mentalwelfare
commission for scotland

VISIT AND MONITORING REPORT

Perinatal themed visit report: Keeping mothers and babies in mind

JUNE 2016

Contents

About the Mental Welfare Commission

What we do

We protect and promote the human rights of people with mental health problems, learning disabilities, dementia and related conditions.

We do this by

- Checking if individual care and treatment is lawful and in line with good practice.
- Empowering individuals and their carers through advice, guidance and information.
- Promoting best practice in applying mental health and incapacity law.
- Influencing legislation, policy and service development.

Acknowledgements

We are grateful to the team at the Margaret Oates Mother and Baby Unit at the Homerton University Hospital, East London[1], who kindly allowed us to visit their unit.

We would also like to thank the women, families and ward staff who participated in this themed visit and the consultant psychiatrists who completed our online survey.

[1] https://www.elft.nhs.uk/service/182/Margaret-Oates-Mother-and-Baby-Unit

Executive summary

Background

This is the first study the Mental Welfare Commission (the Commission) has carried out into perinatal mental health care in Scotland. In this themed visit, we focus mainly on the care of women with severe postnatal mental illness who require admission to hospital.

National clinical guidelines in maternal mental health (SIGN 127[2] and NICE guideline[3]) recommend that women with severe mental illness, who require psychiatric admission late in pregnancy or within twelve months of childbirth, should be admitted to a specialist mother and baby unit (MBU), unless there are specific reasons for not doing so. Section 24 of the Mental Health (Care and Treatment) (Scotland) Act 2003[4] (the 2003 Act) also sets out a duty on health boards to support women to be admitted with their baby. There are two specialist inpatient MBUs in Scotland, in Glasgow and Livingston.

The objectives of this study were to:

- Find out whether women were being admitted to hospital with their babies, in accordance with the SIGN guideline and the 2003 Act.
- Explore the experiences of those women receiving inpatient care.
- Review national perinatal mental health provision, following the 2015 report by the NSPCC and Maternal Mental Health Scotland[5] which highlighted existing gaps in specialist community services.

[2] http://www.sign.ac.uk/pdf/sign127.pdf
[3] NICE guidance
[4] http://www.legislation.gov.uk/asp/2003/13/section/24
[5] Galloway S, Hogg S. Getting It Right for Mothers and Babies: Closing the Gaps in Community Perinatal Mental Health Services. NSPCC Scotland, 2015

Methods

- We carried out a national survey of all 43 general adult acute wards, 11 intensive psychiatric care units (IPCUs) and both MBUs from July to September 2015. During this survey we identified all postnatal women admitted for mental health care across Scotland during a three month period.
- We carried out in depth interviews with 23 of the 44 women admitted across different inpatient settings. We interviewed staff on the wards we visited and also spoke with three carers.
- All 14 health boards returned questionnaires about local perinatal services and policies.
- An online survey was sent to all consultant psychiatrists in Scotland (81 responded).

Key findings

Inpatient perinatal care

- Over one third of the mothers admitted during the survey (36%, 16 of 44) did not receive care with their baby in one of the specialist MBUs.
- We found the care of women in both regional MBUs to be of a high standard. Women we spoke with were positive about the specialist care they received.
- We found that women who received treatment in non-specialist general adult acute wards (without their babies), did not receive the same standard of care. These women were less positive about their experiences of care and were often separated from their babies for prolonged periods.
- Annual MBU admission numbers from 2012-15 suggest that, when regional birth rates are considered, some health boards are under-referring women for specialist inpatient care. Our findings suggest that the option of MBU admission is not always offered or actively promoted to women who are normally the main carer for their baby and require inpatient care. This is contrary to SIGN 127 and the 2003 Act. We found that some women chose admission to a local general adult ward and not their regional MBU because of the distance from home and family. This was particularly the case when women had older children to consider. Nursing staff and consultant psychiatrists, particularly in northern Scotland and remote or rural areas, also shared this concern.

- Family life is important, and the right to family and private life is enshrined in Article 8 of the Human Rights Act[6]. In the adult acute wards we visited: information about a woman's children was often not recorded and there was limited evidence of care plans that considered contact with children or the impact of a mother's admission on family life. There was also a lack of family friendly space to facilitate visits. This was disappointing, particularly in light of the recommendations in our 2013 monitoring report "When parents are detained"[7], in which we advised health boards to audit this and ensure child friendly visitor space is available in every psychiatric hospital.

Community perinatal care

- We found that stigma remains a significant barrier to women seeking help for postnatal mental illness. The fear that their baby would be taken into care was often a concern for women. We believe that better information and education in pregnancy and improved public awareness of maternal mental health is an important area that requires further work. We are encouraged by the progress of the Maternal Mental Health Change Agents[8], a group of women in Scotland with lived experience, who are challenging the stigma of maternal mental illness through research, sharing knowledge and using social media to connect with women and map information on local supports[9].
- When women we spoke with did seek help, the significance of their symptoms and associated risks were sometimes not recognised. We were concerned about a lack of perinatal training and knowledge among health professionals in some cases, both within primary care and mental health services. Severe perinatal mental illnesses can have rapid onset (within hours or days) and may present differently to those seen in the general adult population. Women's symptoms can fluctuate and the risks can be significant. The majority of consultant psychiatrists we surveyed told us they felt confident recognising and treating these illnesses, but over 90% (of 70) said they would value local perinatal expertise when treating women during pregnancy and following childbirth. One third of those surveyed (33%, 23 of 70) said this specialist advice was not currently available in their local NHS board.
- We found that women across Scotland continue to face significant inequity in access to specialist perinatal community mental health care. Only five of all 14 health boards told us they currently offer a local specialist community perinatal service.

[6] http://www.legislation.gov.uk/ukpga/1998/42/schedule/1/part/I/chapter/7
[7] http://www.mwcscot.org.uk/media/123938/when_parents_are_detained.pdf
[8] http://maternalmentalhealthscotland.org.uk/
[9] https://www.google.com/maps/d/viewer?mid=13L4KQ29adjb8TgSzIvWhzwq9dNA

Recommendations

1. Health boards should ensure that all women requiring admission to a mental health unit in late pregnancy, or in the first year following childbirth, should be admitted to a specialist mother and baby unit unless there are compelling reasons not to do so. In every case, options should be discussed with a perinatal specialist

2. Health boards should ensure that staff working with women during pregnancy and postnatally have completed the NES online training module in Maternal Mental Health[10].

3. Health boards should ensure that clinical staff in their community mental health and crisis response/assertive outreach teams receive training in perinatal mental health which enables them to safely assess and, where appropriate, manage women during pregnancy and postnatally.

4. Health boards should ensure there is a standardised system on general adult acute and IPCU wards for recording the following details for all patients with children under 18: name, date of birth and care arrangements in place for any child while the parent is in hospital.

5. Health boards should ensure that when any parent is admitted to a general adult acute or IPCU ward, they have a care plan that considers the impact on family life and reviews contact arrangements during admission. Access to support services should be made available to provide benefits for both parents and children.

6. Health boards should ensure that risk assessments used on general adult acute and IPCU wards include consideration of risk of a parent towards their child/children. Where a woman is receiving perinatal mental health care, the ward managers must ensure that a full risk assessment of mother and baby contact has been carried out.

7. Managers of general adult and IPCU wards should identify at least one member of staff in their team with an interest in perinatal mental health and support them developing expertise in this area and forming links with the MBU. We recommend that every service has at least one 'link worker' who establishes a relationship with the regional MBU.

[10] NHS Education for Scotland (2015) "Maternal Mental Health" online module

8. Health boards should ensure that when a mother, who is normally the main carer for her baby, is receiving treatment on a general adult ward or IPCU for any length of time, arrangements are made available to safely facilitate mother and baby contact during a period of separation. This contact should be supported by staff. Community professionals such as health visitors and social work may be involved if appropriate.

9. Health boards should ensure that all adult psychiatric wards have access to child-friendly spaces for children and families who are visiting a parent in hospital.

10. Health boards should ensure that their regional perinatal service is adequately resourced to promote perinatal mental health, through education and training activities and establishing good working links with health professionals across regional health boards.

11. Health boards should ensure there is specialist community perinatal mental health provision in their area which adequately meets the needs of the local population. Where no current provision exists, a local service should be established.

12. Health boards should ensure that, in accordance with Section 24 of the 2003 Act [4], provision is available for women who want to be admitted to hospital with their babies. In advance of the revised duty introduced by the Mental Health (Scotland) Act 2015[11] (the 2015 Act) coming into effect, health boards should audit their use of regional MBU beds and monitor the number of postpartum women being admitted to general adult wards in their local area.

13. The Scottish Government should establish a national managed clinical network as recommended in SIGN 127 (2012):

[11] http://www.legislation.gov.uk/asp/2015/9/contents

SIGN 127 states:

A national managed clinical network for perinatal mental health should be centrally established in Scotland. The network should be managed by a coordinating board of health professionals, health and social care managers, and service users and carers. The network should:

Establish standards for the provision of regional inpatient specialised mother and baby units, community specialised perinatal teams and maternity liaison services

Establish pathways for referral and management of women with, or at risk of, mental illness in pregnancy and the postnatal period

Establish competencies and training resources for health professionals caring for pregnant or postnatal women with, or at risk of, mental illness, at levels appropriate to their need. Ensure that all pregnant and postnatal women with, or at risk of, mental illness have equitable access to advice and care appropriate to their level of need.

The Mental Welfare Commission will: Work with the Perinatal Managed Clinical Network (once established) and the Information Services Division[12] (ISD), to explore how the monitoring of perinatal admissions across Scotland can be improved and reported on in the future.

[12] http://www.isdscotland.org

Part 1 Introduction

Mental health and wellbeing during pregnancy and following childbirth is important, both for mothers and for their developing babies. We know, however, that as many as one in five women will develop some form of mental health problem during pregnancy or in the first year after their baby is born (the postpartum year).

Mental illness relating to pregnancy or the postpartum year is known as perinatal mental illness. Perinatal mental illness can take many forms and may range from mild anxiety or depressive symptoms which can be successfully treated in primary care to, less commonly, severe mental illness requiring specialist mental health care and sometimes inpatient psychiatric treatment. The impact of these illnesses on women and on their early relationship with their baby can be profound, as can the wider effect on partners and families. Effective treatments are however available. The impact on mothers, babies and their families can be greatly reduced if symptoms are recognised early and appropriate treatment is started promptly.

In Scotland the current annual birth rate is almost 55,000.[13] With as many as 20% of women estimated to be affected by mental ill health during pregnancy or following childbirth, each year up to 11,000 babies could be born to mothers in Scotland who are experiencing mental health difficulties of some kind. It is important that services get care right; not only for mothers, but for babies too.

We focus in this report on women with severe perinatal illness and their journeys through mental health care.

1.1 Background

1.1.1 What are current standards for perinatal mental health care?

There are clear clinical guidelines available for professionals:

- The Scottish Intercollegiate Guidelines Network published SIGN 127 in 2012 2
- The National Institute for Health and Care Excellence updated the NICE guidelines for England in 2014.3

These documents tell us what good care should look like.

[13] www.isdscotland.org/Health-Topics/Maternity-and-Births/data-tables (ref: mat_bb_table1)

Guidance documents are also available for health boards commissioning perinatal mental health services.[14] [15]

Scotland has made provision in law for the care of mothers and their babies:

- Section 24 of the 2003 Act [4] places a duty on health boards to provide 'services and accommodation' for mothers admitted to hospital who care for their baby, and wish to do so in hospital, providing this is 'not likely to endanger the health or welfare of the child.' This includes women who are admitted to hospital voluntarily. This legal requirement was initially specified for 'certain mothers with post-natal depression.'
- In the 2015 Act [11], this remit has been widened to include admission for mothers with 'post-natal depression or a mental disorder (other than post-natal depression)', provided the health board is 'satisfied that doing so would be beneficial to the wellbeing of the child.' This revised duty is expected to come into force in April 2017.

1.1.2 Who is at risk of perinatal mental illness?

Perinatal mental illness may affect any woman during pregnancy or the postpartum year. We know that some women are at higher risk of developing severe perinatal illness. For example:

- Women with a history of bipolar affective disorder have a significantly increased risk of developing postpartum psychosis. For women who experienced postpartum psychosis in a previous pregnancy, the risk is increased further.
- Women with a family history of bipolar affective disorder have a slightly increased risk of developing postpartum psychosis.
- Women with a history of significant depressive illness or postnatal depression are at increased risk of this recurring in subsequent pregnancies.

This is why screening and prevention is key. For women identified as being at risk, the risks of illness can be reduced through careful monitoring, preventative treatment where appropriate and early intervention with specialist support if symptoms arise.

[14] Joint Commissioning Panel for Mental Health (2012). Guidance for commissioners of perinatal mental health services.
[15] Royal College of Psychiatrists (2015) College Report: CR197: Perinatal Mental Health Services: Recommendations for the provision of services for childbearing women.

1.1.3 Why are perinatal illnesses important?

Risks for mothers
Perinatal mental illness can affect a woman's bond with her baby and impair her ability to enjoy this developing relationship. If symptoms are recognised and treated promptly, the impact of illness can be minimised.
Severe perinatal mental illnesses, requiring input from specialist perinatal services, are not common. Research suggests the following rate (incidence) of severe perinatal illnesses per 1000 maternities:

Postpartum psychosis - 2 per 1000
Chronic serious mental illness - 2 per 1000
Severe depressive illness - 30 per 1000

The early postpartum period in particular is the time of highest risk in a woman's life for developing psychotic illness. The effect of these illnesses can be devastating if they are not recognised and treated promptly.

Mental illness remains one of the leading causes of maternal death in the UK.
Nationwide confidential enquiries into maternal deaths have been carried out since 1952. The latest confidential enquiry (December 2015[16]) found that one in seven of all women who died during pregnancy or the postpartum year, died by suicide. Mental health related causes accounted for almost a quarter of all deaths of women who died between six weeks and one year after pregnancy[17].

Suicide has remained one of the leading causes of maternal mortality for over two decades. Extended suicide, involving both mother and baby, remains rare, as does infanticide. The latest enquiry focussed on mental health and we refer throughout this report to key recommendations it made.

