of stakeholders emphasised the need to raise the general public's and health professionals' awareness of perinatal mental health.¹⁸² The RCOG highlighted that knowledge of symptoms of perinatal mental illness was low, especially for conditions other than depression. The College called for better information about signs to look out for and more generally about the impact pregnancy and childbirth can have on well-being.¹⁸³

138. In acknowledgement of the need to raise awareness of perinatal mental health problems, increase recognition of the early signs of problems developing, and encourage people to seek support, the Welsh Government's Health Challenge Wales Voluntary Sector Grant Scheme has provided funding for Mind Cymru's perinatal mental health and resilience (early support) project - 'Enjoy your baby' - since 2013. The Welsh Government stated:

"This project has developed early intervention resources for use in primary care and built capacity in primary care by improving the skills of professionals [...] This project has helped raise the profile of perinatal mental health and the importance of optimising the mother/baby relationship with many differed organisations throughout Wales."¹⁸⁴

139. The project concluded on 31 July 2017 and an evaluation will be undertaken to consider next steps and how its outcomes can be integrated into a national programme. When asked about future plans for the areas in which the Mind pilot and others are working, the Cabinet Secretary told us:

"I can't pretend that, because I think that there are areas of the service where we've had a good return on investment, we'll definitely invest in all of them, because there is the reality that money is finite. If we were talking about a different subject area, you may be asking me about why we're not investing more money in this area as well, and that's because there's a limited sum. So, in all of these we have to be honest with each other, and with the third sector and the public, about the fact that we make choices within our budget about how we provide the service."¹⁸⁵

Training and continuous professional development

140. While there was a general recognition that improvements have been made to the screening and detection of perinatal mental health problems in maternity services in Wales, many stakeholders called for improvements to the skills and knowledge of healthcare professionals. BCUHB highlighted that training was needed for wider professional groups to raise the profile of perinatal mental illness, its prevalence, its implications and how to recognise and signpost patients.¹⁸⁶

141. The RCMidwives noted:

"...when you consider the number of personnel, the number of training opportunities, the investment in their training in the first place and ongoing continual professional development of all the physical knowledge of ill health,

¹⁸² See, for example, written evidence, *PMH 07 - Royal College of Nursing Wales*, *PMH 09 - Royal College of Obstetricians and Gynaecologists*, *PMH 10 - Betsi Cadwaladr UHB*, and *PMH 27 - Action on Postpartum Psychosis*.

¹⁸³ Written evidence, *PMH 09 - Royal College of Obstetricians and Gynaecologists*.

¹⁸⁴ Written evidence, *PMH 29 - Welsh Government*.

¹⁸⁵ Oral evidence, *Record of Proceedings [para 40]*, 12 July 2017.

¹⁸⁶ Written evidence, *PMH 10 - Betsi Cadwaladr UHB*.

as opposed to mental ill health and well-being, it is completely disproportionate.”¹⁸⁷

142. A recurrent theme in our stakeholder event with practitioners and those with lived experience was the importance of ensuring that front line healthcare professionals have sufficient knowledge and training, and the confidence to identify and respond promptly to perinatal mental health issues. There was a feeling that healthcare staff, including health visitors, midwives and GPs are not always trained suitably to recognise the symptoms and do not always understand the clinical care pathway or what help or treatment is available. There was specific mention of the need for “crisis teams” to be trained in perinatal mental health.¹⁸⁸

143. CTUHB emphasised how mothers with perinatal mental illness can benefit from supportive and psychologically informed conversations with midwives and health visitors, providing a non-stigmatising environment, usually within the woman’s home and reducing demands on secondary mental health services. Nevertheless, they commented that there was currently no systematised training provided for midwives and health visitors to give them skills and a level of confidence to enable them to have supportive and useful conversations about a woman’s mental health.¹⁸⁹

144. The RCMidwives supported enhanced training of midwives and health visitors, acknowledging that:

“...there is often a significant delay in seeking and receiving appropriate treatment for perinatal mental health problems and that is likely, in part, to be due to lack of knowledge and confidence from front line health professionals in recognising signs and symptoms in the earliest stages.”¹⁹⁰

145. While the RCPsych,¹⁹¹ RCGPs,¹⁹² and RCMidwives¹⁹³ confirmed that perinatal mental health issues feature in initial training, they all acknowledged that more could be done both in terms of initial training and continuous professional development. As stated in the previous chapter, it was suggested that to protect specialist community perinatal mental health teams from an overwhelming number of referrals, training of primary care practitioners needed to go beyond simply awareness raising, to knowing how to deal with clinical need. The training and capacity building role of the specialist community perinatal mental health teams was highlighted as being key in this regard, with Mind Cymru warning:

“...at Cwm Taf, for example, there are two people in the perinatal mental health team. They take anybody with low mood, basically. So, they are inundated, because now there’s a service to refer them to. Long term, I don’t think the perinatal mental health services will cope like that [...] if your perinatal mental health service is designed to treat and only treat, they you’re going to never cope [...] there’ll never be enough resources [...] perinatal mental health teams should be perhaps dealing with the more unwell mothers, rather than dealing with everybody. So, rather than just shifting all the responsibility to them—

¹⁸⁷ Oral evidence, *Record of Proceedings* [para 186], 24 May 2017.

¹⁸⁸ **Note of stakeholder event held on 18 May 2017**, published 13 June 2017.

¹⁸⁹ Written evidence, *PMH 12 - Cwm Taf UHB*.

¹⁹⁰ Written evidence, *PMH 22 - Royal College of Midwives*.

¹⁹¹ Oral evidence, *Record of Proceedings* [paras 136-44], 28 June 2017.

¹⁹² Oral evidence, *Record of Proceedings* [para 253], 28 June 2017.

¹⁹³ Oral evidence, *Record of Proceedings* [para 224], 24 May 2017.

which I don't think they'll ever cope with—it's actually about building capacity within those front-line staff who meet families all the time.”¹⁹⁴

146. Pockets of good practice in relation to the training of health care practitioners was highlighted in evidence, with the Welsh NHS Confederation pointing to the provision of integrated training of midwives and health visitors with perinatal teams in PTHB and ABMUHB.¹⁹⁵ The Institute of Health Visiting also referred to the delivery of its Perinatal Mental Health Champions Programme to certain Flying Start areas in Wales, training not only health visitors but midwives, GPs, obstetricians, and mental health nurses in:

- recognising risk factors and symptoms of perinatal mental illness;
- managing mild to moderate illness;
- referring confidently mothers and fathers/partners to the right service in a timely manner; and
- feeling confident to recognise and manage risk in relation to suicide, self-harm, risk to others and safeguarding.¹⁹⁶

147. With regard to the more severe end of the spectrum of perinatal mental illness, Action on Postpartum Psychosis argued that all health professionals who come into contact with pregnant and postnatal women “need a lot more training on what postpartum psychosis is, how to manage it, and what care is out there in their own local area and throughout the country”.¹⁹⁷

148. On training for specialist perinatal mental health teams, we were told that £9,750 had been provided by the Welsh Government to enable Consultant Psychiatrists to attend a three day RCPsych training course for Perinatal Consultant Psychiatrists, with a view to those who attended facilitating specialist training via the Community of Practice.¹⁹⁸ We heard that members of the clinical psychology team had to seek training supervision from colleagues in England because there is no Consultant Clinical Psychologist in Wales.¹⁹⁹ Responding to the description of £9,750 of funding for training as “severely limited”, Joanna Jordan, Director of Mental Health for the Welsh Government, clarified:

“I don't think our intention was to fund all the training that needs to be going on in this [the £9,750]. We funded some specific parts of the training for some psychiatrists to go on a specialist course, that sort of thing. There were particular bits of it that we're directly funding, but we would be expecting, within health boards, other training to be going on.”²⁰⁰

149. When asked about the current provision of both generic and specialist training in perinatal mental health in Wales, Karen Jewell, the Welsh Government's Nursing Officer for Maternity and Early Years told us:

¹⁹⁴ Oral evidence, *Record of Proceedings* [paras 95-96 and 102], 24 May 2017.

