OFFICIAL REPORT
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Health, Social Care and Sport Committee

Tuesday 7 December 2021

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Tuesday 7 December 2021

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE

14th Meeting 2021, Session 6

CONVENER

*Gillian Martin (Aberdeenshire East) (SNP)

DEPUTY CONVENER

*Paul O'Kane (West Scotland) (Lab)

COMMITTEE MEMBERS

*Stephanie Callaghan (Uddingston and Bellshill) (SNP)
*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Gillian Mackay (Central Scotland) (Green)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Evelyn Tweed (Stirling) (SNP)
*Sue Webber (Lothian) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Cat Berry (Juno Perinatal Mental Health Support)
Dr Fiona Challacombe (Maternal OCD)
Dr Arun Chopra (Mental Welfare Commission for Scotland)
Dr Selena Gleadow-Ware (Royal College of Psychiatrists)
Clea Harmer (Stillbirth and Neonatal Death Society)
Professor Marian Knight (University of Oxford)
Dr Mary Ross-Davie (Royal College of Midwives)
Joanne Smith (Maternal Mental Health Scotland)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 7 December 2021

[The Convener opened the meeting at 09:00]

Decision on Taking Business in Private

The Convener (Gillian Martin): Welcome, everyone, to the Health, Social Care and Sport Committee's 14th meeting of 2021. I have received no apologies, but a number of members join us virtually.

The first item on our agenda is a decision on whether to take item 3 in private. Do members agree to take that item in private?

Members *indicated agreement.*

Perinatal Mental Health

09:00

The Convener: Our second item is an evidence session with stakeholders as part of our short inquiry into perinatal mental health. All our witnesses join us remotely. I welcome to the committee Selena Gleadow-Ware, who is the perinatal faculty chair at the Royal College of Psychiatrists; Mary Ross Davie, who is the director for Scotland at the Royal College of Midwives; Dr Arun Chopra, who is the executive director at the Mental Welfare Commission for Scotland; and Professor Marian Knight, professor of maternal and child population health, who is representing MBRRACE-UK—mothers and babies: reducing risk through audits and confidential enquiries across the UK.

I will kick off by asking a question for all our witnesses. My colleagues will then ask questions on themes. They will probably direct their initial question to someone in particular, but, if others want to come in, they should put an R or a request to speak in the chat box, so that I know to come to them. That means that they will not be sitting with lots to say without my noticing them. That seems to be the way of managing things in a hybrid meeting.

With the backdrop of Covid—we will ask specific questions about Covid later—what needs to be focused on in perinatal mental health care in the short and medium terms? I will also ask a supplementary question. What needs to be done to ensure consistency of good practice and good service across the whole of Scotland?

Dr Selena Gleadow-Ware (Royal College of Psychiatrists): Thank you for inviting me, convener. I am representing the Royal College of Psychiatrists in Scotland's perinatal faculty. You have asked a valuable and pertinent question that we need to think carefully about. In Scotland, we are addressing developing services, the need for which was highlighted prior to the pandemic, but there is also a need for services to have the support and resilience to recover from the pandemic.

In relation to what is required in the short and medium terms, there are a number of key themes. Primarily, there is a need for workforce support and development. Some services have faced delays in recruitment due to the Covid pandemic, and we might need additional resource because the workforce has been stretched during the pandemic. We know that there has been a particular challenge with staff wellbeing.

We need to think about how, nationally, we support increased recruitment and retention of the specialist perinatal workforce, including staff across the different tiers of the perinatal pathway. Alongside that, we need to think about the infrastructure that services need. Services need safe spaces in which they can work to deliver safe and effective care for women and their families.

In response to the pandemic, services have had to be nimble in adapting to the blended working environment of remote and face-to-face working. Although that has increased access to care for some populations, particular groups in the population might still face certain barriers in accessing care. Those might be people who are excluded digitally, who are on low incomes or who experience domestic violence. It might be particular vulnerable populations, such as women who are affected by substance misuse, or our diverse communities, particularly those for whom there might be language barriers, literacy challenges, sensory impairment or disability needs that could disadvantage access to care or contribute to experiences of discrimination or delay in accessing care. Our service developments must support the most vulnerable people in our populations so that we do not exacerbate any pre-existing inequalities in care that we know are likely to have increased during the pandemic.