One of the main challenges to all health professionals is that the presentation of perinatal mental illnesses can be different from that of similar illnesses in the general adult population. Severe perinatal illness can be unpredictable: symptoms may develop very rapidly (over hours or days), fluctuations are common and risks can be significant.

National guidelines and policy documents on managing perinatal mental illness recommend the provision of specialist perinatal mental health services to help identify and treat these illnesses.

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[16] Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK: MBRRACE-UK (2015) Saving Lives, Improving Mother's Care www.npeu.ox.ac/mbrrace-uk
[17] The rate of maternal deaths from mental health related causes during pregnancy and the postpartum year was 3.7 per 100,000 maternities (UK and Ireland data from 2009-2013).

Risks for babies

Evidence consistently demonstrates the significance of early relationships for babies' healthy development, both cognitively and emotionally. It is now widely recognised that infant mental health is important.

The 2010 report 'Growing up In Scotland',[18] prepared for the Scottish Government, found that 'maternal mental health was significantly associated with child development outcomes and there was evidence that the degree of a child's exposure to maternal mental ill health affected child development outcomes.' The authors noted 'the relationship between maternal mental health and children's social, emotional and behavioural development remained statistically significant, even after we took account of maternal family characteristics and socio-economic factors.' The report concluded that 'supporting mothers with mental health problems may have a direct impact on young children's development and well-being and could enhance children's early school experiences.'

Infant mental health and the potential impact of maternal mental illness needs to be held in mind when treating both a mother and her baby.

From a health service perspective, a focus on maternal mental illness, infant mental health and preventive strategies may also have economic benefits. In 2014 the London School of Economics (LSE) produced a report with the Centre of Mental Health[19] on the cost of perinatal mental health problems in the UK. They estimated that nearly three quarters of the long-term cost of perinatal mental illness related to adverse impacts on the child (72%) rather than the mother (28%).

1.1.4 What do we already know about service provision?

Perinatal mental health provision across the UK is variable. For many women, access to specialist inpatient and community services is dependent upon where they live[20].

[18] Marryat L, Martin C. "Growing up in Scotland: Maternal Mental Health and its impact on child behaviour and development". Scottish Centre for Social Research, Edinburgh (2010)

[19] Bauer A, Parsonage M, Knapp M, Lemmi V, Adelaja B. "The costs of perinatal mental health problems". Centre for Mental Health and London School of Economics (2014)

[20] Information from the Royal College of Psychiatrists Perinatal Quality Network (March 2016) indicates there are currently 18 inpatient Mother and Baby Units in the UK: 16 in England and 2 in Scotland. There are no MBUs in Wales or Northern Ireland. All MBUs are accredited via the RCPsych Quality Network as adhering to national standards. Six units are currently accredited with excellence by the Quality Network. The provision of specialist community perinatal mental health services across the UK is more diverse and constantly changing.

Perinatal inpatient care in Scotland

In Scotland there are two specialist regional mother and baby units (MBUs): the west of Scotland Mother and Baby Unit in Glasgow[21] (opened in 2004) and the Mother and Baby Unit in St John's Hospital, Livingston[22] (opened in 2006). Both six bed units are currently accredited with excellence by the Royal College of Psychiatrists Quality Network [23].

Community perinatal mental health care in Scotland

Both regional MBUs have specialist community perinatal mental health teams providing services for women in the local health board area.

An NSPCC national survey in 2014[5] showed however that in two thirds of health boards in Scotland, perinatal mental health care is being delivered by generic adult mental health teams. None of these teams had dedicated time from a perinatal psychiatrist.

Key organisations

There are undoubtedly many challenges to providing equitable, specialist perinatal care across Scotland.

In 2009, a group of interested professionals set up the Scottish Perinatal Mental Health Forum (now Maternal Mental Health Scotland[24]) with a view to 'sharing knowledge, improving skills and championing the cause of maternal mental health throughout Scotland'. This national network has grown in recent years. Its website provides information for patients, families and professionals and the organisation, continues to drive and promote national service development.

A number of organisations in the voluntary sector are also actively involved in promoting the mental health and wellbeing of mothers and babies, via local groups, individual support and championing maternal mental health. These include Crossreach and Bluebell, Mellow Bumps and Mellow Babies programmes, Home-Start, the Family Nurse Partnership, the NSPCC and PANDAS (Pre and postnatal depression and advice service).

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[21] The Glasgow MBU provides a specialist inpatient service for the West of Scotland. Health boards commissioning this service are: Ayrshire and Arran, Dumfries and Galloway, Greater Glasgow and Clyde, Lanarkshire, West of Highland and the Western Isles.

[22] The Livingston MBU provides a specialist service for the East of Scotland. Health Boards currently commissioning this service are: Borders, Fife, Highland, Lothian and Tayside. Both MBUs accept referrals from outside these areas on a case by case basis.

[23] Royal College of Psychiatrists Quality Network

[24] www.maternalmentalhealthscotland.org.uk Maternal Mental Health Scotland now has charitable status and organises an annual perinatal conference in Scotland. Its membership includes midwives, health visitors, general psychiatrists, nurses, perinatal specialists and women with lived experience, together with voluntary sector organisations

1.2 Why we carried out this themed visit

The Mental Welfare Commission has not previously carried out a review in this specialist area of mental health. We therefore wanted to undertake a themed visit to look at perinatal mental health care in Scotland and to investigate whether the current standards of care for women, as recommended in SIGN 127 [2], are being met.

1.3 Aims of the perinatal themed visit

For this first perinatal themed visit we wanted to focus mainly on inpatient care for mothers and babies, in accordance with Section 24 of the 2003 Act [4].

Our main objectives were to:

1. Explore the pattern of inpatient care for mothers and babies across both specialist MBUs and other inpatient settings.
2. Learn about women's own experiences and journeys through care.
3. Gain a picture of current perinatal mental health service provision across Scotland, in both community and inpatient settings.

National interest in perinatal mental health increased in 2015, as we were planning and progressing this themed visit. Two significant documents were published in Scotland:

Getting it Right for Mothers and Babies (March 2015) [5] This joint report by the NSPCC and Maternal Mental Health Scotland examined many aspects of current community perinatal mental health provision in Scotland and highlighted gaps.

Healthy Start, Healthy Scotland, Improving the mental health of mothers and babies for Scotland's future (September 2015) [25] This document signified the launch of a two year campaign by the Royal College of Psychiatrists in Scotland, who 'identified maternal and early years' mental health as a clinical and public mental health priority'.

[25] http://www.rcpsych.ac.uk/PDF/Healthy%20Start%20Healthy%20Scotland%20Briefing%20Paper.pdf

1.4 How we carried out the visit

In preparation for this themed visit we reviewed recent publications and clinical guidelines in perinatal mental health. We also visited the Margaret Oates inpatient Mother and Baby Unit at Homerton University Hospital in London [1], which is accredited with excellence by the Royal College of Psychiatrists Quality Network[23]. Their service provided inspiration and a helpful benchmark.

There were a number of elements to the study.

1.4.1 National survey of inpatient admissions

We carried out a survey to identify all women in the postpartum year who were admitted to inpatient psychiatric care from July to September 2015. We surveyed all 43 general adult acute (GA) wards and 11 IPCU in Scotland.

Initially, we wrote to the charge nurses of every ward advising them of the study. We asked that their team inform us of any woman admitted during the study period who had given birth in the last 12 months. Many inpatient teams contacted us directly when a woman fitting the study criteria was admitted to their ward. In addition, our administrative staff telephoned each GA and IPCU ward a minimum of once every three weeks. On notification of each new admission, we then contacted staff for further details of the woman under their care.

We collected data from both mother and baby units regarding their admission numbers during this period.

1.4.2 Visits

We aimed to visit twenty women from the above cohort, who had current or recent experience of postpartum inpatient care. We wanted to find out in detail about their experiences. We anticipated that most women would be receiving care on MBUs. We arranged initial visits to both MBUs to interview women, review notes, meet with staff, review the ward environment and, where possible, speak with a family member. We developed questionnaires for each of these purposes. We organised follow up MBU visits to see women who were newly admitted during the three month period and interviewed some women who had recently been discharged (occasionally these interviews were conducted by phone).

Our initial intention was to visit all women treated on GA/IPCU wards. However, due to the unexpectedly high number of women admitted to general adult wards during the study, we visited half (8 of 16) of the women in these settings.

1.4.3 Survey of consultant psychiatrists

We wanted to find out about the experiences of consultant psychiatrists across the country, both in managing the care of women during the perinatal period and to seek their views about current service provision. We sent out an online survey via the Royal College of Psychiatrists in Scotland and NHS clinical directors. We are grateful to both the college and clinical directors for their support with this process.

We received 81 responses. We were encouraged by the time individual consultants took to add comments and offer narratives of their own experiences. Survey findings are referred to throughout this report and are summarised in section 2.3 [60].

1.4.4 Health board questionnaires

All 14 health boards in Scotland returned questionnaires to us. These asked for information about: local perinatal service provision, local integrated care pathways and prescribing policies for pregnant and breastfeeding women. We hoped this would add to the data gathered the previous year and published in the NSPCC report. We discuss the findings in section 2.4 [63] of this report.

Part 2 Findings

2.1 National survey of inpatient admissions

2.1.1 What we expected to find

We expected that a small number of postpartum women might be treated in their local adult acute ward, but that most women would be receiving inpatient care with their babies in a mother and baby unit.

We have already discussed legal provisions in the 2003 Act for mothers and babies requiring admission. Other current guidelines are clear:

SIGN 127 states:

> ***'Mothers and babies should not routinely be admitted to general psychiatric wards'***

The Royal College of Psychiatrists state:

> ***"All women requiring admission to a mental health unit in late pregnancy or after delivery should be admitted together with their infant to a specialised mother and baby unit, unless there are compelling reasons not to do so"***

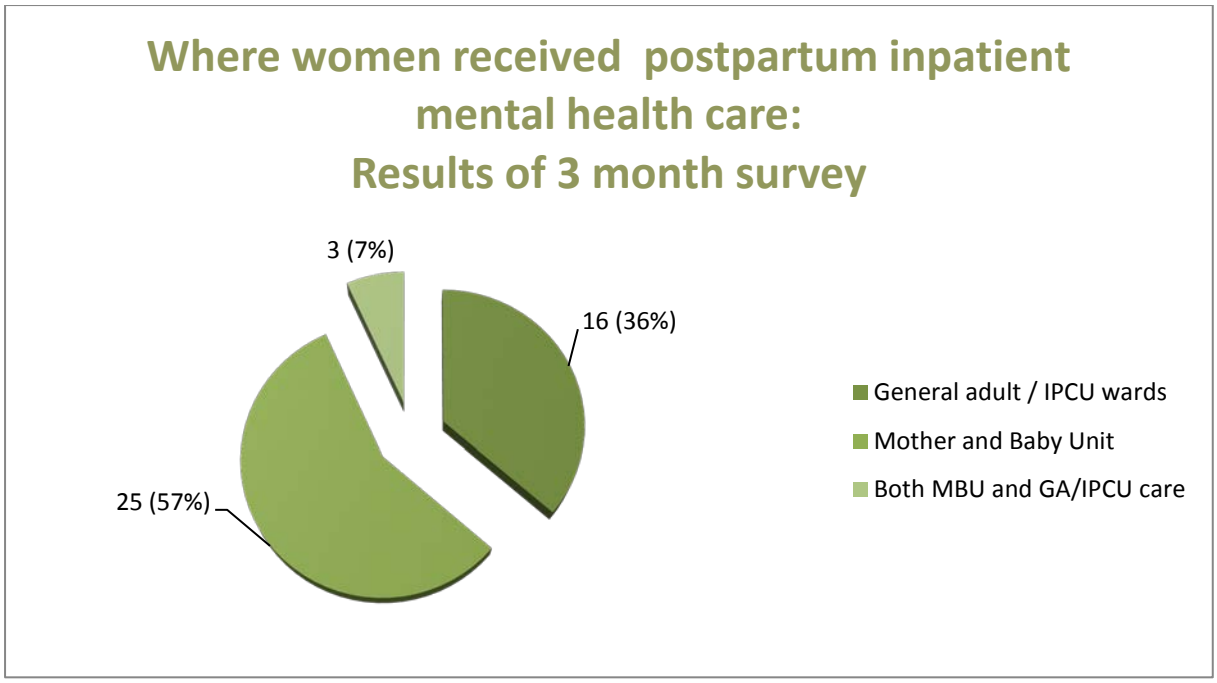
The latest confidential enquiry report states that admission to a mother and baby unit should always be considered where a woman has any of the following:

- Rapidly changing mental state
- Suicidal ideation (particularly of a violent nature)
- Pervasive guilt or hopelessness
- Significant estrangement from the infant
- Beliefs of inadequacy as a mother
- Evidence of psychosis

2.1.2 What we found

Forty four women with babies under one year received inpatient psychiatric care in Scotland during the three month survey. A small number of women were admitted more than once during this period (to the same or different inpatient settings), making the total number of admissions 49.

The chart below summarises where women received inpatient care.



Of the 25 women (57%) receiving care with their babies on an MBU, 15 were treated in the Glasgow unit and ten in Livingston.

Nineteen women received all or part of their care in a GA or IPCU ward; sixteen women received care only in a GA/IPCU ward during the study; three women received care in both GA/IPCU and MBU settings. Of the women who received all or part of their care in a GA/IPCU ward, two were treated in general adult wards offering some perinatal support, enabling daily visits from their baby. These two wards are unique in this respect and are discussed later in this report. **Most women admitted to GA or IPCU care had limited contact with their baby during admission.**

The women treated in GA/IPCU wards received care in 16 different wards, within 13 hospitals, across nine separate health boards. Nine of the 16 women receiving only GA/IPCU care were from areas geographically more distant from central Scotland Tayside, Grampian and Highlands.

We were surprised by the number of women receiving treatment outwith specialist units. This was not primarily due to a lack of MBU beds. During most (but not all) of the study period, MBU beds were available between the two regional units.

2.1.3 Women who received care in general adult or IPCU wards

We had telephone contact with the 16 GA/IPCU wards about women who were receiving inpatient psychiatric care there during the study. When we contacted the wards for detailed information, at times the individual staff we spoke with were unaware that the patient had a baby. We discuss this further below.