¹⁹⁵ Written evidence, *PMH 21 - Welsh NHS Confederation*.

¹⁹⁶ Written evidence, *PMH 24 - Institute of Health Visiting*.

¹⁹⁷ Oral evidence, *Record of Proceedings* [para 331], 6 July 2017.

¹⁹⁸ Written evidence, *PMH 29 - Welsh Government*.

¹⁹⁹ Oral evidence, *Record of Proceedings* [para 193], 6 July 2017.

²⁰⁰ Oral evidence, *Record of Proceedings* [para 179], 12 July 2017.

“Training, at the moment, is in development, so the community of practice have got a training group that’s looking at the training that’s needed across all spheres of [perinatal] health. So, that could be from GPs, to midwives and to health visitors. They’re also looking at scoping what’s actually already in pre-registration training so that we can build upon that as well.”²⁰¹

150. The Cabinet Secretary confirmed that it was the Welsh Government’s intention that all frontline staff would have an element of training of awareness in perinatal mental health:

“The NMC are currently reviewing their educational standards, and perinatal mental health is part of what’s been raised about the core training requirements for nurses and midwives.”²⁰²

151. With regard to continuous professional development and reflective learning among frontline healthcare staff, officials noted that the Nursing and Midwifery Council’s revalidation requirements include the need to reflect on events or training that have taken place so that it can be used towards professional revalidation.²⁰³ Clinical and group supervision in all Health Boards for midwives, and long-established health visitor supervision, were also cited as methods by which shared learning could be achieved.²⁰⁴ In terms of connecting learning between midwives, health visitors and GPs, the Welsh Government stated that the Community of Practice would “bring about learning” that could then be translated into training for respective areas.²⁰⁵

Communication between professionals

152. Written evidence from BCUHB pointed to the fact that reviews of maternal deaths show repeatedly the vital importance of effective and timely communications between professionals.²⁰⁶ Participants in our stakeholder event who had lived experience emphasised that a lack of communication between professionals undermined continuity of care and forced them to repeatedly explain their (often painful) problems and circumstances.²⁰⁷

153. PHW emphasised the importance of communication to ensuring that women are supported by services that are proportionate to their level of need:

“... effective communication [is required] between services that are in contact with a family. This can be particularly important where GPs may be aware of historical mental health issues that have not been disclosed to the midwife. Similarly an effective handover of care between midwife and health visitor after the birth of a baby is vital for ensuring mental health concerns are monitored and acted on promptly.”²⁰⁸

154. The RCGPs called for improved communication between health professionals managing perinatal care, highlighting that:

²⁰¹ Oral evidence, *Record of Proceedings [para 195]*, 12 July 2017.

²⁰² Oral evidence, *Record of Proceedings [para 201]*, 12 July 2017.

²⁰³ Oral evidence, *Record of Proceedings [para 187]*, 12 July 2017.

²⁰⁴ Oral evidence, *Record of Proceedings [paras 189 and 191]*, 12 July 2017.

²⁰⁵ Oral evidence, *Record of Proceedings [para 193]*, 12 July 2017.

²⁰⁶ Written evidence, *PMH 10 - Betsi Cadwaladr UHB*.

²⁰⁷ **Note of stakeholder event held on 18 May 2017**, published 13 June 2017.

²⁰⁸ Written evidence, *PMH 06 - Public Health Wales*.

“Although there are reporting mechanisms between midwives, health visitors and GPs, these are not robust and may not always highlight the concerns of one group to another.”²⁰⁹

155. As well as the importance of communication among frontline health professionals, the importance of the interface between the new specialist teams and primary care was emphasised.²¹⁰ The RCMidwives told us:

“There’s a real challenge with perinatal mental health services in my opinion: that we don’t see it as maternity services asking routine questions or health visitors asking routine questions, a woman triggers on those questions and she is referred to a separate perinatal mental health community service, which may be of an excellent standard, but working separately. I think we lose some of the benefits that women would gain by having a more joined-up service. So, it’s a real challenge to ensure that we haven’t got separate referral areas, that we all work together to have the knowledge and the confidence and the expertise to enhance the woman’s care.”²¹¹

156. The British Psychological Society reported examples of good practice in Wales in terms of different services coming together, citing the ABUHB catchment area in which a perinatal and infant mental health special interest group has been set up to support the integration and shared working of different teams and agencies. This group includes professionals from Flying Start, the perinatal mental health service, the primary health mental health support service and CAMHS.²¹²

157. Other stakeholders, including the Welsh NHS Confederation and those with lived experience who participated in our stakeholder event, referred to the important role played by Specialist Midwives in improving joint working and communication.²¹³ Professor Ian Jones of the Maternal Mental Health Alliance explained:

“...the issue that we have in perinatal mental health is it covers so many [silos] [...] There’s primary care, there’s antenatal care, there’s mental health care, and actually, for good care what’s needed is people talking to each other. And the model of identifying specific midwives to have particular training and particular expertise, develop specific relationships with mental health and to be a resource that midwives in general can use and discuss, I think, is an excellent model. It’s working really well in many parts of Wales.”²¹⁴

Continuity of care

158. Those with lived experience who spoke with us during this inquiry told us that the importance of continuity of care for women suffering perinatal mental illness could not be overstated.²¹⁵ Anita-Louise Rees representing ABMUHB said:

²⁰⁹ Written evidence, *PMH 15 - Royal College of General Practitioners*.

²¹⁰ Written evidence, *PMH 10 - Betsi Cadwaladr UHB*.

²¹¹ Oral evidence, *Record of Proceedings [para 130]*, 24 May 2017.

²¹² Written evidence, *PMH 17 - British Psychological Society*.

²¹³ Written evidence, *PMH 21 - Welsh NHS Confederation* and **Note of stakeholder event held on 18 May 2017**, published 13 June 2017.

²¹⁴ Oral evidence, *Record of Proceedings [para 353]*, 24 May 2017.

²¹⁵ **Note of stakeholder event held on 18 May 2017**, published 13 June 2017.

“...from experience, inconsistency of contact is one of the biggest themes that comes up, certainly when we hear from people with lived experience. That is one of the challenges. In ABMU, certainly where women can be identified early as having possibly predisposing risk factors, there is an aim in ABMU for them to be offered consistency of care with midwives.”²¹⁶

159. Barbara Cunningham, a trustee of Perinatal Mental Health Cymru and a mother who experienced postpartum psychosis, recounted her experience of care in the late 2000s:

“After I was discharged from hospital, I didn’t see a single person twice, and no person saw me after I had my baby that had seen me before I had my baby. So no one had any benchmark, and my husband was desperately trying to get some help because he knew that there was something wrong, and he just kept getting fobbed off all the time, ‘Oh, she’ll be fine, she’s just happy, she’ll be fine.’ No, she wasn’t fine.”²¹⁷

160. The Institute of Health Visiting,²¹⁸ RCMidwives,²¹⁹ RCGPs²²⁰ and RCPsych²²¹ acknowledged the importance of continuity of care for women who require support for perinatal mental illness. Nevertheless, it was noted that within the current structure of services that was very challenging to deliver, particularly for midwifery services.²²²

161. Dr Jane Hanley, Specialist in Perinatal Mental Health at the Institute of Health Visiting, noted that much of the postnatal continuity of care will be delivered by the health visitor.²²³ However, from the evidence we received, it was not clear to what extent women in Wales could expect to see the same health visitor (or other frontline health professional) each time contact was necessary.