Alongside that, we need to think about how specialist services can support universal services across the joined-up care pathways. We have welcomed the investment from the Scottish Government not only in perinatal specialist community services and mother and baby units, but in maternal and neonatal psychological interventions and infant mental health services. We need sustained protected investment across those areas to ensure that we do not roll back on the gains that we have made and that we try to consolidate and continue the robust progress of change. Failure to do that will, unfortunately, lead to adverse outcomes not only for women but for their infants and family networks.

A range of supports and interventions are required in workforce planning, recruitment, estate provision, ensuring joined-up care pathways and supporting staff wellbeing. We are fortunate that we have the managed clinical network, which can help with consistent high-quality standards and support for the professional groups that deliver the services, but continued protected investment is required.

Dr Mary Ross-Davie (Royal College of Midwives): Thank you very much for inviting me. I am the director of professional midwifery with the Royal College of Midwives, and I was previously its director for Scotland. I was also a perinatal mental health specialist midwife in the past, so I have a particular interest in the field.

The first thing to note is the significant investment that the Scottish Government has made in perinatal mental health over the past years. We have really welcomed that. As Selena Gleadow-Ware identified, there has been a huge amount of work with the national network, which has definitely helped to move matters forward.

The pandemic has had an impact on the pace at which those developments can progress. That needs to be acknowledged, and real restoration is needed. Selena Gleadow-Ware is absolutely right about the need to focus on staff wellbeing.

In midwifery, we work very much at the interface between universal services and the role that we have in specialist perinatal mental health services. We need consistent investment in midwives to be able to provide evidence-based high-quality perinatal mental health support. That is a universal service as well as a specialist service. We need midwives who have the time, skills and training to provide adequate support during pregnancy, focusing on preventing the development of significant mental health problems and supporting women’s and families’ wellbeing during pregnancy.

One of the approaches to that is ensuring continuity of the carer. That is one of the mainstays of maternity policy in Scotland, but it has been delayed by the pandemic and significantly affected by a chronic shortage of midwives throughout Scotland, which needs to be addressed urgently.

Another area on which midwifery support should be focused concerns the need—which Selena Gleadow-Ware identified—for specialist facilities to provide services for women who have very acute illness and to ensure that those women continue to receive midwifery support in order to normalise their experiences as far as possible.

Another key area is the prevention of ill health. One significant area of perinatal mental health is post-traumatic stress disorder from childbirth experiences. We now have very few consultant midwives—there are only two working in Scotland. Consultant midwives have a key role in attending birth reflection clinics and talking to women about traumatic birth experiences, including in preparing them for subsequent births. That area sits within universal services, and a focus on the recruitment and development of consultant midwives across Scotland is key.

The Convener: Thank you. That is helpful. My colleagues will dig into some of what you have brought up in more detail, but, first, let us hear from Arun Chopra.

Dr Arun Chopra (Mental Welfare Commission for Scotland): Good morning. I am from the Mental Welfare Commission fort Scotland, which is part of the assurance mechanism to ensure that mental health services are working well for the people of Scotland. We do that in two critical ways: by visiting the settings where people are liable to receive mental health services and by monitoring implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003 and promoting best practice in that regard.

On the basis of those two functions, I will make some observations in response to your question about the short term. First, I echo Mary Ross-Davie's point: the commission very much welcomes the additional funding that has gone towards perinatal mental health services. Through our visiting function in mother and baby units, and from speaking to those who deliver services, we can see the impact that the funding is already having on healthy people.