The following data was gathered during the survey:

The 19 women who received all or part of their care on GA/IPCU wards ranged in ages from 19 to 45 years old; average age 31. The age of the baby ranged from approximately one month old to ten months old at the point of their mother's admission, however, this data was incomplete, as information on the baby's age was often not available.

Eight women were subject to compulsory measures: six were detained on a short term detention certificate (STDC), one was subject to a compulsory treatment order (CTO) and one woman was receiving treatment on a compulsion order (CO).

Three women received IPCU care during the study. One woman had been admitted directly to the local IPCU on an assessment order. Two women had been transferred to their local IPCU from the regional mother and baby unit. Both had asked to be transferred as, at the time, they no longer wished to be treated with their baby. In each case, the severity of the woman's illness and her risk at the time meant that IPCU care was required.

There was a broad range of primary diagnosis for each woman who was cared for on a GA/IPCU ward. Diagnoses included:

- bipolar affective disorder (5)
- postnatal depression (3)
- depression with obsessive compulsive disorder (2)
- psychotic illness (2)
- personality disorder (3)

In four cases the diagnosis was either unclear or under assessment. Co-morbid alcohol or substance misuse was reported as a significant feature for two women. For each woman, we asked inpatient staff if the woman's case had been discussed with the regional perinatal service: six cases definitely had, two cases definitely had

not and the rest were unclear. We also asked if transfer to the regional mother and baby unit had been considered. In eight cases the answer was definitely yes, in three cases it definitely had not. In four cases, MBU admission was not applicable as the woman was not normally the main carer for her baby.

In relation to arrangements for the baby's care whilst its mother was in hospital, in ten cases, the baby's father was undertaking this care role. In two cases it was another family member. Three babies were in foster care and social work were involved with at least six families. The reasons for this were often complex, involving longstanding psychosocial factors which pre-dated admission.

When we asked about contact between mother and baby during admission, this was variable, from daily, to less that fortnightly. Contact was often dependent on how often family members could bring the baby to visit. Again, in many cases, when we asked this question, inpatient staff were unclear about arrangements for contact.

We attempted to see as many of the women receiving care on GA/IPCU wards as possible. In total we interviewed eight women from this group.

2.1.4 Why are women not being admitted to MBUs?

In our telephone contact with staff we discussed this issue. We also explored this question in later interviews with women and their partners. The responses were varied and often complex, but a number of clear themes emerged:

1. Distance and family commitments.
2. Woman's preference to be treated without her baby.
3. Woman is not the main carer for her baby.
4. Staff awareness and knowledge of MBUs.

Distance and family commitments

Some women (or occasionally their families) felt that their regional MBU was too far away from home. This was especially the case when there were older children to consider. Long travelling distances meant further disruption to family life at an already a difficult and distressing time. Childcare arrangements, a partner's work commitments and sometimes family finances meant that travelling long distances for visits (sometimes a 250+ mile round trip) was prohibitive.

Some women also told us that travelling from their home area to an unfamiliar region was too challenging. Several of these women said they would have accessed a specialist resource if it had been more local to them. It seemed to us that socioeconomic deprivation was sometimes a determining factor.

Interestingly, nursing staff themselves also spoke to us in some cases about distance being, in their own opinion, a barrier to referral to the regional MBU. A number of consultants in the online survey also highlighted this issue as a concern.

Woman's preference to be treated without her baby
In a few instances, women themselves had reported feeling too unwell to look after their baby and therefore declined the option of MBU care. One opinion was also expressed that it was a relief not to have this responsibility early in the illness, however, this changed during the course of the woman's recovery.

It was not clear to us if the model of MBU care, with intensive nursery nurse support and treatment in a specialist unit from a dedicated perinatal team, had been fully explained to women who opted for local care.

Woman is not the main carer for her baby
A small number of mothers in the inpatient survey were not normally the main carer for their baby. This was usually the case prior to their illness and admission to hospital. In some cases this was for pre-existing social and child protection reasons. Admission to a specialist unit, where the focus is on maintaining the existing mother and baby relationship, was not therefore appropriate and would not have been in the best interests of the baby.

Staff awareness and knowledge of MBUs
The nursing staff we spoke with on general adult and IPCU wards during the survey had varied awareness of the regional mother and baby units, their remit and purpose. Occasionally, staff had no knowledge of the regional MBU. More often they were aware of the specialist units but had little experience of referring patients or of liaising with the perinatal team, even if only for advice.

During our later visits, we asked senior nurses on both MBUs about referrals and whether they had any concerns about access to specialist perinatal inpatient care for women who needed it. They told us:

> *"Sometimes we get phone calls from adult acute wards where women might have been an in-patient the first couple of weeks. This is very disappointing, why haven't they called us earlier for advice?"*

There was an established culture of liaison, informal discussion and advice seeking with the regional mother and baby unit in only one of the wards we contacted. This was a ward with existing perinatal expertise (whose model we discuss later).

In all the teams we spoke with, the decision about referring to a mother and baby unit was one that would be made by the consultant psychiatrist.

Discussion

This inpatient survey captures only a single period in time. It may or may not be representative of overall annual admission rates in Scotland. However, the high number of postpartum women receiving inpatient care without their babies, in non-specialist units, was a significant concern. In a number of cases in which admission, and therefore mother-infant separation, was prolonged, we were concerned about the impact on the mother-infant relationship, and questioned whether MBU care should have been more actively pursued.

One mother, interviewed in our survey, was admitted to an adult acute ward before being transferred to the regional MBU. She told us:

> *"It was awful, the sense of isolation when you don't have your baby with you is terrible."*

She then described the MBU:

> *"The ward is designed to facilitate the care of the baby. It is brilliant, no matter what you need, they will help you."*

Inpatient care in a dedicated MBU should be the rule and not the exception. We have therefore made the following recommendation:

Recommendation 1

Health boards should ensure that all women requiring admission to a mental health unit in late pregnancy, or in the first year following childbirth, should be admitted to a specialist mother and baby unit unless there are compelling reasons not to do so. In every case, options should be discussed with a perinatal specialist.

RECOMMENDATION FOR GOOD PRACTICE

Where a woman requires perinatal inpatient care and transfer to the MBU is recommended by the perinatal team, but the woman chooses admission to a local adult acute ward instead, we recommend the following should happen:

The consultant treating the patient should ensure that:

- The patient and family are advised that transfer to MBU care is recommended.
- The benefits of MBU admission and specialist perinatal care are fully explained to the patient and family.
- Information about the MBU is provided, either through patient leaflets or other sources (the Glasgow MBU has a website and patients can take a virtual tour).

The consultant treating the patient should satisfy themselves that the patient is making an informed decision about her care. If the patient initially declines transfer to the mother and baby unit, the option of transfer should be regularly re-visited, both with the woman and with her family.

2.1.5 Case example

Case example:

A heavily pregnant woman self-presented to A&E. She described hallucinations, expressed concerns that her unborn baby was depressed and voiced fears that she may harm herself or others. She had a history of psychotic illness following the birth of a previous child. She refused to stay in hospital and was detained for further assessment. No bed was available in the regional mother and baby unit at the time and she was temporarily admitted to her local general adult acute ward.

The patient went into labour one week later. She was transferred to the maternity ward and delivered a healthy baby. Direct transfer to the MBU was planned as soon as a bed was available. Following an assessment by an out of hours psychiatrist over a weekend, the patient's detention was revoked and she was discharged home with her five day old baby. The MBU were not consulted about this decision. There was no local community perinatal health team.

Four days later, the woman's family raised concerns that she was displaying increasingly bizarre behaviour and aggression at home. She was re-detained and re-admitted to hospital. She required treatment for a severe postpartum psychotic illness.

Following a period of treatment on the MBU, the woman made a full recovery and was discharged home with her baby.

This case highlights some of the key characteristics of acute perinatal illness:

- Illnesses can develop very suddenly (within hours or days).
- Symptoms can fluctuate and patients may deteriorate rapidly.
- Risks can be severe and unpredictable.

Due to the fluctuating nature of perinatal mental illnesses, single assessments may be falsely reassuring. A comprehensive assessment should include: corroborative accounts from family members and health professionals, consideration of any history of mental illness or risk behaviour, and detailed mental state and risk assessment.

This example demonstrates the potential dangers of precipitously reducing levels of care for women with perinatal illness, and the importance both of seeking advice from a perinatal specialist, and for services to share information.

The delay in accessing a bed on the mother and baby unit in this case was a concern. Our understanding is that this is not a common occurrence. A change in senior staffing on one of the MBUs during the study meant that the unit was temporarily unable to admit new patients. Admissions recommenced once the new perinatal consultant was in place.

No woman identified as needing admission to a mother and baby unit should be discharged home without liaison with a perinatal specialist.

2.2 Visits: Women's journeys through care

Who we visited
We interviewed 23 women during the perinatal themed visit who were receiving, or had recently experienced, postpartum inpatient mental health care. We met with:

- Eight women receiving care in seven general adult wards[26] across four health boards.
- Seven women from the Glasgow MBU.
- Eight women from the Livingston MBU.

We reviewed women's case files, met with staff and carried out assessments of the environment on each ward we visited.

We focussed on women's pathways into care, their inpatient experiences and, where possible, the transition to the community on leaving hospital. We have presented our findings accordingly.

We interviewed the partners of three women during the study and discuss their views at the end of this section.

2.2.1 Pathways into care

Pre-conception advice
It is important that, wherever possible, professionals in primary care and mental health services identify women of childbearing age who are at risk of perinatal mental illness should they become pregnant. Approximately one in two pregnancies are unplanned and, for women with severe mental illness, this number may increase to as many as four out of five pregnancies.

The NICE guideline recommends issues to "discuss with all women of childbearing potential who have a new, existing or past mental health problem[27]."

Offering pre-conceptual counselling and advice, particularly on issues of prescribing, is an important aspect of women's care.

[26] We did not visit women actively receiving treatment on IPCUs, as we were advised by staff that they were too unwell, but we did meet with two women who had recent experience of IPCU care.
[27] NICE 2014 (section 1.2)

SIGN 127 states:

"All women of childbearing potential who take psychotropic medication should be made aware of the potential effects of medications in pregnancy. The use of reliable contraceptive methods should be discussed" [2]:

In the consultant survey we carried out, 74% of (72) consultant psychiatrists who were not perinatal specialists indicated that they felt confident offering pre-conceptual counselling to women routinely under their care for mental illness.

Of the 23 women we saw, 20 had a history of mental illness prior to their current pregnancy.[28] Eleven women reported a family history of mental illness and in one case, this indicated risk factors for the woman herself developing perinatal illness.

In just this small group of women, there was opportunity for pre-conceptual advice, which few recalled had been used.

During pregnancy

SIGN 127 states:

'All pregnant women should be asked about personal history of postpartum psychosis, other psychotic disorders (especially bipolar affective disorder and schizophrenia) and depressive disorder.'

When we asked women about their experiences, most said their midwife had asked about their personal history of mental illness at the initial booking appointment. A few women couldn't recall. One woman, when asked about her experience said:

"Because I have a history of mental health problems, we discussed what support I would need to be in place whilst pregnant and after I had the baby."

[28] 9 women had a history of depression (3 had significant postnatal depression in previous pregnancies); 5 women had an existing diagnosis of bipolar disorder (4 having had postpartum psychosis in previous pregnancies); 2 women had a history of depression only in the postnatal period; 1 woman had a history of schizophrenia; 1 woman had previous severe OCD and 2 women had a primary diagnosis of personality disorder.

Another woman told us her midwife had discussed a referral to a perinatal clinic if she were to become unwell after the birth of her baby. However, she had no idea what 'perinatal' meant, where the clinic was or what it offered. She felt she would have been more amenable to coming to the MBU earlier had she known of its existence.

SIGN 127 states:

The following groups should be considered as high risk for postpartum psychosis:

- Women with a personal history of postpartum psychosis.
- Women with a personal history of bipolar affective disorder.

  Risk is further increased if there is additional family history of postpartum psychosis or bipolar affective disorder.

The guideline specifies that:

> "Women at high risk of postnatal major mental illness should have a detailed plan for their late pregnancy and early postnatal psychiatric management, agreed with the woman and shared with maternity services, the community midwifery team, the GP, health visitor, mental health services and the woman herself."

Information in the 23 case files we read indicated that:

- Eight women should have been identified as at significant risk of severe postpartum illness.
- In six cases, this risk was clearly identified during pregnancy (in two cases this was unclear).
- Four women had clear antenatal care plans which met the standards above. We could not find care plans in the case notes of the other four women.

Case example:

A woman had experienced postnatal depression in a previous pregnancy. This first illness had been identified by the GP when her baby was a few months old. The woman was treated by the community mental health team, as there was no perinatal mental health service in her area. She had signs of severe postnatal depression and symptoms persisted throughout the postpartum year. She received input from a psychiatrist, community psychiatric nurse (CPN) and psychologist. When her baby was 18 months old, she was still unwell. Follow-up continued after her recovery.

When the woman became pregnant again, the local community mental health team (CMHT) remained involved. There was no clear perinatal care plan or preventative strategy in place. The woman again developed a postnatal illness, this time requiring a prolonged period of inpatient treatment. This care was provided on a local general adult ward, without her baby.

This example highlights why it is important to identify women at risk of recurrent perinatal illness and why getting care right is so crucial for both mothers and babies.

The following are key:

- Screening by midwives of all women at their initial booking appointment.
- Prompt referral to mental health services where risk factors are identified, ideally specialist perinatal mental health services.
- Clear communication with women explaining what is meant by perinatal care and talking through the options.
- Having clear perinatal care plans in place for those women at risk, and that these are shared with all professionals involved.
- Where preventative treatment may be appropriate, this should be discussed with women.

Postnatal care

Detecting illness and seeking help

Stigma and how women felt about seeking help

Difficulties seeking help

We asked women when they first knew that something was wrong, and any fears they had in letting others know they were experiencing symptoms. The responses were equally balanced between women who had no difficulties seeking help and those who feared speaking out about their mental health.