Third sector

162. Words such as “crucial”,²²⁴ “instrumental”,²²⁵ and “excellent”²²⁶ were used to describe the role of the third sector in helping support those with perinatal mental health issues and their families. All Health Boards who provided evidence acknowledged the important role played by the voluntary sector in the delivery of services,²²⁷ and a number of witnesses referred to the contribution it makes to identifying and plugging gaps in statutory services.²²⁸ The important role the third sector plays in supporting women and their families was emphasised by those who contributed to our stakeholder event, with many of those with lived experience highlighting the importance of peer support, particularly in reducing stigma around certain conditions.²²⁹

²¹⁶ Oral evidence, *Record of Proceedings* [para 309], 28 June 2017.

²¹⁷ Oral evidence, *Record of Proceedings* [para 335], 6 July 2017.

²¹⁸ Oral evidence, *Record of Proceedings* [para 143], 24 May 2017.

²¹⁹ Oral evidence, *Record of Proceedings* [para 202], 24 May 2017.

²²⁰ Written evidence, *PMH 15 - Royal College of General Practitioners*.

²²¹ Oral evidence, *Record of Proceedings* [para 37], 28 June 2017.

²²² Oral evidence, *Record of Proceedings* [para 202], 24 May 2017.

²²³ Oral evidence, *Record of Proceedings* [para 142], 24 May 2017.

²²⁴ Oral evidence, *Record of Proceedings* [para 217], 6 July 2017.

²²⁵ Oral evidence, *Record of Proceedings* [para 143], 6 July 2017.

²²⁶ Oral evidence, *Record of Proceedings* [para 321], 24 May 2017.

²²⁷ See, for example, oral evidence *Record of Proceedings* [para 454], 28 June and [paras 21 and 143], 6 July 2017.

²²⁸ See, for example, written evidence, *PMH 23 - Mind* and oral evidence, *Record of Proceedings* [para 91], 24 May 2017.

²²⁹ **Note of stakeholder event held on 18 May 2017**, published 13 June 2017.

163. The main challenge raised in relation to the third sector’s role in perinatal mental health services was the need to maintain funding, with projects described as “coming and going” depending on the financial support given.²³⁰ Professor Ian Jones of the Maternal Mental Health Alliance said there were “always difficulties” with funding arrangements for third sector organisations in the field and that this was “a big issue”.²³¹

164. Other challenges highlighted included difficulties faced by some voluntary organisations in certain parts of Wales building links with statutory services.²³² We heard that it was important to ensure that voluntary services receiving patients and their families are adequately resourced and trained to deal with them²³³ and have a clear pathway into which patients can be referred if their need is greater than a voluntary service can meet.²³⁴ To encourage this Jenny Burns of Mind Cymru suggested that one of the outcomes measurements for the new perinatal mental health services should be to evidence joint working with the third sector:

“If your outcomes are only treating mums and families, you’ll never get partnership working. But if you make an outcome, with evidence of how you partnered, or how you have worked with the third sector, you will then see that, because outcomes shape services.”²³⁵

165. Mind Cymru, CVUHB and ABMUHB highlighted the need to map perinatal services so that statutory providers could be more aware of what is available via the third sector.²³⁶ A number of witnesses referred to work underway, led jointly by Mind, the NSPCC and the National Centre for Mental Health, which will investigate provision across statutory and voluntary sectors for perinatal mental health services in Wales and report in March 2018.²³⁷

166. Representatives of Perinatal Mental Health Wales raised the plight of charities who support mothers and their families without public funding. They explained that they were established to respond to the lack of services available to founding members when they experienced severe perinatal mental illness. Providing peer support from those with lived experience, the group receives both self-referrals and referrals from statutory agencies, reporting high demand for their services. Nevertheless, due to their lack of a charity number until recently, they have been unable as yet to access public funding.²³⁸

167. Responding to questions about funding arrangements for the third sector, officials explained that direct funding from the Welsh Government is given only to all-Wales projects, but that Health Boards are expected to build on that in contact with organisations that provide services on a very local basis. While acknowledging the valuable contribution of voluntary organisations such as Perinatal Mental Health Wales, officials emphasised the importance of maintaining good governance and accountability arrangements when public funding is in the question:

²³⁰ Oral evidence, *Record of Proceedings* [para 77], 24 May 2017.

²³¹ Oral evidence, *Record of Proceedings* [para 323], 24 May 2017.

²³² Oral evidence, *Record of Proceedings* [para 79], 24 May and [para 284], 6 July 2017.

²³³ Oral evidence, *Record of Proceedings* [paras 217 and 284], 6 July 2017.

²³⁴ Oral evidence, *Record of Proceedings* [paras 233], 6 July 2017.

²³⁵ Oral evidence, *Record of Proceedings* [para 81], 24 May 2017.

²³⁶ Oral evidence, *Record of Proceedings* [para 93], 24 May and [paras 449 and 454], 28 June 2017.

²³⁷ Oral evidence, *Record of Proceedings* [paras 84 and 323], 24 May 2017.

²³⁸ Oral evidence, *Record of Proceedings* [paras 277, 281 and 286], 6 July 2017.

“...for local health boards, as with all of us, it is sometimes quite difficult to fund an organisation that isn’t formally established on a charity basis, because of governance issues and monitoring et cetera. So, it seems to me that that organisation is doing the right thing, actually, by formalising their arrangements, which I think will make it easier to engage with the statutory sector for funding. It’s very difficult, with public money, to give money out to local organisations that don’t necessarily have any formal basis to them, but are very well meaning.”²³⁹

168. The important contribution of the third sector was acknowledged by the Cabinet Secretary who explained that its role was illustrated by the fact that the sector is “...part of an active conversation on what the future [perinatal mental health] service should look like”. He recognised that for many people support from the third sector is more useful because they will not necessarily want to have conversations in a medical setting.²⁴⁰

Neonatal care

169. Bliss, the UK charity that supports premature and sick babies and their families, noted its disappointment that the Welsh Government’s Together for Mental Health Delivery Plan does not make specific reference to the mental health of parents whose babies spend time in a neonatal unit, and nor are they considered a high-risk group. This, they argued, is despite the fact that research has shown that the prevalence of perinatal mental health conditions is much higher in that group, with suggestions that mothers were up to 40 per cent more likely than the general population to suffer from postnatal depression after their baby had been premature and admitted to a neonatal unit.²⁴¹

170. While the All-Wales neonatal standards say families should have access to services that include psychiatric and psychological support and the British Association of Perinatal Medicine’s service standards make it clear that an intensive care unit should provide parents with access to a trained counsellor without delay from admission, we were told that in 2016 only five of the 11 neonatal units in Wales were able to offer parents any access to psychological support of any kind, either on the neonatal unit or via referral to an outside service. Bliss said:

“What’s particularly concerning is that none of the three intensive care units reported having a dedicated trained mental health worker on site. That is a great concern, because these units will look after the very sickest babies. They’re likely to have the highest rates of bereavement, as well, and parents really need that support.”²⁴²

171. Bliss described the provision of psychological support in the neonatal setting as “woefully inadequate”, blaming a lack of resource to invest in professionals, and a lack of awareness of the fact that neonatal parents have distinct needs.²⁴³

172. The need to continue to support parents after leaving the neonatal unit was also highlighted:

²³⁹ Oral evidence, *Record of Proceedings* [para 49], 12 July 2017.

