

Mental Health

The Royal College of Psychiatrists in Wales welcomes this opportunity to respond to the CYPE Committee's inquiry into perinatal mental health. In February, we responded to the [First 1,000 Days inquiry](#) and proposed that the Committee further explore the provision of perinatal mental health services. There have been significant improvements in recent years with the injection of funding for community perinatal mental health but more must be done to meet the needs of those with serious mental illness requiring specialist inpatient treatment.

The leading cause of maternal death is mental health related illness. Postpartum depression affects 10 to 15 out of 100 women having a baby. It is more prevalent in women who already have a mental illness, who have suffered with depression during pregnancy, or recently experienced a traumatic event such as bereavement. A smaller number (1 in every 1,000 women having a baby) will experience psychotic episodes, or postpartum psychosis, which is classed as a serious mental illness. Postpartum psychosis can happen to any woman, although the risk is higher in women with bipolar disorder or schizophrenia. The symptoms of the illness can change from hour to hour or day to day. Women who suffer with postpartum psychosis are often not able to look after themselves or look after their baby and require specialist help.

Key Points

- Community-based perinatal mental health has improved considerably after the Welsh Government agreed the recurrent funding of £1.5m in 2015. Specialist healthcare staff have been in place in community teams across Wales since 2016.
- However, there has always been a shortfall of perinatal mental health services in Wales so we are working from a very low baseline. More investment is needed to meet the needs of those requiring treatment, to improve the availability of training in perinatal mental health to health professionals, and to address the shortfalls in some areas across Wales.
- In 2013, the only Mother and Baby Unit in Wales was closed. There are no inpatient services for women who need admission with their babies so patients must either be treated on an adult psychiatric ward with no contact with their baby, or be treated out of area in England.
- Service provision for expectant mothers from some populations continue to receive below standard treatment. These include those with dual diagnosis or those with learning disabilities.
- Service redesign and delivery is coordinated by the Community of Practice, administered through Public Health Wales and a multidisciplinary steering group including mental health professionals, representatives from maternity and

obstetrics and the third sector. Although this is excellent it falls short of an adequately resourced “managed clinical network”, currently being developed in England.

The Welsh Government’s approach to perinatal mental health, with a specific focus on accountability and the funding of perinatal mental health services covering prevention, detection and management of perinatal mental health problems. This will include whether resources are used to the best effect.

- 1) The Welsh Government has developed a positive approach to perinatal mental health and is keen to improve existing services available to women before and after giving birth. It has provided significant recurrent funding to strengthen community perinatal mental health services across Wales and the College is pleased with these developments. Since the injection of money the provision of such services has improved considerably. New money promised for perinatal mental health reached clinical services far quicker in Wales than in England.
- 2) Wales is now a more attractive place to train and work for those interested in community perinatal mental health; this at a time when recruitment and retention is very low. We do have some way to go to understanding the specific needs of pregnant women with mental health needs and to gather a stronger evidence-base for detection and treatment. Across the border, the NHS England and Health Education England have commissioned the College to manage and deliver the *Building Capacity, Psychiatry Leadership in Perinatal Mental Health Services project*.¹ One of its aims is to expand the numbers of psychiatrists with perinatal training, to develop local specialist perinatal mental health services where these are currently lacking. This is to ensure that the Five Year Forward View can achieve the outcome of reaching over 30,000 women needing community and inpatient care can receive treatment closer to home.
- 3) There is a general lack of awareness among many health professionals and the public around the importance of treating maternal mental illness, particularly around the use of medication. There is a perceived risk to the baby if taking medication during pregnancy or whilst breastfeeding. There is growing evidence that the management of the risk of the mother’s mental illness is crucial, not just to the mother but to the baby, who may be at risk of neglect, or may not bond with the mother. It is important to weigh the risk of taking medication versus not taking medication. Suicide is a significant cause of maternal death. We are only beginning to understand the trends, which means that evidence to provide suicide prevention in this group is scarce.² Many

¹ <http://www.rcpsych.ac.uk/workinpsychiatry/faculties/perinatal/buildingcapacityinperinatal.aspx>

² Khalifeh, H. et. al. (2016) *Suicide in perinatal and non-perinatal women in contact with psychiatric services*. The Lancet. vol. 3. pg. 233.

professionals do not feel equipped to detect or treat maternal mental illness therefore we would recommend that all relevant health professionals are given training in preventing, detecting and treating the risks in perinatal mental health.

- 4) There is further apprehension in the health service to treat expectant mothers who have learning disabilities or who are alcohol and drug dependent. This is perceived as added complexity and added risk which has led to a lack of awareness, reluctance, and even fear to treat such patients.