Three women recognised there was a problem within the first week of giving birth. When asked if they discussed these difficulties at the time, one woman said:

> *"I didn't tell anyone. I felt too ashamed."*

Several women told us they were worried their child would be taken from them if they spoke of their mental health issues:

> *"I was very worried (my baby) would be taken off me. My mum noticed, she started speaking to my support network and then my health visitor came to see me. It was my community psychiatric nurse (CPN) who arranged for me to be seen and it was agreed, with me, that admission would be best."*

Another woman told us:

> *"I think most women who become ill stop asking for help because they are terrified of having their baby taken off them. You are not rational. Women should now that places like these (mother and baby units) exist."*

A number of women said they only got help when they had reached 'crisis point' or when things had 'become worse'.

One woman told us she kept telling her partner and her mother that she was fine but had stopped answering the door or her phone, and had hardly left her bedroom with the baby for several days before she agreed she needed help.

It is a concern that for a significant number of women, issues of stigma around mental illness and fears about what would happen to their baby remained a significant barrier to seeking help. This is an area where increased information for perinatal women is likely to be helpful.

Feeling supported in seeking help

Of the women who had no fear about articulating their distress, they said they had no concerns because:

> *"As soon as I realised I was unwell, I went to my GP because I wanted to continue to look after my baby."*

> *"I had been told that if I became unwell, my child would not be taken off me."*

> *"I had the (community mental health) team to talk to."*

> *"I had depression before, I knew when I asked for help, I would get a lot of support and my children would not be taken off me."*

We found these responses encouraging. This group of women felt supported to seek help, with the confidence they would receive a positive response. It seemed that previous experience of working in partnership with healthcare professionals was key.

Challenging stigma

Raising awareness and reducing stigma is a focus of much ongoing work by Maternal Mental Health Scotland and the Change Agents: a group of mothers with lived experience of perinatal mental illness who are promoting education and aim to challenge the stigma associated with these illnesses [8]. They have received funding

from See Me Scotland[29] to help achieve this goal and are currently undertaking a research project in this area. The Change Agents are using social media to reach women and to share information about supports available across the country. The group are also promoting positive messages about perinatal mental health issues in the wider media. These developments are very encouraging, and we look forward to further progress in this area.

Recognition of illness by health professionals

> **SIGN 127 states:**
>
> "Enquiry about depressive symptoms should be made, at minimum, on booking in and postnatally at four to six weeks and three to four months."

Primary care

Of the 23 we interviewed, most women received timely support when they sought help. Unfortunately this was not always the case.

We asked women if their health visitor had asked about them about their mood or mental well-being after their baby was born, most women said they had.

Asked about their experiences, one woman said the health visitor was the first person she told about how she was really feeling, another told us that her health visitor helped negotiate with her GP to get her into hospital (she reported that the GP had initially been dismissive of her symptoms).

One woman spoke positively about having a health visitor whom she knew and who had been supportive after the birth of her first child with whom she had also been unwell. Another woman said of her health visitor:

> *"....just because I present well, my house was tidy and my baby looked well cared for, she didn't look beyond that."*

She looked at this as being a missed opportunity.

In relation to care at the GP surgery, one woman said that the triage nurse and GP at her surgery had been dismissive of just how ill she was, and the nurse had initially sent her away with a mindfulness CD. Another said that her outward appearance deceived too many people: she looked well and her baby looked well, but inside she felt as if she was 'falling apart'.

[29] https://www.seemescotland.org/

Two other women felt that support from the GP could have been better. One woman receiving MBU care told us:

> *"I was at the GP a few times over a few months but they didn't do much to help. They kept rationalising it, saying it was down to my personal circumstances. By saying that they were not appreciating the depth of how I was feeling."*

GPs

In 2015, the Centre for Mental Health published a report "Falling through the gaps: perinatal mental health and general practice."[30] This report analysed GP surveys and the experiences of women with perinatal mental illness in general practice. The report suggested a number of barriers to identifying perinatal illness. These included 'insufficient training and confidence among GPs in dealing with mental health problems and in the management of perinatal mental health care.' Just under half of those GPs surveyed said they had received no specific training in perinatal mental illness. In the report, women described mixed experiences when they did disclose mental health concerns to their GP. The author noted "It is clear from this study that voluntary disclosure of distress should be regarded as a "red flag" moment for GPs, requiring further active and compassionate investigation."

Based on the NICE guideline CG192 [3], the Royal College of General Practitioners and the Maternal Mental Health Alliance developed a short, ten point document to aid GPs in this area[31].

Health Visitors

The recent NSPCC report looked at health visitor training in Scotland. It found some improvement in the perinatal content in post-registration health visiting courses compared with an earlier 2006 survey. However, two of the five higher education institutes did not have dedicated sessions in perinatal mental health and only four health boards had health visiting staff with accredited training in perinatal mental health.

> **SIGN 127** suggests that one of the roles of a managed clinical network for perinatal mental health in Scotland would be to:
>
> "Establish competencies and training resources for health professionals caring for pregnant or postnatal women with, or at risk of, mental illness, at levels appropriate to their need"

[30] Khan L. "Falling through the gaps: perinatal mental health and general practice"
[31] RCGP and MMHA "Practical implications for primary care of the NICE guideline CG192: 10 Questions a GP should ask themselves (and their team) – http://www.rcgp.org.uk/clinical-and-research/toolkits/~/media/92F73D8AA0014DEAB37B55CDF7F2CE2B.ashx

In September 2015, towards the end of this survey period, NHS Education for Scotland (NES) published an online perinatal training module "The Maternal Mental Health e-learning Resource [10]."

This module was developed to provide an introduction to maternal mental illness for health professionals working with women during pregnancy and the postpartum period. The two online modules are free and accessible to all. Together they provide around four hours of learning. It is hoped that this new resource will assist in providing a baseline level of knowledge for doctors, nurses, midwives and health visitors. Additional specialist training should be accessible for mental health professionals, as we will discuss later, but access to this online training is an important first step.

Recommendation 2
Health boards should ensure that staff working with women during pregnancy and postnatally have completed the NES online training module in Maternal Mental Health [10].

Community mental health support

- Ten women received support from their local community mental health team prior to admission.
- Nine women had support from specialist community perinatal mental health teams.
- Two women received support from both.
- Ten women had crisis team/intensive home treatment team (IHTT) support prior to admission.

Issues were raised with us by a few women and their families, and by some professionals, about perinatal care being provided by crisis response/IHTT teams.

One partner told us his wife had recently been discharged from a psychiatric ward. After returning home she developed a suicide plan and was in crisis. The local crisis response team initially refused to visit, instead offering her an appointment the following day. The husband felt he had to be very assertive and insist they came to see that day. His wife was admitted to hospital the same day.

A senior MBU nurse we interviewed also spoke of some concerns in this area:

> "*We sometimes get phone calls for advice from IHTTs who are maybe seeing a woman two or three times a day. No discussed admission for this very high risk group of women is a concern....it indicates that staff lack an awareness of just how high a risk these women are and how this is managed."*

Managing risk

Information in case files suggested that 12 women had a history of previous risk, including suicidality in eight cases and deliberate self-harm in seven. At the point of admission 19 women were identified as having active risk factors, with 13 women posing a suicidal risk. Seven women had psychotic symptoms on admission and three women reported thoughts of harm to others, including their baby in two cases.

The latest confidential enquiry [16] emphasises that any expression of suicidal thoughts in pregnancy or the postpartum period should be taken seriously and that mental health services should have a low threshold for initial and ongoing assessment.

One (non-perinatal) consultant psychiatrist raised this issue specifically in our survey:

> "*The recent confidential enquiry reveals that a substantial proportion of general adult psychiatrists not only do not know how to safely manage perinatal cases but think that they do. I have witnessed this locally: risk assessments that would be entirely appropriate in a general adult psychiatry context but which miss vital perinatal-specific factors, when pressed the general adult service doesn't accept that anything was wrong."*

A key message for all professionals in the latest confidential enquiry is that the following should always be considered as **RED FLAG SYMPTOMS**:

1. **New thoughts of violent self-harm[32].**
2. **Sudden onset or rapidly worsening mental symptoms.**
3. **Persistent feelings of estrangement from their baby.**

The report is clear that any woman who reports these symptoms needs urgent referral to a specialist perinatal mental health team.

[32] The reasoning behind the first red flag symptom is that one of the findings from the report was that 82% of the women who died by suicide, did so by violent means. This is striking, particularly when compared with a rate of 60% among women in the general population.

Recommendation 3
Health boards should ensure that clinical staff in their community mental health and crisis response/assertive outreach teams receive training in perinatal mental health which enables them to safely assess and, where appropriate, manage women during pregnancy and postnatally.

Delays in admission
We asked women if there were any delays in accessing inpatient care when this was needed. Most women told us that admission had happened promptly.

Two women however said there had been delays.

One woman with postnatal depression said her general adult psychiatrist told her that referral to an MBU would be inappropriate as it was 'just for women who had psychosis'. Her mother had to persuade the psychiatrist - via the GP - that this was not the case.

One woman said she wished she had known of the MBU earlier. Her CPN had suggested she had crisis team support at home. The woman told us she herself rejected this in favour of MBU care as the care at home option was too intrusive.

Discussion
These examples highlight the importance of professionals being adequately trained in recognising and responding to women who present with perinatal mental illness.

This includes:

- Primary care professionals: GPs and health visitors.
- Maternity specialists: midwives and obstetricians.
- Mental health professionals: both in general adult CMHTs and in crisis response/assertive outreach teams.

It is essential that women presenting with symptoms of perinatal mental illness are assessed and treated in a timely manner. Wherever possible, care from a specialist perinatal mental health team should be offered. If admission is required, this should happen swiftly and, as previously discussed, referral to a specialist mother and baby unit should be the rule, with admission to general adult ward considered the exception. Issues of gaps in service provision across Scotland are covered later in this report.

2.2.2 Inpatient care

Specialist mother and baby units

Glasgow MBU
This was the first MBU to open in Scotland. It has recently moved to a purpose built unit at Leverndale Hospital. The inpatient unit accepts referrals for women at any stage of pregnancy and during the postpartum year. The service also has a community perinatal team, offering outpatient clinics and outreach support for women in Greater Glasgow and Clyde and liaising with local maternity services.

The six-bed unit is a large light and spacious ward occupying the ground floor of a two storey new building, which houses the west of Scotland perinatal service. It has a private garden and multiple recreational areas within the ward where mothers and babies can relax and spend time together. Each of the six rooms is en-suite and has a cot. There is a nursery sited within the core of the unit. Its design, with windows onto the ward, allows staff to observe mothers and babies without being intrusive. There is a separate milk kitchen. There is a large, bright open-plan lounge and dining area in the centre of the ward, a family room and a separate play room, providing space for individual and group activities.

Livingston MBU
The Livingston MBU is on the first floor of St John's, a general hospital in West Lothian. The unit accepts referrals for women from the late stages of pregnancy until their baby is one year old. The service also has a small community perinatal team which covers East Lothian, Midlothian, Edinburgh City and West Lothian and offers maternity liaison in the hospital.

The six-bed self-contained MBU was converted from part of the neighbouring general adult acute ward. The maternity wards are on the same floor and the special care baby unit is also nearby. Due to its location, the unit does not have direct access to outdoor space. Within the ward itself space is limited, however every effort has been made to maximise the available space for women and their babies. The lounge area serves multiple purposes: as a kitchen and dining area, a TV lounge and play area for babies. It is also used for group activities. There is a separate, comfortable family room which has child-friendly play equipment. Each of the bedrooms has a cot and en-suite facilities. There is a nursery off the main corridor which again has a large window allowing for unobtrusive observation, with a milk kitchen alongside.

Who we interviewed

Of the 15 women we interviewed from the mother and baby unit group, almost two thirds lived within the health board area of the MBU itself (four women were from Lothian and five were from Greater Glasgow and Clyde respectively). This reflects overall admission patterns for the MBUs, as we will discuss later. All women were receiving treatment on an informal basis.

We interviewed the charge nurses of both units and also spoke with other members of staff about patients, the care offered, and their experience of the ward.

What we found

Care and treatment

Admission documentation

Within the notes we reviewed on both MBUs, there were detailed admission pro-forma completed by both medical and nursing staff. We found clear documentation of family circumstances, including the name and date of birth of the baby. Where there were older children, we found details about them and of the care arrangements in place while their mother was in hospital.

Care plans

The care plans we reviewed were generally individualised and person-centred, with a clear focus throughout on maintaining the mother-infant bond. Women were often involved in the care planning and review process.

Each baby also had a set of notes, in which nursery nurses updated details of their care, including mother-infant interaction. Both units used standardised tools to monitor and measure infant wellbeing.

Risk assessment

On both wards we found risk assessments were thorough and clearly outlined risk factors for both mother and baby. Risk assessments informed care plans, particularly in relation to the level of supervision required to maintain mother and baby contact safely.

Medical and nursing care

We found a co-ordinated approach to care on both units, with regular reviews by the consultant psychiatrist, and weekly ward rounds with members of the multidisciplinary team. In both units, women were invited to attend each meeting and their supportive family member was also encouraged to participate.

It was evident on our visits and from reviewing patient notes, that staff on both MBUs were skilled, experienced and confident in managing women with perinatal mental illness. The staff we spoke with were knowledgeable about the specific needs of this patient group and the risks that needed to be considered to safely provide care for mothers and their babies. Nurses spoke about the differences in recognising and treating perinatal illnesses compared to the mental illnesses unrelated to childbirth normally treated on a general adult acute ward.

Information about medication

Most women told us they felt well informed about their medication. Information on medications (including in breastfeeding) was printed out, and doctors and nurses discussed this with patients. None of the women we met with were breastfeeding, but staff told us that they often care for women who continue to breastfeed on medication. Practical advice and support on breastfeeding for new mothers is also available from nursing staff, nursery nurses and midwifery specialists when this is required.

Multidisciplinary working

We were impressed by the multidisciplinary team working evident on both units and the range of skills among the staff teams.