²⁴⁰ Oral evidence, *Record of Proceedings* [para 32], 12 July 2017.

²⁴¹ Oral evidence, *Record of Proceedings* [para 15], 24 May 2017.

²⁴² Oral evidence, *Record of Proceedings* [para 69], 24 May 2017.

²⁴³ Oral evidence, *Record of Proceedings* [para 72], 24 May 2017.

“...the parents’ journey obviously doesn’t stop at the neonatal doors. It carries on, either into the community or coping with their loss. I would say that after the neonatal doors needs to be looked at as well. So, how will those community services be equipped to deal with parents who’ve been in a hospital for six months? Who is coming out to visit the mum who doesn’t have her baby and the dad who doesn’t have his baby anymore? I think that needs to be looked at as well.”

173. Dr Sue Smith, Consultant Psychiatrist at CVUHB, acknowledged the need to look in further detail at psychological support for neonatal parents, and highlighted her experience of neonatal parents being particularly concerned about being able to access ongoing help once they were home.²⁴⁴ ABMUHB representatives told us:

“In ABMU, there isn’t a specific psychological dedicated service in neonatal care at the moment, but women are able to access the perinatal pathway into our service, and we would recognise that women who have babies in neonatal care—recognise that as an added risk factor for their mental health and well-being.”²⁴⁵

174. On the issue of neonatal services, the Cabinet Secretary told us:

“...we recognise that it isn’t where it could or should be. So, it’s still about getting the right staff in place, and we’re investing in our neonatal services and reconfiguring the way they’re provided to make sure that services are configured around them as well. We think, actually, the investment that we’re making in those services should make it easier for us to do that, but I won’t pretend to you that we’ll sit back and say ‘Actually, everything is fine as it is’, because we recognise the comments that Bliss are making about needing to improve on the service.”²⁴⁶

175. When asked about the publication of the next (third) edition of the neonatal standards, and whether they would be endorsed by the Welsh Government, the Cabinet Secretary said:

“We work to the standards that exist, so you won’t find a position where the Welsh Government says, ‘We don’t like the new updated version of standards’. We will work to them. So, that will be part of what we expect health boards to meet and what we work to and plan for our service to deliver.”²⁴⁷

Bereavement support

176. The RCGPs highlighted that bereavement by miscarriage, stillbirth or neonatal death are more likely to lead to mental health problems in both parents.²⁴⁸

177. PHW noted that the effects the loss of a baby has on maternal mental health are well recognised and referred to the RCMidwives’ call for specialist bereavement midwives to support

²⁴⁴ Oral evidence, *Record of Proceedings* [paras 386-387], 28 June 2017.

²⁴⁵ Oral evidence, *Record of Proceedings* [paras 384], 28 June 2017.

²⁴⁶ Oral evidence, *Record of Proceedings* [para 214], 12 July 2017.

²⁴⁷ Oral evidence, *Record of Proceedings* [para 216], 12 July 2017.

²⁴⁸ Written evidence, *PMH 15 - Royal College of General Practitioners*.

families. It noted that roles for bereavement specialist midwives/officers had been established across Wales, to provide expert knowledge, insight and support to staff, women and families. Its written evidence stated that there is a link between bereavement specialist midwives and perinatal mental health teams as they offer the potential to signpost those women whose grieving process may be complicated and needing additional perinatal mental health support both now and in the future.²⁴⁹

178. The RCOG noted that its UK wide survey of women who had experienced perinatal mental health problems highlighted that some respondents who had experienced miscarriages and stillbirths did not feel that there had been enough support following these events, or in subsequent pregnancies. Some women reported not being offered any bereavement support, despite asking for it, or receiving it a long time after the event. The Royal College reported that on occasions where women were being offered support, often their partners were denied it, with many reporting feeling that there was an assumption that these events do not affect men in the same way they do women.²⁵⁰

179. Bliss told us that two bereaved mothers who responded to their annual parents' survey in Wales last year were not able to be referred to psychological services - instead they relied on the support of nurses. Bliss went on to state:

“...all of the comments that we received from parents about psychological support praised the nurses no end for the support they provided. But, nurses are not trained mental health workers, and it's not fair for nurses to carry that burden.”²⁵¹

Our view

180. We note the mixed evidence about the extent of antenatal and pre-conception advice. The antenatal period is a crucial time when women and their families can learn about the symptoms of - and treatment options for - perinatal mental illness. It is also an opportunity to normalise discussions about parents' wellbeing and address more proactively the stigma associated with mental illness.

181. Regardless of background and circumstances, most pregnant women will see a midwife. As such, we believe training midwives to conduct and act on conversations about perinatal mental health during the ante- and post- natal period is of crucial importance.

Recommendation 13. That the Welsh Government and Health Boards work together to raise awareness of perinatal mental health issues amongst the public and health professionals, particularly midwives. This should take the form of a public awareness campaign to improve understanding of the symptoms and risk factors associated with perinatal illness and should encourage the normalisation of discussion of emotional well-being in order to reduce stigma and fear of disclosure.

Recommendation 14. That the Welsh Government review information provided in standard pre- and post-natal packs given to women in Wales to ensure that it includes the necessary details about emotional well-being, perinatal mental health and where to seek help and support.

²⁴⁹ Written evidence, *PMH 06 - Public Health Wales*.

²⁵⁰ Written evidence, *PMH 09 - Royal College of Obstetricians and Gynaecologists*.

²⁵¹ Oral evidence, *Record of Proceedings [para 70]*, 24 May 2017.

Recommendation 15. That the Welsh Government design and provide for all Health Boards a national framework for antenatal classes and require Health Boards to do more to encourage attendance. The framework should include conversations about emotional wellbeing and the realities of parenthood in order to break down the significant and damaging stigma surrounding perinatal mental illness.

182. The need for training and continuous professional development (CPD) for health professionals on perinatal mental health was a key theme in our inquiry. We are concerned about the evidence we received suggesting that frontline staff lack the skills and confidence to identify, manage and refer perinatal mental illness correctly. We are further concerned that this lack of skills and confidence can either lead to delays in care being provided or perinatal mental health issues being missed altogether.

183. We welcome work underway by the Community of Practice to scope training needs across the spectrum of health professionals. Dedicated staff are key to ensuring that other colleagues are educated in this field - we believe that this will be vital in recognising and managing perinatal mental illness in future. Nevertheless, we firmly believe that it should be the norm that all professionals who could come across perinatal women have greater general awareness of the symptoms of perinatal mental illness, and how these symptoms should be managed and/or referred effectively and efficiently.

Recommendation 16. That the Welsh Government work with the relevant bodies to ensure that perinatal mental health is included in the pre-registration training and continuous professional development (CPD) of all health professionals and clinicians who are likely to come across perinatal women. The Welsh Government should ensure coverage of perinatal mental health as a discrete topic within midwifery and health visiting education is improved and forms part of the pre-registration mental health nursing programme. The Royal College of General Practitioners' core curriculum for general practice training also needs to better equip GPs to deal with perinatal mental health problems.

Recommendation 17. That the Welsh Government undertake work to develop and deliver a workforce strategy/competency framework to build capacity and competency across the specialist workforce, looking to experience in England and Scotland's Managed Clinical Networks (MCNs) which take responsibility for training as part of their leadership and co-ordination role.