The pattern of inpatient care for mothers with severe mental illness who require admission to hospital across both specialist mother and baby units (designated mother and baby units in England) and other inpatient settings in Wales. (Since 2013, there has not been a mother and baby unit in Wales).

- 5) One of the most pressing issues in Wales is the lack of provision for inpatient services for women who need admission with their babies. These services have specialist knowledge of the risks and benefits of medication during pregnancy. They provide specialist treatment and management of women with serious mental illness and enable them to support the needs of their babies. The College recommends that “all women requiring admission to a mental health unit in late pregnancy or after delivery should be admitted with their infant to a specialised mother and baby unit, unless there are compelling reasons not to do so”.³
- 6) This has become more of an issue with the development of community services and the increased identification and realisation of the need for women to be admitted with their babies if they need to be in hospital. Because we have no specialist beds available, if a woman needs admission with her baby we must look across the border into England. Bristol will not take Welsh women because they are not NHS England patients. The nearest options are Birmingham, Winchester or London. However these are often full with a waiting list so some patients have been sent as far as Derby and Nottingham. When there is a bed available closer to home, it is often the case that women and their families do not want them to travel such a distance and so they remain on the acute ward separated from their baby. This is clearly deleterious to both mother and baby; women take longer to get better and babies are denied close contact with their mum at this crucial stage.
- 7) The lack of specialist beds is costing the NHS in Wales in staff time and resources and it denies healthcare professionals the opportunity to gain valuable skills and experience in this specialised area. Trainees wishing to specialise in perinatal mental health will

³ The Royal College of Psychiatrists in Wales (2015) *CR197 Perinatal Mental Health Services: Recommendations for the provision of services for childbearing women*. London: RCPsych.

choose to work elsewhere. Many hours, sometimes days, are spent looking for an available bed, which is a poor use of staff time and skills.

- 8) Fathers who wish to be close to their partners and new-born babies must pay for travel and accommodation. This can be expensive as some hospital admissions may last up to several weeks. Very often many patients will chose to stay on an adult psychiatric ward where they can be closer to their families even if this means that they are not getting the right treatment. We are seeing a number of women being admitted into adult psychiatric wards with no contact with their babies.
- 9) We urge the Welsh Government and the Welsh Health Specialists Services Committee to consider opening a centrally funded Mother and Baby Unit in Wales, which can provide services in the medium of Welsh. It has wrongly been accepted that the previous mother and baby unit in Cardiff closed because of lack of need. This was not the case and there is an urgent need for such a service to be provided for the women of Wales. There is work going on with WHSSC to look at this but this is likely to take some time. We would hope the Committee can consider ways in which this could be brought forward.

The level of specialist community perinatal mental health provision that exists in each Health Board in Wales and whether services meet national standards.

- 10) Prior to the injection of funding, the baseline of service provision differed widely between health boards. Cardiff and Vale UHB already had a community perinatal team and has been able to expand on this and now provides a service which meets the standards of the [Quality Network of the Royal College of Psychiatrists](#). Abertawe Bro Morgannwg UHB already had a service in Bridgend which is now extended to the Swansea area. Other health boards around Wales have begun developing their services. Their aim is to be able to meet national standards and to be part of the Quality Network and we have learnt recently that ABUHB has received funding to take part in the programme. We have consultant psychiatrists with specific perinatal sessions in Cwm Taf, ABUHB, Hywel Dda, Cardiff and Vale and the Bridgend part of ABMU but are awaiting appointments in BCUHB, Swansea and Powys. In areas where provision is good, we regularly see patients during their subsequent pregnancies who wished that these services had been available in the past. However, there is still an unacceptable variation in provision, which has arisen from the way the funding was originally distributed.

The current clinical care pathway and whether current primary care services respond in a timely manner to meet the emotional well-being and mental health

needs? Of mothers, fathers and the wider family during pregnancy and the first year of a baby's life.

11) The current clinical care pathways do not meet all patients' needs in a timely manner, however there is work in progress to identify and address the specific issues. The Community of Practice, administered through Public Health Wales, is chaired by Professor Ian Jones and Dr Sue Smith. This is a multidisciplinary group including mental health professionals and representatives from maternity and obstetrics. Third sector representation is also much valued on this committee and issues such as education, training for health professionals and provision for preconception advice are discussed. There is much work to do but there is a clear commitment to developing a clinical care pathway that can meet the needs of families antenatally and reduce the likelihood of mental ill health postnatally.