- Nursery nurses:
  Nursery nurses form an integral part of the team in both MBUs, supporting mothers with the day-to-day care of their babies. Each unit also has input from a health visitor, who provides regular health checks for each baby, ensuring vaccinations and any health concerns are reviewed.
- Psychology:
  Both units have their own psychologist, who can offer individual psychological therapy for women on the ward when this is needed. Additional therapies, including couple therapy and behavioural family therapy, are offered by the psychologist and/or other members of each team. A small number of staff on both MBUs are trained in video interactive guidance (VIG), a therapy designed to help mothers and babies with bonding difficulties.
- Occupational therapy:
  Each unit has dedicated time from an occupational therapist (OT) and both wards offer a weekly programme of activities, run and supported by ward staff and the OT.

- Perinatal social worker:
  Both units have a dedicated social worker in the team who is dual trained in child protection and mental health. Their roles include helping families to access community support and liaising with outside agencies including education, social work and voluntary sector organisations. Where there are child protection issues, they can offer specialist assessment and liaison with local agencies.

Women's experience of the ward

When we met with women we asked them what it was like to be on the ward. Most women were extremely positive about their experiences. Women on both units talked enthusiastically about the staff, particularly about how staff expertise gave them confidence. They felt reassured that their experiences were recognised, were part of an illness and that they would be supported to recover:

> *"My previous experience was terrible - I wasn't offered hospital before. The experience of this hospital was amazing. The staff really understand, and that is such a huge help. It takes the burden off you. They had seen it all before. I could ask them questions as they have seen other people come through it. They are on hand day and night for you. It is so helpful."*

> *"I have found it really helpful. I was very nervous about coming in but everyone has been very welcoming. I have been in hospital before and I thought it would be similar to (name of local general adult ward) and it is nothing like that."*

One woman also told us how visiting the mother and baby unit during pregnancy had provided reassurance and helped her opt for a planned postnatal admission to the MBU:

> *"I had a look around the ward when I was pregnant and that was very helpful. It was an alien concept - I had never been in hospital before. The lead nurse persuaded me and it was well worth it.... I had a very positive experience, I really enjoyed my time there, the nurses were amazing."*

We asked women if they felt safe in the unit, and the response was a unanimous 'yes'. We also asked if women had any concerns about their baby being on the MBU, again, the response was unanimous, they had no concerns. One woman commented:

> *"Not at all. I was just so thankful she could be there with me. If they had taken her away I would have been so much worse. Even though I was ill, I was still bonding with her."*

In our discussions with women and staff, one important recurring theme related to reducing the fears associated with perinatal illness, providing reassurance and instilling hope.

One of the units has folders on the ward filled with cards and letters from former patients. These are prominently displayed and women and their families are invited to read them if they wish. Some women commented on how helpful they found these, especially in maintaining hope for recovery.

Women also told us about the importance of peer support, and the positive effect of sharing experiences with other mothers on the wards:

> *"It is comforting to have other women here because we are all going through the same thing. Before I came in I thought I would be in a bed on an adult ward. I didn't know it would be like this. It is better than I thought it would be."*

> *"It is great to have the chance to talk to other women who are here and being able to have a laugh is great."*

The focus on recovery and the role of peer support is important. We were encouraged by the approach we found in both units.

Supporting mother and baby

The focus on maintaining mother and baby's relationship throughout admission was evident from our visits to both units. Women themselves clearly emphasised how important it was to receive care with their baby whilst in hospital.

> *"It has been a very positive experience. I was caring for the baby round the clock but not looking after myself. I was exhausted. I wasn't sleeping or eating. When I first arrived here the nurses showed me to my room and they asked me what I wanted to do and I wanted to sleep. They asked if I would like them to take over (my baby's) care until I felt able to take over her care. For first forty-eight hours I slept. After that they let me decide when and how I got to take over her care again. I was so stressed and experiencing psychosis. They built up my confidence. They also taught me how to look after her one step at a time. The overall experience has been amazing. Two weeks ago I came here a broken woman. This is day thirteen and for the last three nights I have taken over complete care of my baby."*

> *"Brilliant having baby with me....made a big difference just having her there."*

"I didn't know places like this existed, the fact you're kept together (with your baby) is great."

"It's great that this is available for mums with babies, an extremely valuable service."

Women also spoke of their immediate relief at being in an environment which welcomed their babies, including even the smallest practical details:

"Absolutely great. Really well equipped. I love that I am in my own room and everything I need is set out for me - cot, feeds, changing mat, bag, nappies. When you are not well and very disorganised that is so helpful."
"It has got everything you need."

"Very well equipped: baby gym, activities every day, my own room was lovely."

On admission, women are usually acutely unwell and often unable to provide the level of care they normally would for their baby. Nursery nurses and nursing staff work closely with women to provide practical support in areas such as sleep routines, feeding and bathing as well as helping to support and maintain the emotional bond between mother and baby. Different levels of supervision and support are offered, depending on individual circumstances and risk. This is constantly reviewed for each mother and baby, to provide a balance between maintaining safety and developing a mother's confidence and skills.

Support with sleep was something several women told us was especially important:

"I think its good I've got my own room and that sort of thing. It'll be good when I can spend more time with (my baby) and have him overnight."

"I am really worried I won't get into a routine, but I can't cope with her waking up during the night and not getting enough sleep."

We asked women about the support they received in caring for their babies. They told us:

"Best thing is all the support if you need it. Depending on the staff they leave you to it if you are doing well and help when you are not so great."

"The staff are helpful but I try to do all the stuff for my baby myself. They would intervene if I did need help and that feels quite reassuring."

"When I'm tired they take over, they encourage me to take a rest. They obviously know a lot about these illnesses and how to take care of you."

"They were on hand to take my baby when I needed a break. I was still providing full care, but they were on hand to take over...they were totally in tune with what I needed and what (my baby) needed."

Activities

Both MBUs have a daily/weekly activity programme for patients. We asked women about the activities on the units, both for themselves and for their babies and they told us:

"(My baby) is only 3 weeks old, so it is all about changing, feeding and holding him. I don't really want to do anything else."

"They did hand painting, relaxation classes, and walks. It was nice to get out and about. We had music for mums and babies that we could both enjoy."

"You've really got a mixture of everything if you want to and it's your own choice, you don't have to if you don't want to."

Participation

In both units, we found evidence from looking at patient notes, and speaking to staff, that women were involved in decisions about their care and treatment.

We asked women to rate how involved the felt in decisions about their care (from very involved, to somewhat involved, to not at all involved). Almost all of the women receiving MBU care said they felt 'very' involved. These women appreciated and remarked upon the frequency and consistency of communication with the nursing and medical staff, which contributed to a sense of teamwork with the professionals. They felt they knew what was going on and felt involved in making choices about what they wanted to do, whether it was activities, meetings about their own care and treatment or even making suggestions towards the running of the ward. Most felt involved in their care planning.

Two women told us they felt 'somewhat' involved. They raised issues about how daunting the weekly ward round sometimes felt and found it difficult to meet with so many professionals. They did however say that they were offered the alternative of meeting their psychiatrist after the ward round instead.

We also asked women if their partner/other close family member was being involved in their care. Again, the majority said yes. Just two said no. These are some of their comments:

"*My husband was involved at all stages. We had to work very closely and it actually brought us closer together."*

"My mum and partner are both equally involved and they are both included in meetings and discussions. My partner is working but they both speak to (the consultant) for their perspective on how I am doing. He also answers their questions."

Visiting

On both wards, there is extended visiting to allow partners and other family members to see mother and baby during the day or after working hours. The approach on both wards is flexible to individual circumstances. Women can spend time with visitors in their own rooms or in the family room on each MBU. Both family rooms are comfortable and offers child friendly play facilities. We found the environments of both units to be bright and welcoming, with a family friendly, non-institutional feel.

We asked women on both MBUs about visiting arrangements. They were generally very positive:

"My visitors are made to feel so welcome."

"When you needed your family there they facilitated that. There was never any problem about visiting."

The flexibility of visiting times offered was particularly important for women and their families:

"Dads can come from 2pm to 8.15pm so they get the chance to be included in the whole process, not just of me getting better but also see first-hand how well (baby) is cared for."

"Flexible for my older children, grandparents and my husband."

We asked about family-friendly space on the wards. We had a variety of responses. Again these were generally positive although limitations on space on one of the units, and toys available for older children on both, were highlighted by some women:

"There is a "family room, playroom - great for my daughter, she is 3 and thinks it's brilliant! Last night we played with building blocks and it's good to see her in a place she loves."

"There is a Wii with games station for older children."

We asked women about any barriers to visiting; most said no. However distance was a factor for several women and their families:

> "*My partner visits daily. It's a lot of travelling. He had to take two weeks sick leave and has to go back to 12 hour shifts."*

> *"It would have been helpful for families to stay overnight. My mum had to drive from (distance 120 miles away) and to know she could stay overnight would have been good. One of the staff members took me as a one off to (home-120 miles away). On weekend passes, my mum would have to drive down and pick me up and bring me back. It was a nightmare for my mum."*

The staff we interviewed on both MBUs were also very aware of the challenges that distance posed for some families:

> *"Finances for families visiting is very difficult. It is sometimes so costly. One woman was admitted from the Western Isles and it was an eight hour round trip....Sometimes the cost of petrol and hotel costs alone make it so expensive that the women might ask to go to a local hospital due to the difficulties of visiting."*

Both units are now using internet technology to help with 'virtual' contact for families who are separated by distance: via Skype or video conferencing facilities on the ward. One of the units had recently installed video conferencing facilities that families could access via a mobile phone application:

> *"It is very new...a couple of women tried it and it has been positively received."*

Ward environment

The only environmental issue raised was by staff and a few patients on the Livingston MBU, about the limited physical space on the unit and one patient commented:

> *"The courtyard would be great if it could be developed but it needs work and money spent on it. You can't open the windows, and getting fresh air is so important. This open space should be part of the recovery process."*

We were told by the staff team that there are active plans in place to look at solutions to this problem. An architect has been employed to look at options for extending into another ward. Interim options of re-purposing some office space on the unit are also being considered. We look forward to seeing further developments on future visits.

General adult wards

Where we visited

We visited seven different general adult wards in four health boards. Of these, two wards offer one/two beds specifically for perinatal women, supporting daytime contact between mother and baby. These are not mother and baby units but provide alternative care for women who do not want to travel to their regional MBU. We discuss these models of care separately at the end of this section.

The other wards we visited were general adult acute wards and are collectively discussed below. These wards varied greatly: in size, accommodation, facilities, access to outdoor space and family friendly visiting areas. On this perinatal themed visit, we were particularly interested in looking at care provided from the perspective of mothers with young babies and their families. Given the very small number of wards we visited, we have tried to focus on themes that emerged rather than specific findings from any single ward.

Who we interviewed

We interviewed eight women about their care in general adult wards (including two women from the wards which offer some perinatal provision). A number of women had previous experience of MBU care, either with their current baby or with previous pregnancies. Of the eight women, three were receiving treatment under the 2003 Act: two on a short term detention certificate (STDC) and one on an interim compulsory treatment order (CTO).

We interviewed senior staff, asked about the ward and about their experiences of caring for perinatal women.

What we found

It is important to note that when we spoke with staff on each general adult ward visit, it was apparent that it was relatively rare for a woman to be admitted to their care either during pregnancy or the postnatal period. In the wards we visited, we were told that only one or two women a year at most would be admitted perinatally.

Care and treatment

Admission documentation:

Different wards had different admission documents, which in general were completed satisfactorily. It was however concerning to us, that in some of the notes we examined, there was no information at all about the woman's baby, or any older children, and no details about childcare arrangements while the mother was in hospital. When we asked nursing staff, at times there was still a lack of clarity. Many patients are parents, even if they are not mothers of small babies. Our 2013 monitoring report "When parents are detained" [7] explored similar issues.

We are aware that in some health board areas, part of the admission pack for every adult has a section relating to children, where the names and dates of birth and care arrangements for any children are recorded. We believe this is an important and necessary part of documentation for all wards, helping staff to identify potential child safeguarding issues at the point of admission, so that any concerns can be addressed.

Recommendation 4
Health boards should ensure there is a standardised system on general adult acute and IPCU wards for recording the following details for all patients with children under eighteen: name, date of birth and care arrangements in place for any child while the parent is in hospital.

Care plans
The care plans we reviewed varied in quality. Some were individualised and person-centred, whilst others were generic and lacked detail about the individual. One common finding in all the cases we reviewed was an absence of any care plans focussing on the woman's maternal role or of maintaining the mother-infant bond during admission.

One of the recommendations in the report, 'When parents are detained'[7], was that care plans should consider the impact of hospital admission on family life. It is disappointing that three years on, we found little evidence of this.

Recommendation 5
Health boards should ensure that when any parent is admitted to a general adult acute or IPCU ward, they have a care plan that considers the impact on family life and reviews contact arrangements during admission. Access to support services should be made available to provide benefits for both parents and children

Risk assessment
No specialist perinatal risk assessment tools were used in the acute general adult wards we visited. Whilst this may be understandable, we were concerned that in the risk assessments we saw, there was a lack of reference to potential safety issues involving the baby or other children. This is an important part of assessing a perinatal patient, as we saw on the MBUs.

When we asked staff about provisions for mothers having contact with their baby, this was almost always dependent upon family members facilitating visits. Staff told us that the woman's partner or other family member would be responsible for the baby when visiting. This included responsibility for safety.

When we asked staff “Would you envisage any risk issues associated with such contact?” the responses from nurses we interviewed referred only to potential risks from other patients or around the ward environment. No-one we interviewed spoke about potential risk issues relating to contact between mother and baby. This is a sensitive but important area of safety.

When a woman is suffering from an acute perinatal mental illness, she may unknowingly and unintentionally put her baby at risk. For example, if the illness affects mood or thinking, it may be difficult for her to sustain concentration and attention for even short periods of time. For a new mother, this may affect her ability to focus on everyday tasks in caring for her baby (such as feeding and changing), which she may normally do with ease.

Some risk factors are more subtle, such as recognising when a mother is struggling to emotionally connect with her baby and the baby is beginning to become withdrawn. These risks would normally be assessed by a combination of detailed mental state examinations and by observing mother and baby together in a safe and supportive environment. In MBUs, risk assessments are informed by the observations of nursery nurses, perinatal psychiatric nurses and medics on the unit.