184. Communication between professionals, particularly given the issues relating to continuity of care raised in evidence, is paramount. We were worried to hear methods of communication between practitioners in primary care described as not robust. Furthermore, the prevalence of women who do not see the same practitioner regularly and are therefore forced to repeat their issues each time they encounter someone new was a matter of concern. While antenatal care no longer sits within the GP's remit, we believe that it is important they remain part of the care pathway in order to maintain continuity of care and contact. Furthermore, we believe that the evidence we received suggesting that the appointment of a specialist perinatal mental health midwife can improve communication between professionals should be acted upon.

Recommendation 18. That the Welsh Government ensure every Health Board has a specialist perinatal mental health midwife in post to encourage better communication

between professionals to enable women who are unwell to get the very best care and support they need.

Recommendation 19. That the Welsh Government ensure all Health Boards work towards a situation in which every woman has a continued relationship with either a midwife or health visitor. While meeting with the same individual may not be possible on all occasions, continuity of care should be an aspiration to which all Health Boards actively commit resources, with a named lead responsible for each woman's perinatal care.

185. The invaluable contribution of the third sector to perinatal mental health services was clearly articulated in our inquiry, as was the evidence suggesting that it is both identifying and plugging gaps in statutory provision. Furthermore, evidence suggested that people may be more likely to engage with services in a non-medical setting, rendering the support provided by the third sector vital in many cases. We recognise the need for good governance and accountability arrangements when allocating public funds to voluntary projects and organisations, but note that it seems anomalous that statutory services are referring to voluntary services with little to no financial support being provided. We welcome the work underway by Mind, NSPCC and NCMH to map services and how they interact with statutory services especially in light of some of the evidence we received suggesting third sector organisations struggle in certain areas in Wales to refer in to statutory services where need is identified.

186. We note the importance of joined up services, and the need for more to be done to improve the links between statutory and voluntary sectors to ensure non-statutory provision is more formally integrated into mainstream services. We emphasise the importance of ensuring that third sector services and interventions are evidence-based, clinically effective and cost-effective.

Recommendation 20. That the Welsh Government work with Health Boards to ensure appropriate levels of third sector provision are properly funded, especially where referrals are being made to and from statutory services. A directory of third sector services should be made available to increase awareness of their availability and relevant third sector providers should be invited as a matter of course to attend training jointly with statutory services.

187. Requiring neonatal care for a child can be one of the most distressing situations faced by parents. We received worrying evidence about the lack of support for neonatal and bereaved parents, despite requirements outlined in the All Wales Neonatal Standards. The Welsh Government and Health Boards in Wales need to be address this a matter of priority.

Recommendation 21. That the Welsh Government outline within six months of this report's publication how it expects the lack of psychological support for neonatal and bereaved parents to be addressed and standards to be met, and what steps it will take if compliance with the standards is not achieved. The third edition of the neonatal standards should be published as a matter of priority.

07. Bonding and attachment

188. According to the RCPsych:

“Social relationships in early life have crucial influence on the infant brain. Brain development is dependent on strong, early bonds with an infant’s main caregiver –most often the mother. The interaction with the primary caregiver in the first year of life shapes the infant’s social, emotional, cognitive and language development, facilitating development of good mental health through childhood and into adulthood. Supporting mothers to bond and develop healthy attachment with her baby is therefore an important aspect of the provision of services, both generic antenatal and postnatal care and in mental health services and specialist perinatal mental health care.”²⁵²

189. We were told that if secure attachments are not established early in life children can be at greater risk of a number of detrimental outcomes including:

- poor physical and mental health;
- relationship problems;
- low educational attainment; and
- emotional difficulties and conduct disorders.²⁵³

190. PHW stated:

“A strong bond between an infant and a primary caregiver is developed through positive and responsive behaviours from the care-giver. As a result poor parental mental health can have a significant impact on children’s health and development. Even relatively mild or moderate mental health problems can impact on a parent’s ability to parent, particularly their ability to develop a strong bond and ensure optimal attachment to the infant.”²⁵⁴

What can be done to encourage bonding and attachment?

Before a baby is born, promotion of antenatal bonding with the bump, preparation for parenthood and early detection of antenatal depression are all crucial.

After birth, key factors such as feeding, skin to skin contact, mirroring behaviours, responsive parenting, and a stimulating play environment can also contribute positively to overall healthy development and relationship building between an infant and caregiver.

All parents/carers play a critical role in ensuring good mental health development for their children and in preventing poor developmental outcomes.²⁵⁵

²⁵² Written evidence, *PMH 19 - Royal College of Psychiatrists*.

²⁵³ Written evidence, *PMH 06 - Public Health Wales*.

²⁵⁴ Written evidence, *PMH 06 - Public Health Wales*.

²⁵⁵ Written evidence, *PMH 06 - Public Health Wales*.

Interventions

191. Evidence from Health Boards suggested that the importance of services to help support bonding and attachment is recognised and that it is a key area of development for many of the new specialist community perinatal mental health teams.²⁵⁶ PTHB referred to the fact that the importance of supporting mothers to bond and develop a healthy attachment with their baby during and after pregnancy is reflected throughout the Healthy Child Wales programme and Flying Start Programme.²⁵⁷ The Children's Commissioner for Wales emphasised the importance of bonding and attachment given the prevalence of issues relating to resilience and attachment highlighted to her by children, young people and professionals.²⁵⁸

192. However, according to PHW:

“It is not clear currently whether the full range of interventions to address poor attachment are in place in each local area. There has been investment in perinatal mental health services which is to be welcomed, however, this is likely to support only the most serious of cases and further investment and a more co-ordinated and strategic approach is needed which encourages system working and builds on a universal base to begin to meet people's needs in a proportionate fashion. Public Health Wales is working with the Together for Children and Young people Programme and the First 1000 Days Programme, to identify actions in this area.”²⁵⁹

193. The RCPsych believed that, in order to deliver the necessary developments in the field of bonding and attachment, local perinatal mental health networks should include professionals providing infant mental health services and those from CAMHS to help develop and share best practice in mother-infant interventions.²⁶⁰

194. A key issue raised in our inquiry was the effect on bonding and attachment of separation of a mother and baby due to the lack of MBU provision (or due to distance to neonatal units in some cases). This also applied to the impact on fathers' bonding and attachment (see earlier chapters).

195. Responding to concerns about bonding and attachment the Cabinet Secretary for Health, Wellbeing and Sport referred to the work of both the universal Healthy Child Wales and more intensive Flying Start health visitor services. He reported that the Welsh Government has invested in a family resilience assessment tool (FRAT) to better understand health visitors' caseload and workload, and to enable individualised assessment of the level of potential need within a family. He acknowledged that the challenge once the evidence base emerges is “making sure we do something about it”.²⁶¹

Feeding

196. Evidence from BCUHB highlighted that women who want to breastfeed but cannot, or do not, have approximately double the risk of perinatal mental health problems:

²⁵⁶ See, for example, *PMH -2 - Hywel Dda UHB*, *PMH 03 - Aneurin Bevan UHB* and *PMH 21 - Welsh NHS Confederation*.

²⁵⁷ Written evidence, *PMH 28 - Powys THB*.

²⁵⁸ Written evidence, *PMH 05 - Children's Commissioner for Wales*.

²⁵⁹ Written evidence, *PMH 06 - Public Health Wales*.

²⁶⁰ Written evidence, *PMH 19 - Royal College of Psychiatrists*.

²⁶¹ Oral evidence, *Record of Proceedings [para 220]*, 12 July 2017.