Consideration of how well perinatal mental healthcare is integrated, covering antenatal education and preconception advice, training for health professionals, equitable and timely access to psychological help for mild to moderate depression and anxiety disorders, and access to third sector and bereavement support.

12) (See paras. 3 and 4) We note below that there are a number of health inequalities with regard to service provision, in particular those who are dual diagnosed. We are concerned that there is lack of consistent Public Health messages in relation to drugs and alcohol in pregnancy by the Department of Health, Public Health Wales, Welsh Government and academics. Dr Raman Sakhuja, Chair of the Substance Misuse Faculty in RCPsych in Wales says, "No amount of alcohol in pregnancy should be 'the' message but inconsistent messages are still heard at various levels of healthcare".

Whether services reflect the importance of supporting mothers to bond and develop healthy attachment with her baby during and after pregnancy, including breastfeeding support.

13) Social relationships in early life have crucial influence on the infant brain. Brain development is dependent on strong, early bonds with an infant's main caregiver – most often the mother. The interaction with the primary caregiver in the first year of life shapes the infant's social, emotional, cognitive and language development, facilitating development of good mental health through childhood and into adulthood.

14) Supporting mothers to bond and develop healthy attachment with her baby is therefore an important aspect of the provision of services, both generic antenatal and postnatal care and in mental health services and specialist perinatal mental health care. For

many women with mental health problems, treating the mental illness will allow them to develop a health attachment and bond with their babies. However, for some women more in depth work will be needed to address attachment issues specifically. Even where maternal mental ill health is effectively treated, additional work may be required to help strengthen the mother–infant relationship. Prompt treatment of mental ill health in pregnancy can bring about improvements for a child growing up, as well as help to develop a child’s ability to manage stress in later life. A comprehensive service will enable women who need this specialist care to receive it no matter where they live in Wales. Local perinatal mental health networks should include professionals providing infant mental health services and those from CAMHS to help develop and share best practice in mother-infant interventions

The extent to which health inequalities can be addressed in developing future services.

- 15) **Substance Misuse:** This inquiry needs to look further into whether the needs of pregnant, dual diagnosed (addiction plus mental illness/disorder) women and their children are met during the perinatal period. There are many women seeking treatment for alcohol and opiate dependence syndrome who are pregnant who face many obstacles, including the diagnosis of addiction that hamper accessing appropriate services to assess and manage perinatal health and well-being.
- 16) In Cardiff, the community perinatal service has limited input with women with substance misuse issues who are already under the Community Addiction Unit (CAU). The CAU prioritises women with substance misuse who become pregnant and work with a specialist midwife. The community perinatal team in Aneurin Bevan also relies on a specialist midwife who will be responsible for these patients.
- 17) This is the tip of the iceberg. Many women with dual diagnosis are not picked up by specialist teams for several reason, including the stigma attached around mental health and around substance misuse. Those who then fall pregnant may continue not to seek help so will be missed by the system altogether. We would argue that community perinatal mental health services need to work more closely with these patients and their families by integrating knowledge of substance misuse management within the Perinatal Teams and employing a liaison worker from specialist drug and alcohol services within the Perinatal Team.. We would also argue for a better early screening and identification process to detect substance and alcohol misuse. There is a much greater role of public health, primary care and all other primary prevention strategies along with education and awareness within the Community Midwifery and antenatal service providers.

- 18) **Intellectual Disabilities:** Expectant mothers with intellectual disability similarly face many barriers and their needs often are not met due to lack of expertise and resources. We would welcome the inclusion of the service for expectant mothers with intellectual disability and their families. It is important that their specific needs are met within generic services that have a better understanding for their vulnerabilities and management of risks. Unfortunately, people with ID continue to receive poor treatment from the NHS because of their disability.
- 19) **Teenage Pregnancy:** The risk of depression is higher for teenage mothers and for women living in poverty, experiencing domestic abuse, poor housing or homelessness. Perinatal mental health services should ensure that there are no barriers to access for childbearing women with other conditions who develop serious postpartum disorders. These include adolescent (teenage) mothers. In these circumstances perinatal mental health services should work closely with other colleagues and services, for example those in CAMHS, intellectual disabilities, eating disorders and Social Services, contributing to the patients' care as appropriate.
- 20) **Welsh Language provision:** It is important that Welsh language speakers are able to access services in Welsh if they so wish.

We are delighted to be providing oral evidence to the Committee in June. If you have any further questions in the meantime, please contact Manel Tippett, Policy Administrator at the College (manel.tippett@rcpsych.ac.uk.)

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