It is relatively rare for a woman to pose a direct risk to her baby, for example having thoughts about harming her baby due to delusional beliefs. The risks mentioned above are also not present for every woman suffering from a perinatal mental illness. It is however essential that these risks are assessed. This is why the absence of detail in the risk assessments we reviewed was a significant concern.

Recommendation 6
Health boards should ensure that risk assessments used on general adult acute and IPCU wards include consideration of risk of a parent towards their child/children. Where a woman is receiving perinatal mental health care, the ward managers must ensure that a full risk assessment of mother and baby contact has been carried out.

Medical & nursing care
The main focus of treatment for the women we met was general nursing care and medication. Most notes evidenced regular reviews by the consultant psychiatrist and inpatient team at weekly ward rounds. Sometimes family members were invited. In most instances, the focus of ward rounds was on medical treatment. From our reading of the notes and discussions with staff, there was not a focus on issues relating to the mother’s relationship with her baby.

In the general adult wards we visited, only one member of staff we interviewed had any perinatal experience or training (this nurse had previously worked on an MBU). A lack of knowledge, expertise and confidence in caring for women with perinatal illness was something that a few members of staff highlighted to us. For others, this

felt less of an issue. One nurse explained that the staff team were confident managing perinatal women, as many nurses were parents themselves. This suggested to us a lack of understanding of the particular needs and risks associated with women who have a perinatal illness.

When we asked about training needs, all the staff we spoke with told us they were keen to learn more and take advantage of training opportunities in perinatal mental health, if they were available. When we spoke about the new e-learning tool [10], staff expressed an interest in this.

Recommendation 7
Managers of general adult and IPCU wards should identify at least one member of staff in their team with an interest in perinatal mental health and support them developing expertise in this area and forming links with the MBU. We recommend that every service has at least one 'link worker' who establishes a relationship with the regional MBU.

Information about medication
We asked staff about information available regarding medication in breastfeeding. Some of the wards told us this could be accessed in individual cases if needed by the hospital pharmacist. Of the women we visited, none were breastfeeding. This was for a variety of reasons. We noted that it would have been difficult for a mother to maintain breastfeeding if she was staying on an acute adult ward, due to limitations on visiting and other practicalities, such as a lack of equipment for expressing and storing milk.

Multidisciplinary working
The general adult wards we visited had a multidisciplinary approach, usually with at least occupational therapy input. Some wards had access to psychology, others did not.

None of the wards had dedicated social work support. Where this was required, support and advice came from the local child and families' social work team. Given the pressures within these teams, this frequently presented a challenge, particularly in cases where child protection issues meant that women were reliant on social work to facilitate contact with their baby. It was disappointing that liaison with social work, including attendance at multidisciplinary team (MDT) meetings, was not routinely documented within the notes we reviewed.

There were no specialist nursery nurses employed on the general adult wards we visited. This is entirely understandable. It does however highlight a significant gap in the care perinatal women receive when they are treated in general adult wards rather than an MBU. Some staff mentioned liaison with health visitors in the community, which was positive. None of the women or staff we interviewed spoke of

engagement with community groups or organisations which may have focussed on parenting or perinatal mental health issues and might have provided some additional support to women. One nurse we spoke with suggested that knowledge of, and contact with, appropriate community services would have been helpful.

Women's experience of the ward

When we met with women, we first asked them what it was like to be on the ward. Their experiences were very varied. They told us:

> *"It's different. It's a good ward, it's just a busy ward.'* This patient went on to say she spent a lot of time in her room."

> *"Nothing good about being on this ward. It is too open - too many people coming and going. I would rather be in an IPCU where it is much quieter. I am not coping very well with all this noise and activity."*

Some women were given individual rooms, with en-suite facilities, others were in small shared rooms or dormitory style accommodation; this depended on the ward environment and the individual needs of other patients at any particular time. One woman told us:

> *"I was having to take him into a six bed dormitory. Not a good place for a baby. All the other women wanted to see him."*

In all interviews, we asked if women felt safe on the ward, and if they had any concerns about their baby coming to the ward. One woman told us:

> *"I think this is a horrible place for a mum with a young child..... It isn't right for a toddler either.... The other patients all want to meet and touch my baby and I am not keen. It's a nightmare."*

When we asked women about the care they received on general adult wards and whether staff had time to listen to them, the diverse responses we received were striking:

> *"Staff are absolutely wonderful. Nothing is too much trouble."*

> *"Staff are really good. If they don't have time, they say and will come back."*

One woman talked about extremely negative experiences she had:

> *"Sometimes they listened, but with OCD I would ask for a lot of reassurance. They kept just referring me to psychology sheets. One time a health care assistant said 'we're not listening to this anymore' and shut the door in my face."*

This is unacceptable.

One woman commented about the lack of perinatal expertise among staff:

> *"(They listen) only if it's about me. Not if I am with my son. No-one is trained in perinatal nursing. They are out of their depth."*

Another woman spoke about the lack of focus she felt in her care, particularly in relation to recovery:

> *"Nothing to work towards. No mini-goals to look forward to. No forward planning."*

One patient gave us a very moving written account of how she felt a lack of psychological therapy had affected her care:

> *"I have been in and out of psychiatric wards since my daughter was born, including a stay at the mother and baby unit. I had a particularly severe case of obsessive compulsive disorder and it totally disabled me from functioning as a mother. I recovered once the hospital's psychologist finally gave me therapy (tailored to my specific needs).*
>
> *.....as a result of being away for so long, my baby daughter has forgotten who I am and won't let me pick her up/put her to bed etc. The only person who she'll let do these things is my partner who is caring for her while I'm in hospital. I have missed about a third of my daughter's life by being in hospital. Why didn't they give me therapy earlier? ... I just hope that my daughter and I recover our bond quickly when I return home."*

Whilst a few women described positive experiences of their care on the ward, the negative aspects highlighted by others were very concerning. The impact of mothers being separated from their baby, as with the patient above, was a significant loss for many, as we will see below.

Supporting mother and baby

Some of the most poignant discussions we had with women were when we asked about how much contact they had with their baby whilst in hospital. These are some of their comments:

> *"They didn't visit. ... Staff were thoughtful. One time I was upset and one of the staff drove me home (to see her children)."*

> *"I only see my baby on a weekly basis. My daughters, who are older and who will be really missing me because I look after them all the time, are brought up on a fortnightly basis. I really miss them and I know they will be missing me."*

> *"Aye - kinda. They don't stop him coming. When I was in IPCU I got fifteen minutes in the back of mum's car. It was horrendous."*

> *"I'm not supported with his care by staff. Open visiting though. My husband brings him in."*

Frequency of women's contact with their baby, and with older children, was usually dependent on family members (or in a few cases, social workers) bringing them in and supervising visits, and this varied:

> *"I see her every other day."*

> *"Once a week."*

> *"Not that often. Been here for nine weeks. Have seen her a few times in that time. One day she was here and something kicked off and it wasn't safe for her to be here. I can sometimes take her to the hospital café with (baby's father) and the nurse sits close by."*

> *"I didn't have any initially.... Five weeks without seeing my children at all. Probably best for my baby, she was at the crawling stage, hard flooring and probably best being at home with brother."*

For one woman, social work had to arrange visits for her baby and sometimes this did not happen:

> *"I have hardly seen my baby in the nine weeks I have been in hospital."*

Another woman with a nine month old baby and toddler at home had been in hospital for three weeks when we met her. She was normally the main carer for her children and told us:

> *"My husband brought (baby's name) in and I've seen (baby) twice'. [She had not seen her older child.] I probably won't see him until I get home."*

We subsequently learned that this woman had an inpatient stay of several months before she was discharged. This was her second admission to a general adult ward since her baby's birth.

A great deal is understood about the importance of the early years and the establishment of secure attachments for babies. For babies whose mother is normally their primary carer, the impact of extended periods of separation should be considered by the teams caring for the mother. Indeed this is embedded in the Mental Health Act, when it places a duty on health boards to make provision for mothers requiring inpatient treatment to be cared for with their babies.

If there is a good reason for a woman receiving care on a general adult ward rather than an MBU, the needs of both mother and baby should be considered by the inpatient team and any other professionals involved.

It was concerning that on the general wards we visited, responsibility for supporting mother and baby contact was seen to be the role only of family members (or social work in a few cases). Alongside the issues of safety, it is our opinion that placing this responsibility solely on family members is not appropriate. A mother and baby will likely benefit from skilled support and supervision by trained staff.

Inpatient staff with some perinatal training and experience could be key in supporting safe contact between mother and baby. They might also offer guidance and support, helping a woman with both the physical and emotional care of her baby during visits. This can also be an opportunity where simple, thoughtful interventions can help a mother and baby who may be struggling with separation.

It may be appropriate to involve community professionals such as health visitors if there is no local community perinatal team to offer input and support to inpatient staff.

We would advise the managers of each ward to consider the options available to them locally, and have a plan or protocol around admitting a woman for perinatal care.

Recommendation 8
Health boards should ensure that when a mother, who is normally the main carer for her baby, is receiving treatment on a general adult ward or IPCU for any length of time, arrangements are made available to safely facilitate mother and baby contact during a period of separation. This contact should be supported by staff. Community professionals such as health visitors and social work may be involved if appropriate.

Activities
In most of the wards we visited there was an activity programme available for patients, offering a variety of groups or events on a daily basis. Due to the non-specialist nature of the wards, there was no focus on parenting or activities to encourage mother and baby contact. We did not come across any instances where one to one support from nursing staff or OT offered opportunities to encourage and nurture a mother and baby's relationship.

Participation
We asked women how involved they felt in decisions about their care and treatment. For the women on general adult wards, one woman felt 'very' involved, half felt 'somewhat' involved and a few women felt they had no involvement at all.

Where patients felt 'somewhat ' involved in decision making about their care and treatment, there were some positive comments about meetings with the named nurse, but reservations were expressed about meeting with the doctor/psychiatrist.

The women who commented about not being involved spoke about a difference of opinion with a psychiatrist and a sense of not having goals to work towards. Generally, women spoke of there being some involvement of supportive family members in their care.

Visiting
When we asked women about visiting, the responses were quite polarised. A few women told us visiting was okay and had no particular comments:

"Can use the quiet room. Usually sit in dining room when visiting time."

Most women, however, had a number of complaints. The first issue highlighted was lack of private space:

"Well, I can see them in the Spiritual room but it's not very private."

"The only room available is a family room but it isn't for families with young children. Neither is it private. On one side is a glass wall facing into the corridor, on the other are windows overlooking the benches were patients smoke."

When we asked women if they felt the ward was equipped for visits from their baby, some also commented on this lack of provision:

"Definitely not. It doesn't cater for babies or young children."

"The family room isn't private, it isn't comfortable either. There is no lounge. There is no changing facilities, not even a changing mat. No bottle heating facilities."

Other women felt the busy ward environment made family visiting difficult:

"It is very busy. Too busy and too stimulating even for me. Not calm and not suitable for a family visit. IPCU would have been better, it is quieter."

One woman suggested that visiting could be improved by having a family room away from the main ward.

Several women highlighted a lack of child friendly facilities:

"No toys, books, games or DVDs for children. Nothing."

"I have discussed the lack of child friendly facilities with staff. Partner brings in toys."

"There is no space for children or facilities for my youngest son to play. I have played football outside with him."

All women on the general adult wards we visited were being treated within their local health board area. A few mentioned how distance impacted on visiting. One woman who had previously been in the regional MBU found it better being closer to home:

"In (local hospital) there are no travel costs as it is local and my dad can visit. In (MBU) it was just too far."

However another woman told us that distance was still a problem for her visitors:

"I am from (nearby area), 16-17 miles away. Costs a lot of money for mum and baby's dad to get here."

Ward environment and facilities

It was clear that the general adult wards we visited did not have facilities to support babies visiting. We did not find facilities for feeding or changing babies (such as equipment for making bottles or for nappy changing).

As noted above by patients, not all wards were able to provide private space for families visiting either. When a family room was available, we did not find the space to be family friendly. There were issues about privacy, an overly clinical environment, lack of comfortable furniture and lack of age-appropriate toys or games for younger or older children.

This was disappointing. Again, in the Commission's 2013 report on patients who are parents [7], the provision of child friendly space in hospitals was highlighted as a recommendation. We advised then that health boards should audit the availability of these facilities and ensure arrangements were made to provide them in every psychiatric hospital. We found no evidence that this was being effected in the health boards we visited.

Under Section 278 of the 2003 Act[33], service providers have a duty to mitigate the effects of compulsory measures on parental relations. The Commission has previously made recommendations to improve the experiences of parents admitted to hospital, and their families, suggesting that recommendations are implemented for all parents admitted, not just those detained under the Act. Some of the staff we met acknowledged a lack of child-friendly facilities as a gap in provision. They also had good ideas about how to make visitors spaces more inviting and family friendly. Often, however, challenges were highlighted. There were particular concerns about how to make a space more comfortable and homely and to provide toys, books or games for children, within the constraints of local infection control policies (which may for example prohibit the use of items which cannot be sterilised). This was a subject that we feel it is important for each ward to consider in conjunction with local policies and to negotiate with senior managers and the local hospital acquired infection (HAI) team. The MBUs could also be a helpful source of information and advice in how to overcome these issues.

Recommendation 9

Health boards should ensure that all adult psychiatric wards have access to child-friendly spaces for children and families who are visiting a parent in hospital.

[33] http://www.legislation.gov.uk/asp/2003/13/section/278

General adult wards with perinatal input

Description of units

The two acute general adult wards in Scotland which offer additional facilities for mothers with babies up to one year old are based in The Royal Cornhill Hospital, in Aberdeen and Forth Valley Royal Hospital, near Falkirk. Both allow mothers to bring their baby in to visit during the day, but neither are able to accommodate babies overnight.

Care and treatment offered

Women are admitted to both these units from the local health board area. In both units, specialist community perinatal teams usually work alongside the inpatient staff.

Both teams are very clear that their facility is not a specialist mother and baby unit and that they cannot provide equivalent care. The first line is to promote admission to the regional MBU. If a woman does not wish to receive MBU care, however, (distance from family is usually the main reason), the units aim to provide an alternative. They offer inpatient care in a safe and supportive environment where a mother can be supported in maintaining her relationship with her baby. Whilst neither unit is staffed by nursery nurses, a number of inpatient staff have additional perinatal skills and training and are supported by the attached community perinatal consultant and team.