“In North Wales, we consistently see a high drop off in breastfeeding in the first 10 days. There is a link with this pattern and Perinatal Mental Health - both in terms of the negative impacts on the continuation of breastfeeding for women experiencing mental health issues and the increased risk in mental health issues arising for women who want to continue breastfeeding but aren’t able to through lack of early support or other reasons.”²⁶²

197. There was consensus among those who gave evidence that breastfeeding should be normalised and encouraged so that Wales’s poor rate of breastfeeding could be improved. Nevertheless, a number of witnesses warned of the negative impact that can occur if women who are unable, for whatever reason, to breastfeed feel pressure to do so, and believe that they have failed as a mother if they bottle feed instead. An individual response from parents with lived experience said:

“Another factor we believe needs addressing is the promotion of breastfeeding as the “Gold standard of baby nutrition” both at prenatal classes and within the healthcare system in general. Although, ‘Breast is best’ nutritionally for the majority of babies it is not always best for their Mothers who naturally want to do the best for their children and may feel pressured to continue breastfeeding even when it is pushing them emotionally and physically to their limits. [...] While there is a stigma against public breastfeeding conversely, not breastfeeding also has a stigma attached to it. Some Mothers feel more pressurised to conform rather than to bottle-feed.”²⁶³

198. Dr Sue Smith, Consultant Psychiatrist at CVUHB, told us that she sees a lot of women whose depression seems to have been triggered by not being able to breastfeed and feeling that that makes them an “absolute failure”.²⁶⁴ She noted that she spends a lot of her time trying to encourage mothers not to feel that way, but agreed that, in the perinatal period, it is very important to acknowledge a woman’s feeling of failure rather than brushing it aside and telling her not to worry about it. She referred to the use of “acceptance and commitment” therapy as a possible tool that could help:

“...instead of trying to encourage people to, ‘Oh, feel okay about that’, you’re allowed to feel awful about something, actually, and that’s okay, and you’re bound to feel like that.”²⁶⁵

199. Helen James, Head of Children’s Public Health Nursing and Paediatric Service at PTHB, told us:

“Breastfeeding will obviously promote attachment and bonding, but I would say just successful feeding for these women is also really important. I think some of these women feel really guilty if they can’t breastfeed, so I think the focus has to be on feeding successfully, and feeding with closeness, and the same principles of breastfeeding. So, we must really try not to focus so much

²⁶² Written evidence, *PMH 10 - Betsi Cadwaladr UHB*.

²⁶³ Written evidence, *PMH 16 - Individual response*.

²⁶⁴ Oral evidence, *Record of Proceedings [para 20]*, 28 June 2017.

²⁶⁵ Oral evidence, *Record of Proceedings [para 30]*, 28 June 2017.

on the breast, just successful feeding, and not make women feel guilty if they can't breastfeed.”²⁶⁶

200. The Cabinet Secretary acknowledged the challenges associated with providing public information about feeding babies:

“... there's a challenge about making sure that people don't feel that they have failed if breastfeeding doesn't work. We should still positively talk up the fact that it is entirely normal to breastfeed [...] There's a lot of evidence about not just the health of the child, but the health of the mother as well, about successful breastfeeding. But actually not then saying it is all about the mother, and it's down to the mother to make sure that it works, and it's their failure. I think it's right to say that using the word 'failure' is a really unhelpful and pejorative word [...] part of this is how we support people to get through that and say, 'Look, if it hasn't happened, then here's what we can do to give your child the best possible start in life, even if that isn't with breastfeeding.' I think there's a real challenge there in, on the one hand, wanting to encourage more people to take breastfeeding seriously and to actually try it and to be supported in doing it, and, on the other, there's how we support people where that hasn't worked out.”²⁶⁷

Medication

201. An area of significant concern raised by several participants in our stakeholder event was the issue of using medication to treat perinatal mental health issues, with some participants saying their GP was unsure about which medication to prescribe during pregnancy and / or when breastfeeding.²⁶⁸

202. BCUHB highlighted a general need to address prescribing in lactation within primary care as mothers experiencing perinatal mental health issues regularly report that they have been told to stop breastfeeding in order to take medication.²⁶⁹ The RCPsych warned:

“There is a general lack of awareness among many health professionals and the public around the importance of treating maternal mental illness, particularly around the use of medication. There is a perceived risk to the baby if taking medication during pregnancy or whilst breastfeeding. There is growing evidence that the management of the risk of the mother's mental illness is crucial, not just to the mother but to the baby, who may be at risk of neglect, or may not bond with the mother. It is important to weigh the risk of taking medication versus not taking medication.”²⁷⁰

203. While there was general recognition that more work needed to be done to increase primary care knowledge of how medication can be used by perinatal women, the RCMidwives, the RCGPs and

²⁶⁶ Oral evidence, *Record of Proceedings* [para 173], 6 July 2017.

²⁶⁷ Oral evidence, *Record of Proceedings* [paras 230 and 232], 12 July 2017.

²⁶⁸ **Note of stakeholder event held on 18 May 2017**, published 13 June 2017.

²⁶⁹ Written evidence, *PMH 10 - Betsi Cadwaladr UHB*.

²⁷⁰ Written evidence, *PMH 19 - Royal College of Psychiatrists*.

the RCPsych all warned that it was impossible to be able to guarantee 100 per cent safety. The general view was summed up by the Royal College of Psychiatrists:

“...it’s about educating professionals in primary care, in particular, about what’s safe and what’s not, and being able to weigh those things up [...] But the trouble is we can’t say definitely. You can never say to a woman, ‘It’s absolutely safe’. So, it’s about discussing risk, and often saying to women, ‘Even though the risk is very small, that doesn’t mean it won’t happen. So, if it does happen, you’ve got to consider how you would feel if something did go wrong.’”²⁷¹

204. Professor Ian Jones of the Maternal Mental Health Alliance explained that while he did not want to say that medication does not have a role during the perinatal period, he believed that there were probably women receiving medication where better options - particularly psychological therapies - exist. He referred to recent evidence he had seen suggesting that the proportion of pregnant women in Wales who are taking selective serotonin reuptake inhibitor anti-depressant medication is considerably higher than the UK average. He acknowledged, however, that there are probably women who are not getting medication that may help during the perinatal period:

“I do think in the perinatal mental health period it’s a really good time to really look to see if this medication is indicated, if it’s beneficial and if it’s doing good, and if there are other options that are available that could equally be as effective in treating this condition. If there’s no access to those psychological therapies—the cognitive behavioural therapies and the other really evidence-based therapies—then that is a problem.”²⁷²

Our view

205. We note PHW’s evidence that it is currently unclear whether the full range of interventions to address poor attachment are in place in each local area and that, while there has been investment in perinatal mental health services, it is likely to support only the most serious of cases of poor attachment and bonding. We further highlight that specialist health visitors in perinatal and infant health are in post in England and encourage further consideration of the development of such a role in Wales to help with challenges relating to attachment and bonding.

Recommendation 22. That the Welsh Government give consideration to developing a specialist health visitor in perinatal and infant health role in Wales to liaise with - and work in - a multidisciplinary way with CAMHS and infant mental health services, provide specialist support to mothers, fathers and their children, and provide specialist training and consultation to the wider health visiting and early years’ workforce, particularly with regard to issues relating to attachment and bonding.

206. The benefits to both mother and baby of breastfeeding are clearly documented. Notwithstanding this, we are concerned by evidence we received suggesting that feeling pressure to breastfeed can contribute to - and in some cases cause - the development or deterioration of perinatal mental illness.

²⁷¹ Oral evidence, *Record of Proceedings* [para 151], 28 June 2017.

²⁷² Oral evidence, *Record of Proceedings* [para 340], 24 May 2017.

Recommendation 23. We recognise the benefits of breastfeeding especially with regards to bonding and attachment and recommend that the Welsh Government commission work to look in further detail at the impact of feeding on perinatal mental health and translate this into guidance for professionals and the public.