I also echo Selena Gleadow-Ware's point about staffing and staff wellbeing. As we all know, the pandemic has put pressures on the health and social care sector like never before. That said, there are things that we could do to improve the situation in the short term. One thing—which fits in with your supplementary question on consistency—would be to ensure that there are clear pathways. The MBRRACE-UK report "Saving Lives, Improving Mothers' Care" spoke about the need for

> "clear ... explicit pathways into ... perinatal mental health care".

If we had those pathways, that would be an improvement, and it would remove any uncertainty around what women and their families might expect.

In addition to what we have heard, I would highlight the issue of monitoring and data. The commission has a role in monitoring the implementation of the 2003 act. We have some of the most progressive legislation in the world and some brilliant fundamental ideas about ensuring that women are offered the chance to be admitted with their baby, yet we do not always have the required notification systems to ensure that that is being delivered. There is work that we can do around data and monitoring—we might pick up that issue later.

It is also important to ensure that staffing is on a secure footing. Training is vital, and not just in specialist perinatal services. People are often also engaging with other parts of the mental health system—general adult mental health services or even child and adolescent mental health services—whether that is primary care or secondary care. That important aspect came through in the MBRRACE-UK report with regard to younger women. We need to ensure that staff in crisis teams and intensive home treatment teams are knowledgeable about the particular challenges and risk assessments that apply during the perinatal period. That would make a difference.

In the short term, as we recover and restore, we also need to think about equity and equitable access to all parts of the perinatal system. Whether we are thinking about women who misuse substances or about women who come from more socioeconomically deprived backgrounds or minoritised ethnic communities, there is an opportunity for us, in the short term, to build back better.

Going back to the very first point, about consistency and pathways, it is important to ensure that we have a clear national service specification that operates across Scotland, so that people know exactly what to expect. That will provide a really good benchmark for organisations such as ours in assessing how things are progressing.

09:15

The Convener: Thank you. That was very helpful for my colleagues, who will be able to dig in deeper.

Professor Marian Knight (University of Oxford): I will pick up on a number of the points that Arun Chopra has just made. For those of you who are not aware, MBRRACE-UK is the programme that has responsibility for investigating the care of all women who die during pregnancy or up to a year after the end of pregnancy.

To put that in context, maternal suicide is the leading direct cause of death in the period of six weeks to a year after the end of pregnancy. Substance misuse and suicide together represent more than a third of maternal deaths in that period. Perinatal mental health is crucially important to preventing maternal deaths. The overwhelming theme that we see when we are investigating the care of women who have died is gaps in services. For me, the number 1 short-term thing is to minimise those gaps in services.

That includes a variety of themes. There may be thresholds such that women are denied access to specialist services because they are not considered to be ill enough. Essentially, that is to do with the capacity of those specialist services, and we need to ensure that specialist services have sufficient capacity to accept referrals. That might be at a lower threshold in the perinatal period, and that is important when we are thinking about exclusions on the basis of diagnosis, particularly for women with comorbid conditions. Too often, substance misuse services will not accept referrals of women with mental health problems and mental health services will not accept referrals of women with substance misuse problems. If women have both, where do they go?

The other big theme for me represents a big gap in perinatal services—I imagine that Clea Harmer will talk about this later in the meeting. I am thinking about women who have experienced a loss event. By "loss event" I mean not just miscarriage, baby death, stillbirth or neonatal death; I also mean child removal, which we know makes women extremely vulnerable. Perinatal mental health services do not typically accept women who have had a loss event, yet they have all the needs for perinatal mental health care of women who have living babies.

For me, bridging that gap and ensuring that the pathways can cope with the needs of all individuals is the number 1 thing that we need to think about in the short term. As Arun Chopra mentioned, having a service specification that means that the pathways are clear and having communication between the different services means that those gaps no longer exist, and that will be one of the most important actions.

The Convener: Thank you for that. There is lots for us to think about there.

Before handing over to my colleagues, I will pick up on one issue that has been mentioned, which I was aware of before: the policy around continuity of carer—for instance, knowing, when you go into labour, who the midwife is and knowing that it will be not be someone you have never met before. As you say, that policy is still to be rolled out. This question is for any of you. When it comes to the practical aspect of that, and given what you have said about the shortage of midwives—it will not be easy, and I am not asking how easy this will be to roll out—do you think that that policy will be doable within the next couple of years, as we come out of the pandemic? Could you reflect on the importance to mental health of having continuity of midwifery care? What difference would that make?