We spoke with women who had recent experience of care in each of these units. Both said that they valued the opportunity to receive care locally whilst being able to maintain contact with their baby when they wanted. Both also had experience of MBU care and did not feel their care on these local units was compromised in comparison.

Admission numbers for these units are relatively low. Both had cared for between one and three perinatal women each year over the previous few years. Maintaining specialist skills and knowledge is therefore a challenge. We discuss below how the team in Forth Valley have developed a model of care to creatively address this issue.

GOOD PRACTICE EXAMPLE: NHS FORTH VALLEY

We were impressed by the quality of care offered in this service and by clear policies and frameworks underpinning this care. The service had up-to-date care pathways, prescribing guidelines and used detailed admission packs designed for perinatal patients. In additional to generic risk assessments, inpatient staff use specialist perinatal (FACE) risk assessments for women, in addition to standardised tools for assessing mother-infant interactions. There is a perinatal admission checklist to help junior doctors and non-specialist staff.

This small service, led by one advanced nurse practitioner, has achieved much since it became operational in early 2013. The community perinatal mental health team has four consultant sessions per week and nursing input from band 5 and band 7 nurses from local CMHT and IHTT teams and one OT, all of whom have dedicated weekly time with the perinatal service. This model means that a specialist service can provide for a relatively small population, with only one full time member of staff. It also means that perinatal expertise is becoming established within generic local adult mental health teams.

The community team has very close links to the inpatient service, which has a core team of nurses who each have additional perinatal training. Nursing staff are able to offer women a combination of additional therapies including mindfulness and bonding support. At least one member of this team is always on duty on the ward (even if no perinatal women are on the unit), in case perinatal support is required. This expertise makes a difference. We learned for example that a woman recently admitted to a neighbouring ward was identified by one of the perinatal nurses as being postpartum and was subsequently offered inpatient care with her baby. The team are also flexible, and told us that they offer admission to women from early pregnancy to one year postpartum. They have also offered admission to a woman who lost her baby via stillbirth, as it had seemed more appropriate for her to receive specialist care than be admitted to a general adult bed. Both patient and staff felt this had been the right thing to do. The approach is reflective and responsive. The team meet to have in depth case discussions following each admission, to share any learning points, and consider whether a woman's care might have been further improved.

The staff team are aware of the challenges in maintaining expertise when they may only admit a small number of pregnant women or mothers and babies to the unit every year. The service have therefore developed a programme for staff which helps maintain their knowledge and skills. This includes:

- Fortnightly supervision with the advanced nurse practitioner
- Monthly meetings
- Inpatient staff joining the senior nurse practitioner perinatal clinics
- Regular teaching and training events
- Reflective groups

The team have close links with both MBUs and strive to continually improve.

2.2.3 Transition from inpatient care to the community

During the visits, we spoke with some women who were actively going on home passes and for whom discharge was planned. We also interviewed some women who had been discharged from inpatient care. We asked nursing staff on both MBUs and general adult wards, how they managed pass planning and discharge, as well as reviewing information about this from case files.

Pass planning and discharge
The process of beginning to have passes home after a period of inpatient care can be both exciting and daunting for mothers with babies, as well as for their families. The time of transition home, particularly immediately following discharge, can be a period of particularly high risk for women. It is therefore important that this process takes place in a planned, thoughtful and supportive way.

Mother and baby units
Passes usually begin with women having short periods of supported time out locally, and progress to passes home with their baby. Home passes are usually supported by family, and progress from brief daytime visits to overnight and then extended periods at home.

Ensuring the safety of mother and baby on pass is paramount. Within both inpatient teams, there was a focus on risk assessment and careful planning before passes began. Family members and local services were involved in the planning process. In one unit, the patient, her partner and local services were all provided with written copies of the pass plan prior to home passes. These included information such as crisis plans, contact numbers, and contingency plans if any difficulties arose on pass.

Both teams told us that they routinely contact all the professionals involved in a woman's care at the point of admission. The key health professionals are invited to attend MDT meetings and are kept updated of progress throughout admission. When a woman is ready to begin home passes, inpatient staff liaise with the local teams to make appropriate plans.

For women who live in the MBU health board area, the community perinatal mental health team are usually involved, as are the local crisis team, if indicated. However, senior nurses from both units told us that one of the main challenges their team faced was arranging passes and planning discharge for women from other health board areas:

> *"Main challenge is transitioning women from hospital to home with each health board having different services available. Some have more than others. Most services who take the women on are generic general adult teams and that is not ideal."*

"For out-of-area patients, pass planning and discharge planning can be difficult. Also, the lack of knowledge and risk management by non-specialist teams.....In two health boards, the local policy for visiting women on pass does not meet our standards."

The MBU teams told us that out of hours support varies across the health board areas. A few mental health teams are able to offer crisis support for women on pass if required. Many are not. For many women living far from the MBU, their local services cannot offer out of hours support in the event of a crisis. Whilst both MBUs offer 24 hour telephone support and advice to women on pass, if they need immediate help, the options may be to call NHS 24 or to return to the MBU (which may be several hundred miles away).

Both staff teams also spoke of variability in social work support available to families in different health boards.

General adult wards

Pass planning and discharge plans varied across the general adult wards we visited. In general, pass planning appeared less detailed and robust and was less likely to involve detailed risk assessment. Whilst good links generally existed for mental health services able to support women in the community, few health boards we visited offered specialist perinatal support.

Experiences of women and their families

The women we interviewed described a range of experiences surrounding passes and discharge:

"The progression of passes was gradual, even on my own. It really builds your confidence. This led to me going home overnight. It was good going out and good to come back. I think most women who become ill stop asking for help because they are terrified of having their babies taken off them. You are not rational. Women should know places like this exist."

"I will have a CPN and a social worker who I know won't be wanting to take my baby off me, but will help me. A nursery nurse - honestly the care and support doesn't stop on discharge."

One woman however highlighted gaps in communication which caused concern for her partner, particularly when it came to planning passes:

"He feels that he and my mum should be more involved planning for it. I was just told I was getting a pass, given medication and just expected to get on with it."

One woman who had recently been discharged told us she had a good support package from the community perinatal service (attached to the MBU):

> *"Weekly visits from perinatal team... consultant, CPN and social worker. My baby is doing fantastic, thriving, so alert and so happy."*

Another woman who had been discharged described rather different experiences:

> *"I am not getting any support just now. I am going back to see the psychiatrist in two weeks' time but nothing else - I am on an anti-depressant which seems to be working."*

We discuss issues of the geographic variability of specialist community perinatal services in the final sections of this report. Whilst regional health boards need to address inequity in this area, there also appears to be a disparity between the two regional specialist services, which may also impact on effective links and perinatal training provided across health boards areas, as discussed below.

Promoting perinatal education and link-working across health boards

We noticed a difference in the outreach, key working and educational role offered by each of the two regional perinatal services. In Glasgow, the community team are actively involved in developing links with interested professionals in regional health board areas and with local services (primary care, secondary care and maternity services) to promote learning, raise awareness of perinatal issues and increase collaborative working. This education and link-working role was less evident in the east of Scotland.

Both perinatal teams however clearly acknowledged the important role of outreach and collaborative working with regional health boards, and were enthusiastic about improving networks in this regard.

Recommendation 10

Health boards should ensure that their regional perinatal service is adequately resourced to promote perinatal mental health, through education and training activities and establishing good working links with health professionals across regional health boards.

2.2.4 Carer views

During the study, we interviewed three partners (or carers) of women who had received inpatient care. We asked them a number of questions in relation to their experiences and the support their partner – and the family - received before to admission, during admission and after discharge.

One man's wife received inpatient care only on a general adult acute ward. Two men told us their wives had received care both on a general adult ward and on an MBU.

Given the small number of carers we spoke with, it is difficult to generalise comments. Themes did emerge in relation to certain experiences, though these should be treated with caution.

Pathways into care

Prior to admission, one partner felt there was support from the community mental health team (CMHT) and that admission to hospital, once it was recognised as being needed, happened without delay. Unfortunately, the experiences of the other two men were different. One man spoke of feeling his wife's symptoms were 'dismissed' as unimportant both by the triage nurse at the GP practice and by the GP. Only after the forceful approach of the health visitor and community psychiatric nurse, who was supporting his wife with another matter, did a second GP finally take notice. At the point of admission his wife, whose mental health had been deteriorating for two weeks, had not eaten or drunk anything for two days and had not left their bedroom. He said he felt that his wife's high level of social skills was a factor which 'worked against her' and masked her symptoms. She was able to present better to professionals than she was actually feeling. This partner felt that that the nurse and GP could not see beyond this.

Inpatient care

We asked our interviewees if they felt welcome on the ward and unanimously all said they did. One man included the cleaning staff as being as welcoming as the nursing staff and that this was helpful. Another man, who had no previous experience of psychiatric care, spoke of how he would have liked a 'greeter' on the ward, someone who had responsibility for welcoming people onto the ward and who had the time to explain the ward routine. He added that a welcome pack for both the patient and carer, which included a leaflet specifically targeted at carers/supporters, would have been helpful. This man was unaware of ward rounds and had never been approached for his views on his wife's well-being. The same man also said how lonely he felt. He explained that he did not know anyone who had been through a similar experience; neither did he feel that anyone acknowledged what he was going through. He said that being able to make contact with others and share experiences would have been helpful.

Another man said he had not been asked how he was managing or feeling, and the third spoke of being asked how he was feeling during the early days of his wife's admission but that this had stopped once his wife had been an inpatient for a while (she had been in for ten weeks).

We asked our interviewees about how included they felt in decision making and planning. Their responses differed from feeling 'very included' and being invited to ward rounds, to being disappointed by the communication. One man asked repeatedly for a phone call after each home visit, so he could tell the doctor how his wife had been, but this did not happen. The same person said his wife had five consultants during her stay. He said this had inevitably meant communication was not always consistent and that his wife's care was compromised as result of these changes. The third respondent said that if he had something to say, he would be listened to, but he was not invited to a ward round and his views were not actively sought.

Impact of admission

We asked our interviewees about visiting and if there had been any difficulties. The distance involved when visiting the MBU (which was some distance from the family home) was a major consideration for two men. One man said visiting his wife and looking after his older children would have meant he could have committed only to visiting at weekends, so he advised his wife not to go there. Two men spoke of the financial difficulties of reducing hours or taking unpaid leave to enable visiting to take place. One man spoke of juggling visiting his wife on the ward with a full time job (with redundancies looming) and complicated childcare arrangements that were difficult to manage. On the positive side, each time he phoned in advance when he wanted the older children to visit, the family room was always made available for them.

The distance of the MBU from home was clearly a factor. However, both men said they appreciated that a MBU could offer more one-to-one care from specialist nursing and medical staff and was good for the mother/baby attachment, though logistically it interfered with visiting, passes home and discharge planning. Both men said they would have appreciated a small MBU closer to home.

Transitions from hospital to home

One man said that if there had been a community perinatal team closer to home, he believed his wife might have avoided admission altogether, as her illness would have been picked up and dealt with much more expediently. This man also felt that support on discharge from a perinatal team would also have been helpful, as once the intensive home treatment team (IHTT) became involved on discharge they seemed unsure about what support they could offer and asked to be directed by them. His wife's reluctance to admit she was seriously unwell prior to admission meant she was also reluctant to ask for the support she needed on discharge. He

was of the opinion that a skilled perinatal nurse would see beyond her veneer and challenge his wife and in doing so and be able support her more effectively. The last respondent valued the support of the CMHT prior to admission and on discharge.

Positive experiences
When also asked about any particularly positive aspects about care during the period their wives had been unwell. Experienced, knowledgeable nurses were highlighted as being important. The needs for routine for restoring sleep pattern were other important factors. Good CMHT support prior to admission and on discharge was also referred to by one respondent who said this was valuable.

With regard to aspects of care which could be improved, one respondent said the lack of information about the illness, and lack of information on support networks or groups for carers, was a disappointment. Another said the lack of perinatal expertise in the community before and after discharge was a significant loss.

We believe that inpatient teams, both on MBUs and general adult wards, and indeed community services, can learn much from these partners' responses. We hope that the issues these men have openly and honestly highlighted may lead ward managers and staff teams to further consider carer experiences, such as information and support provided and encouraging participation throughout patient stays.

2.3 Results of the consultant survey

A total of 81 consultant psychiatrists from at least ten health boards across Scotland[34], responded to the online survey. Not all consultants answered every question, therefore respondent numbers are shown for each question.

- Consultants from a wide range of specialities were represented, the majority being general adult psychiatrists (63% of 73).
- Those surveyed had from under a year, to over 20 years, consultant experience, with the largest group having between 11-20 years (37% of 73).

Full details and analysis of results can be found online[35]. We have summarised the main findings below:

[34] In total, 69 (of 81) consultants told us which NHS Board they worked in.
[35] http://www.mwcscot.org.uk/media/320710/results_of_consultants_survey.pdf

Experience and confidence in managing perinatal illness

Excluding perinatal psychiatrists:

- Over 90% of (71) consultants said they had experience of treating at least one patient with postpartum psychosis and moderate/severe postnatal depression.
- Over 85% of (70) consultants told us they felt confident recognising and treating severe postnatal illness (postpartum psychosis or severe postnatal depression).
- **Over 90% of (70) consultants indicated they would find it useful to consult with a perinatal specialist** concerning each of the following:

    - The risk of perinatal illness in an individual patient.
    - An unusual or worrying perinatal presentation.
    - The safety of treating an unwell mother and her baby at home.
    - The decision to admit a woman to an MBU or general adult ward.

- One third of consultants surveyed (33% of 70) said this specialist advice was not currently available in their local NHS board.
- Over 80% of (68) consultants did however consider that specialist advice was available via their regional MBU.

Access to perinatal services

- Almost half of those consultants surveyed (46% of 70), said they had no access to a community perinatal mental health team in their area.
- Almost two thirds of consultants (64% of 70) said they had experience of referring a patient for MBU admission. Most consultants reported positive experiences in this regard.
- Over 80% of consultants surveyed (57 of 70) said that if a woman required treatment for postnatal illness, they would routinely discuss MBU admission: both with the patient and family, and with the MBU team.