207. The problems caused by mixed messages about the use of medication during the perinatal period and the importance of weighing the risk of taking medication versus not taking it was a recurring theme in our inquiry. There was a clear consensus that more work is needed to: increase primary care practitioners' knowledge of how medication can be used by perinatal women; promote primary care practitioners' confidence in having conversations about the risks involved; and supporting primary care practitioners' ability to refer women, where appropriate, to psychological therapies as a possible alternative.

Recommendation 24. That the Welsh Government ensure Health Boards have in place established standards, advice and guidance on psychological medication during pregnancy and breastfeeding, and ensure that they are implemented.

08. Health inequalities

208. According to PHW:

“Evidence suggests that universal service provision should be the starting point for action to address inequalities, with further support delivered proportionate to need. In the first 1000 days of life the universal service is the NHS through its midwifery and health visiting services.”²⁷³

209. A number of stakeholders including the Institute of Health Visiting,²⁷⁴ BCUHB,²⁷⁵ British Psychological Society²⁷⁶ and the Royal College of Paediatrics and Child Health²⁷⁷ highlighted the importance of ensuring services to support women and families during the perinatal period are universal in order to tackle inequalities. Some also commented that enhanced provision was required in certain areas to support populations in greater need, while others proposed that Flying Start and similar programmes would have a greater impact at population level if the additional NHS services funded through these programmes were flexible enough to provide intensive preventative interventions to all families where need is identified, regardless of postcode.²⁷⁸

Mental health and inequalities

Source: Public Health Wales²⁷⁹

- Inequality is a key determinant of mental ill-health;
- Mental ill health leads to further inequality;
- Social disadvantage is known to increase the likelihood of suffering poor mental health postnatally;
- There is a well-established link between social disadvantage and poor self-rated health among mothers with newborn infants;
- Depression and help-seeking for depression are patterned by ethnic group;
- Women from deprived areas and some from ethnic minority groups are more at risk of antenatal depression which is a risk factor for postnatal depression.

210. Cwm Taf, the University Health Board with the highest levels of mental illness and poor well-being in Wales, noted that the strongest negative impact of economic downturn is on mental health. It noted that due to high referral rates within the first 6 months of the new perinatal health team’s establishment, and the allocation of funding being based on birth rate without consideration of levels of social deprivation or health inequalities, it has had to reduce referral window to the specialist team from 12 months postnatal to one month in order to meet demand.²⁸⁰

211. The Mental Health Foundation told us:

“The perinatal period offers a particular opportunity for safeguarding well-being in the long term. Whilst disadvantaged groups are generally the least

²⁷³ Written evidence, PMH 06 - Public Health Wales.

²⁷⁴ Written evidence, PMH 24 - Institute of Health Visiting.

²⁷⁵ Written evidence, PMH 10 - Betsi Cadwaladr UHB.

²⁷⁶ Oral evidence, Record of Proceedings [para 265], 6 July 2017.

²⁷⁷ Written evidence, PMH 04 - Royal College of Paediatrics and Child Health.

²⁷⁸ Written evidence, PMH 06 - Public Health Wales.

²⁷⁹ Written evidence, PMH 06 - Public Health Wales.

²⁸⁰ Written evidence, PMH 12 - Cwm Taf UHB.

likely to access or maintain contact with services, during the perinatal period even the most disadvantaged individuals have contact with health and care professionals. Crucially, these contact points are not experienced as stigmatising (as contact with mental health professionals can be). This is also the period when both mums and dads report being most open to change in terms of dealing with their own mental health.”²⁸¹

212. Both the Mental Health Foundation and PHW highlighted the important role of the third sector in engaging with health inequalities by developing and delivering innovative and effective interventions that reach the most vulnerable and socially disadvantaged, who are at higher risk of perinatal mental health problems.²⁸² The Mental Health Foundation noted:

“Third sector, community agencies and peer support are often key for engaging with this demographic, who may be less likely to access or maintain contact with formal services.”²⁸³

Dual diagnosis and learning disabilities

213. The RCPsych’s written evidence stated:

“Service provision for expectant mothers from some populations continue to receive below standard treatment. These include those with dual diagnosis or those with learning disabilities [...] This is perceived as added complexity and added risk which has led to a lack of awareness, reluctance, and even fear to treat such patients.”²⁸⁴

214. The RCPsych highlighted that many women seeking treatment for alcohol and opiate dependence syndrome who are pregnant face many obstacles, including the diagnosis of addiction, which hamper their ability to access appropriate services to assess and manage perinatal health and well-being. Those who are picked up within the Cardiff and Vale area via joint working between a specialist midwife and the Community Addiction Unit were described as “the tip of the iceberg” with many women with dual diagnosis reported as going unnoticed. The RCPsych called on community perinatal mental health services to work more closely with these patients and their families by integrating knowledge of substance misuse management within the teams and employing within the perinatal team a liaison worker from specialist drug and alcohol services.²⁸⁵

215. We were told that expectant mothers with learning disabilities face similar barriers and their needs often go unmet due to lack of expertise and resources. The RCPsych noted that people with learning disabilities “continue to receive poor treatment from the NHS because of their disability” and that more effort needs to be made to improve both generic and specialist perinatal care for them.²⁸⁶

216. Professor Ian Jones of the Maternal Mental Health Alliance noted that dealing with dual diagnosis was a “big problem” due to lack of training,²⁸⁷ while the Institute of Health Visiting described

²⁸¹ Written evidence, *PMH 13 - Mental Health Foundation*.

²⁸² Written evidence, *PMH 06 - Public Health Wales*.

²⁸³ Written evidence, *PMH 13 - Mental Health Foundation*.

²⁸⁴ Written evidence, *PMH 19 - Royal College of Psychiatrists*.

²⁸⁵ Written evidence, *PMH 19 - Royal College of Psychiatrists*.

²⁸⁶ Written evidence, *PMH 19 - Royal College of Psychiatrists*.

²⁸⁷ Oral evidence, *Record of Proceedings [para 317]*, 24 May 2017.

the situation as “not great”.²⁸⁸ ABMUHB did, however, note that they were currently managing dual diagnosis well, with a specialist perinatal midwife and specialist alcohol and substance misuse midwife working jointly to assess and support women in need.²⁸⁹

217. Evidence received from the AWPMSHG highlighted that it “supported the equitable delivery of services for those with a learning disability including the development of appropriate documentation and interventions” to be delivered by learning disability nurses working with women with a learning disability who may experience a perinatal mental health problem.²⁹⁰

Language and communication

218. The importance of language and communication was highlighted by the British Psychological Society, who noted that the mental health needs of women whose first language is not English, and women seeking asylum, require further attention.²⁹¹ The Mental Health Foundation concurred:

“Communication issues are critical and access can be significantly improved where local areas take an active approach to engagement. This might involve ensuring that information about treatment and care is culturally appropriate; publishing in languages other than English; making independent translators available; or addressing additional needs relating to physical, sensory or learning difficulties. Clinical and service staff often benefit from specific training on working with women from a range of backgrounds, and in understanding the individual barriers to engagement.”²⁹²

219. Some stakeholders referred to the importance of ensuring that Welsh speakers are able to access services in Welsh if they so wish.²⁹³ However, it was noted that it can prove challenging to find specialist staff who speak Welsh, and it is even more difficult to address when services are procured over the border.²⁹⁴

Teenage pregnancy

220. We were told that the risk of depression is higher for teenage mothers.²⁹⁵ As such, the importance of joint working between perinatal mental health teams and CAMHS counterparts was emphasised by stakeholders. Both the Welsh NHS Confederation and Health Boards who provided evidence to our inquiry confirmed that perinatal teams would work jointly with colleagues in CAMHS where anybody under 18 required specialist support.²⁹⁶

²⁸⁸ Oral evidence, *Record of Proceedings [para 180]*, 24 May 2017.