Education and Training

- 62% of (78) consultants surveyed were aware of SIGN127.
- Almost one quarter (24% of 78) general adult consultants however were not aware of SIGN 127.
- Over 80% (54 of 70) of respondents said they had previously received teaching in perinatal mental health. Often this was at specialist registrar level.
- 83% of (70) respondents indicated they would be interested, if training were available. All new consultants expressed interest in a perinatal training event.

Discussion

Some of the survey findings were surprising. For example, a high number of consultants surveyed said they had experience of treating women with significant perinatal illness. Whilst most consultants who had treated women with postpartum psychosis estimated they had seen between one and five cases, very high numbers felt confident in recognising and treating severe postnatal illness.

We were encouraged that many consultants had seen how these illnesses can present. Perinatal psychiatrists themselves usually indicate that it takes time working within the specialty to gain confidence treating these conditions. We wondered if the high levels of confidence among non-specialists surveyed in managing these illnesses, could explain in part why women are sometimes not referred to specialists for their perinatal care.

Almost all those consultants surveyed did say that it would be useful to consult a perinatal specialist concerning several aspects of patient care. There was also a high level of interest in further education and training among the consultant group who completed this survey, which we found very encouraging.

Other issues raised

Many consultants took time to add individual comments about their experiences and some common themes emerged. These included highlighting groups of women for whom inpatient perinatal care may not currently be very accessible, including women with a primary diagnosis of eating disorder or personality disorder. This is an important area for services and a clinical network to further consider.

Several consultants also spoke of inequity in current service provision, highlighting a range of issues that impact on patient care in some regions, including:

- Limited local resources.
- A lack of specialist staff.
- Small numbers of patients in some rural areas.

We explore this issue further in the next section.

2.4 Providing good perinatal mental health care throughout Scotland

Current provision in Scotland

Patterns of community care

As mentioned previously, the NSPCC report "Getting it Right for Mothers and Babies" [5] was published in March 2015. In it, the researchers published findings of a survey they conducted across health boards in 2014, looking at perinatal mental health provision across Scotland. They received responses from 12 of the 14 health boards.

All 14 health boards returned the perinatal questionnaire we sent as part of this themed visit. Little progress had been made in the intervening year in terms of national service provision:

- Only five health boards in Scotland have a community perinatal mental health service (at the time of our study, the funding for one of these was only secured until March 2016).
- Only five health boards have perinatal integrated care pathways.
- Only four health boards provide guidelines on prescribing for women who are pregnant or breastfeeding.
- Three health boards provide annual updates in perinatal mental health for health visitors and midwives (one board told us they were in the process of developing this).

There remain gaps in perinatal community service provision across Scotland. At the present time, where women live affects the services available to them locally.

The accounts from women and their families demonstrate how a lack of specialist support can impact on their journey through care. It is our opinion that community perinatal mental health service provision is an area that needs to be prioritised.

Given the diverse geography, population and demographics across the 14 health boards, this is not a simple task. However, several boards are already demonstrating how services can be developed and adapted to creatively respond to the needs of their local population.

As one consultant in our survey remarked:

> *"There is no 'one size fits all' model of care appropriate here. There is no concept of what kind of service is optimal for large health board areas with relatively low birth rates.... A managed clinical network would be ideal with a standardised approach where possible, for example with patient information leaflets and guidance for staff etc. Investment in some areas will be necessary to reach equity across Scotland."*

We discuss the need for a national managed clinical network in Scotland at the end of this section.

Recommendation 11
Health boards should ensure there is specialist community perinatal mental health provision in their area which adequately meets the needs of the local population. Where no current provision exists, a local service should be established.

Patterns of inpatient care
Our three month survey of admissions found considerable numbers of women receiving postpartum inpatient care in their local general adult mental health ward and not in a specialist mother and baby unit. Many women we visited on MBUs were from the local health board area, with fewer from other regional health boards.

Given that our study was small and carried out over just three months, we were interested in admission patterns over a longer period.

No monitoring data is currently collected on the numbers of postpartum women admitted to general adult wards in Scotland every year. Both MBUs do however collate annual data on their admission figures.

We collected data from the MBUs on their admission numbers from each Health Board during 2014 and 2015. The authors of the NSPCC report kindly gave permission for us to reproduce their data from 2012-13. The table below combines these data sets, to show annual admission rates to Scottish Mother and Baby Units by health board area over the last four years. To provide meaningful comparison, we have included the latest published data from ISD Scotland, to show 2014 birth rates in each health board.[36]

[36] www.isdscotland.org/Health-Topics/Maternity-and-Births/data-tables (ref: mat_bb_table1)

Annual birth rates are used in perinatal psychiatry to predict the number of women who may develop severe postnatal illness. It is a useful way to estimate the likely need for specialist service provision in a geographical area. The higher the birth rate in an area, the higher the number of women expected to become unwell after their baby is born and to require perinatal care.

In their 2015 report, [15] the Royal College of Psychiatrists estimated admission numbers to an MBU should be four women per 1000 births. We have estimated annual MBU admission numbers that might be expected from each health board, based on this figure. We have also included a more conservative estimate, based on what we would consider a minimum expected admission rate of two per 1000 births (this would reflect admission rates only for women with postpartum psychosis). The results are shown below:

NHS Board	Actual annual MBU admission numbers per NHS Board				Annual birth rate	Estimated annual MBU admission numbers by NHS board, calculated (to 1 d.p)for the following admission rates:	
	2012 [a]	2013 [b]	2014[c]	2015 [c]	2014[d]	2/1000 births[e]	4/1000 births[f]
Ayrshire & Arran	3	2	1	4	3513	7.0	14.1
Borders	5	3	1	0	1025	2.1	4.1
Dumfries &Galloway	2	0	0	1	1278	2.6	5.1
Fife	8	3	4	8	3878	7.8	15.5
Forth Valley	2	1	1	5	3029	6.1	12.1
Grampian	1	2	2	2	6229	12.5	24.9
GG&C[g]	32	30	36	41	12034	24.1	48.1
Highland	4	2	1	1	2890	5.7	11.6
Lanarkshire	5	1	2	4	6755	13.5	27.0
Lothian	38	44	33	37	8919	17.8	35.7
Orkney	0	0	0	0	182	0.4	0.7
Shetland	0	0	0	0	239	0.5	1.0
Tayside	7	5	8	5	3992	8.0	16.0
Western Isles	0	0	1	0	245	0.5	1.0
Scotland total	107	89	90	108	54,467	108.9	217.9

[a,b]2012 and 2013 MBU admission data reproduced as published with kind permission of NSPCC "Getting it Right"[37]
[c]2014 & 2015 MBU admission data provided by Glasgow and Livingston MBUs
[d] Annual birth date data from ISD Scotland: All births by NHS board (year ending 31 March 2014)[40]
[e]Minimum expected admission rate based on incidence of puerperal psychosis alone (2/1000 births)
[f]Admission rate of 4/1000 births based on Royal College of Psychiatrists recommendation for MBU bed provision
[g] Greater Glasgow and Clyde

We can see from the table, that even if we estimate annual MBU admission rates for each health board based remain on the conservative figure of two admissions per 1000 births (50% of that suggested by the Royal College), several boards are still admitting significantly fewer women to mother and baby units than would be expected.

Conversely, women who live within the catchment area the MBUs are being admitted to MBU care at much higher rates (more consistent with those recommended by the Royal College of four per 1000 births).

It is possible that in areas where there is a specialist MBU, perinatal mental health has a higher profile, resulting in higher referral rates. The specialist community perinatal teams in these areas are also skilled in identifying high risk women and are likely to have lower thresholds for admitting mothers and their babies to inpatient care.

What the above data does suggest is that, in Scotland at the present time, **where women live affects how likely they are to access specialist inpatient care on a specialist mother and baby unit.** This is potentially in breach of the duty placed on health boards under S24 of the 2003 Act. It is also against the recommendations of SIGN 127 and other current guidelines.

It is not possible to know what is happening to women in each region who would be expected to need MBU care, but are not receiving it. These women could be:

- Receiving inpatient care on local general adult acute wards.
- Receiving treatment in the community, via local mental health services or primary care.
- Undiagnosed and untreated.

As we have already discussed, it may not be appropriate for all women to receive treatment on a mother and baby unit with their babies. Some women also opt for local care. It is however important to ensure that in every case where a woman is normally the main carer for her baby, the option of MBU care is made available.

Recommendation 12
Health boards should ensure that, in accordance with Section 24 of the 2003 Act[4], provision is available for women who want to be admitted to hospital with their babies. In advance of the revised duty introduced by the 2015 Act[11] coming into effect, health boards should audit their use of regional MBU beds and monitor the number of postpartum women being admitted to general adult wards in their local area.

Improving future perinatal care in Scotland

To improve perinatal care on a national scale, we believe that a national managed clinical network needs to be established in perinatal mental health.

This was one of the recommendations in SIGN 127 in 2012:

‘A national managed clinical network for perinatal mental health should be centrally established in Scotland. The network should be managed by a co-ordinating board of health professionals, health and social care managers, and service users and carers. The network should:

- Establish standards for the provision of regional specialised mother and baby units, community specialised perinatal teams and maternity liaison services.
- Establish pathways for referral and management of women with, or at risk of, mental illness in pregnancy and the postnatal period.
- Establish standards for the provision of advice and guidance to maternity and primary care services on the use of psychotropic medication in pregnancy and breast feeding.
- Establish competencies and training resources for health professionals caring for pregnant or postnatal women with, or at risk of, mental illness, at levels appropriate to their need.
- Ensure that all pregnant and postnatal women with, or at risk of, mental illness have equitable access to advice and care appropriate to their level of need.’

The findings of this themed visit highlight the importance of establishing a managed clinical network. As above, the scope of the network would be wide. It would also aid national discussion about questions this study raises such as:

- Are more inpatient MBU beds required in Scotland?
- If more beds are required, where should these be based?
- Should another regional specialist unit be established to provide better access to women in health boards in northern Scotland, the Highlands and Islands?
- How might community services best be established in small health board areas where the annual birth rate may mean that only small numbers of women require a specialist service?

The Mental Welfare Commission would hope to work with the national managed clinical network and with the Information Services Division (ISD), to explore how monitoring of perinatal admissions across Scotland can be improved and reported on in the future.

A network is yet to be established, but we understand that talks are currently underway with the Scottish Government to make the necessary resources available. We welcome this timely and important development.

Recommendation 13

The Scottish Government should establish a national managed clinical network as recommended in SIGN 127 (2012):

Part 3 Conclusions

This perinatal themed visit has highlighted a number of areas where the mental health care of mothers and babies in Scotland should be improved.

Inpatient perinatal care
The survey and visits we carried out suggest that a significant number of postpartum women are currently receiving inpatient care without their babies. One third of women in our survey were being treated on general adult wards and not specialist mother and baby units.

When we met with women receiving inpatient care, there was a considerable contrast in the experiences of those being treated on MBUs and those treated on general adult acute wards. Women reported more positive experiences when they received care with their babies in an MBU.

The most important aspect of care for women was the experience of receiving treatment with their baby. Women on general adult wards were separated from their baby, often for prolonged periods, and this was a significant loss. Other important differences for women were: perinatal expertise; support from nursery nurses on MBUs; a strong recovery focus and peer support from other mothers. These were absent on most general adult wards we visited. Two general adult wards in Scotland currently offer additional perinatal expertise and support for those women who opt for local care in preference to travelling to the regional MBU.

On the general adult wards we visited, we had concern about some aspects of care including: documentation regarding children; care planning; risk assessment specific to mothers and lack of supported contact between mothers and their babies. There was also a lack of child-friendly provisions for families visiting. Keeping mothers and their babies in mind was a challenge for many staff, who were unfamiliar with providing perinatal care.

We have made a recommendation that all perinatal women requiring admission should be admitted to an MBU, unless there are compelling reasons not to do so.

Data gathered from annual MBU admissions over a four year period from 2012-2015 suggests that some health boards are referring significantly fewer women to MBU care than would be expected. We know from our interviews with women, their families and the professionals treating them, that care on a local adult acute ward is preferred over MBU care in some circumstances, particularly where there are older children and long travel distances are involved. For this reason it is particularly important that perinatal expertise and specialist support is available in each local area, to advise on women's care. Health boards must ensure that high quality

inpatient care and support is provided for women. We have made a number of recommendations for improving care in GA/IPCU wards.

Community perinatal care

Although we did not specifically examine community perinatal care in this themed visit, we gathered information from women, staff, consultants and health boards about current service provision.

We found that specialist community perinatal mental health services are currently available in only five of the fourteen health boards in Scotland. Many women who receive inpatient care do not therefore have access to local specialist support on discharge. General adult mental health services or crisis response teams often provide community support for perinatal women. Concerns were raised by women, their families and some professionals, that the lack of specialist support sometimes compounds risks for mothers and babies. We highlighted examples where we found this. Lack of perinatal training and specialist knowledge among professional teams appeared an important factor.

Training and education

Improving perinatal mental health training among professionals involved in the care of women during pregnancy and postpartum is important. This is particularly the case for mental health professionals. The need for better knowledge about the risks associated with this patient group, the different way that perinatal illness may present and the lower thresholds for intervention and admission, have been discussed.

We have made a number of recommendations in this area. We encourage the use of the NES online training modules in maternal mental health by relevant health professionals (whether in primary care, maternity or mental health services). We have recommended that community and inpatient mental health professionals access perinatal training appropriate to their role, which may be additional to the online training above. We have also recommended that both MBUs are adequately resourced to provide teaching, education and link working across regional health boards. This is an area that we hope the managed clinical network can further develop nationally.

Managed clinical network

The results of this themed visit strongly support the rationale for establishing a managed clinical network for perinatal mental health in Scotland. Such a network would drive further development of specialist services, championing equitable access for women, irrespective of where they live. The Mental Welfare Commission would also hope to collaborate with this network, to look at improving reporting and monitoring of perinatal admissions across Scotland. We have recommended that the Scottish Government make resources available for a national managed clinical network in perinatal mental health to be established. This will be an important step towards improving the mental health care of both mothers and babies in Scotland.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Mental Welfare Commission (Jun16)