²⁸⁹ Oral evidence, *Record of Proceedings [para 435]*, 28 June 2017.

²⁹⁰ Additional written evidence provided by the All Wales Perinatal Mental Health Steering Group on its work and remit, published 12 July 2017.

²⁹¹ Written evidence, *PMH 17 - British Psychological Society*. More detailed consideration of matters relating to refugees and asylum seekers is given in the National Assembly for Wales Equalities, Communities and Local Government Committee’s report ‘I used to be someone: Refugees and asylum seekers in Wales’, April 2017.

²⁹² Written evidence, *PMH 13 - Mental Health Foundation*.

²⁹³ See written evidence, *PMH 18 - Royal College of Psychiatrists and oral evidence [paras 130-131 and 255]*, 6 July 2017.

²⁹⁴ Oral evidence, *Record of Proceedings [paras 542 and 544]*, 28 June 2017.

²⁹⁵ Written evidence, *PMH 19 - Royal College of Psychiatrists*.

²⁹⁶ See written evidence, *PMH 02 - Hywel Dda UHB*, *PMH 12 - Cwm Taf UHB*, *PMH 21 - Welsh NHS Confederation*, and oral evidence *Record of Proceedings [paras 131 and 343]*, 28 June and *[paras 57 and 59]*, 6 July 2017.

221. When asked about the extent to which he was satisfied that perinatal services are meeting socioeconomic needs and socioeconomic disadvantage, the Cabinet Secretary emphasised the expectation that all services will link with existing schemes such as Flying Start. He went on to say:

“Our challenge then in terms of things like the Healthy Child Wales programme is to make sure that we’re actually spreading and using that learning across the piece. Because whilst we get to a high number of particularly deprived communities with Flying Start, we recognise that isn’t the only place where there are deprived community groups within the country as well.”²⁹⁷

222. The Cabinet Secretary noted that while he had not set out formal requirements for reporting on linkages between perinatal mental health services and Flying Start, he would expect them to be made and for Flying Start activity to be considered in the way teams plan and deliver the community mental health services. He stated that linkages will vary from one Health Board to another, but he felt assured that deliberate thought is given to how the perinatal service is planned to take account of the fact that there are Flying Start areas and Flying Start services and people working within those settings.²⁹⁸

Our view

223. In relation to the language in which services are provided, we believe Welsh speaking patients should be able to access services in their language of choice, particularly when seeking support for mental health issues which may require long, difficult and challenging conversations with clinicians and others.

Recommendation 25. That the Welsh Government ensure all workforce planning for perinatal mental health service provision considers - and provides for - the Welsh language needs of the population.

224. We believe that perinatal mental health services have the potential to make a significant contribution to addressing health inequalities in Wales, not least due to the clear link between a mother’s mental health and the long-term health and wellbeing of her child. However, a more concerted effort to reach more vulnerable groups including those with a dual diagnosis or learning difficulty, and others, is needed. Evidence submitted to our inquiry leads us to believe that more research is required to improve understanding of how support for perinatal mental health, including early identification, helps address health inequalities.

Recommendation 26. That the Welsh Government require Health Boards to report on the extent to which their perinatal mental health teams are engaging - and undertaking joint work - with other services such as CAMHS, Community Addiction Units (CAUs) and primary and secondary care mental health teams.

Recommendation 27. That the Welsh Government undertake further work on the link between health inequalities and perinatal mental health, focusing in particular on the best mechanisms for the early identification and treatment of those populations in greatest need.

²⁹⁷ Oral evidence, *Record of Proceedings* [para 204], 12 July 2017.

²⁹⁸ Oral evidence, *Record of Proceedings* [para 206-208], 12 July 2017.

Annex A – List of oral evidence sessions

The following witnesses provided oral evidence to the Committee on the dates noted below.

Transcripts of all oral evidence sessions can be viewed on the Committee's website.

Date	Name and Organisation
24 May 2017	<p>Rhiannon Hedge, Mind Cymru</p> <p>Jenny Burns, Mind Cymru</p> <p>Josie Anderson, Bliss</p> <p>Dr Sarah Witcombe-Hayes, NSPCC</p> <p>Helen Rogers, Royal College of Midwives Wales</p> <p>Sarah Fox, Royal College of Midwives</p> <p>Jane Hanley, Institute of Health Visiting</p> <p>Sharon Fernandez, Institute of Health Visiting</p> <p>Professor Ian Jones, Maternal Mental Health Alliance</p>
28 June 2017	<p>Dr Sue Smith, Royal College of Psychiatrists</p> <p>Dr Jane Fenton-May, Royal College of General Practitioners</p> <p>Ian Wile, Cardiff and Vale University Health Board</p> <p>Dr Sue Smith, Cardiff and Vale University Health Board</p> <p>David Roberts, Abertawe Bro Morgannwg University Health Board</p> <p>Anita-Louise Rees, Abertawe Bro Morgannwg University Health Board</p> <p>Carole Bell, Welsh Health Specialised Services Committee</p> <p>Carl Shortland, Welsh Health Specialised Services Committee</p>
06 July 2017	<p>Jon Morris, Betsi Cadwaladr University Health Board</p> <p>Dr Annemarie Schmidt, Betsi Cadwaladr University Health Board</p> <p>Sharn Jones, Betsi Cadwaladr University Health Board</p> <p>Carol Shillabeer, Powys Teaching Health Board</p> <p>Helen James, Powys Teaching Health Board</p> <p>Dr Dwynwen Myers, The British Psychological Society</p>

Charlotte Harding, Perinatal Mental Health Cymru

Barbara Cunningham, Perinatal Mental Health Cymru

Dr Jess Heron, Action on Postpartum Psychosis

Sally Wilson, Action on Postpartum Psychosis

12 July 2017

Vaughan Gething AM, Cabinet Secretary for Health, Well-being and Sport

Joanna Jordan, Welsh Government

Karen Jewell, Welsh Government

Annex B – List of written evidence

The following people and organisations provided written evidence to the Committee. All [consultation responses and additional written information](#) can be viewed on the Committee's website.

Organisation	Reference
Four Individual Health Practitioners	PMH 01
Hywel Dda University Health Board	PMH 02
Aneurin Bevan Health Board	PMH 03
Royal College of Paediatrics and Child Health	PMH 04
Children's Commissioner for Wales	PMH 05
Public Health Wales	PMH 06
Royal College of Nursing Wales	PMH 07
NSPCC Joint response from: NSPCC Wales, The National Centre for Mental Health and Mind Cymru	PMH 08
Royal College of Obstetricians and Gynaecologists	PMH 09
Betsi Cadwaladr University Health Board	PMH 10
Individual	PMH 11
Cwm Taf University Health Board	PMH 12
Mental Health Foundation	PMH 13
Bliss	PMH 14
Royal College of General Practitioners Wales	PMH 15
Individual	PMH 16
British Psychological Society	PMH 17
Welsh Health Specialised Services Committee	PMH 18
Royal College of Psychiatrists	PMH 19
The Wales TUC	PMH 20
Welsh NHS Confederation	PMH 21
Royal College of Midwives	PMH 22
Mind	PMH 23

Institute of Heath Visiting	PMH 24
Abertawe Bro Morgannwg University Health Board	PMH 25
Perinatal Mental Health Cymru	PMH 26
Action on Postpartum Psychosis	PMH 27
Powys Teaching Health Board	PMH 28
Welsh Government	PMH 29