Dr Ross-Davie: Thank you for focusing on that key area. We have real concerns about the practical implementation of the continuity of carer policy, given the significant shortage of midwives and the huge pressures from the pandemic. There are a number of ways in which we can implement the policy more effectively than we have done so far.

Greater focus on providing ring-fenced investment is needed in order to implement the continuity of carer policy. There has been less investment in that than there has been in perinatal mental health. That is one key area. When implementing such a significant service-wide change, it is really important that there is ring-fenced investment in the process and in the leadership of that process. As was mentioned earlier, in Scotland, we have a lack of consultant midwives, who could have a real role in implementing the service change.

On the continuity of carer policy, we also need to recognise that we cannot go the whole hog all at one time. We need to focus on women who are particularly vulnerable to having poor outcomes. In that regard, it is key that we focus on women who are vulnerable to mental health problems.

Generally, when we implement the continuity of carer policy, midwives work in small teams, which enables women to get to know their midwives really well during pregnancy and to have a much greater chance of having with them during labour a midwife whom they know. That is particularly important for women with mental health issues. Implementation should focus on women with particular needs, such as those who live in deprivation and have much poorer outcomes—Marian Knight will be able to speak to such issues very well—as well as black and brown women, and women from ethnic minorities.

We need to focus the implementation of the continuity of carer policy in those areas first, and ring-fenced investment is required to make that happen.

The Convener: That is helpful.

Professor Knight: [*Inaudible*.]—said. The majority of women who die have complex adversity. They have had adverse childhood experiences or they are victims of domestic abuse. They might have issues with substance abuse, or social services might be involved. To ensure the best outcomes for such women, a trusted therapeutic relationship—having somebody whom they trust to help them to navigate the system and be their advocate—is crucial.

I agree with Mary Ross-Davie that focusing on vulnerable groups is really important, but the main point for me is that midwives need training in order to have the specialist skills to work with extremely vulnerable groups of women. It is not just about the continuity of carer model; it is about having that model with specialist trained teams.

The Convener: That is very helpful. My colleague Evelyn Tweed has questions about funding.

Evelyn Tweed (Stirling) (SNP): Good morning. There are only a couple of mother and baby units in Scotland. Do we need more such units?

Dr Chopra: This is a good opportunity for me to drill down a little bit into what we found through our visiting function at the two mother and baby units, which will help me to build up to answering the question whether we need additional resources.

As I mentioned, the Mental Welfare Commission visits mother and baby units to see how they are working and to understand the experience of the women and families who use those services. We were very encouraged by what we saw in our last visit to the west of Scotland and we have a visit to St John's hospital in Livingston coming up early next year. We have seen improvements in staffing, in the ability to have parent-infant mental health nurses and in relation to peer support workers. We have also seen really good care plans. That is possibly because women are being admitted to the two units.

However, there is a clear difference in admission rates to the units based on which health board one is in. If a health board has a mother and baby unit in its area, there are more likely to be admissions from that health board. For example, NHS Lothian and NHS Greater Glasgow and Clyde have admission rates that are above three per 1,000 births to their units, whereas for other health boards, the rate can be two per 1,000, or sometimes lower than that.

It is quite clear from the data that the availability of a mother and baby unit leads to a greater awareness of what such a unit offers the mother and the infant. When we looked at why mothers were sometimes not admitted with their babies to mother and baby units but to general adult wards, it became clear to us that sometimes it was a choice; at other times, it was about particular disadvantages. The distances that people needed to travel were an issue; childcare was also a factor.

However, another factor was a lack of awareness from the referring unit about the advantages that a mother and baby unit might provide. That came through to us quite clearly, both when we did this work in 2015-16 and more recently, when we have been discussing the possible reasons for people not being admitted to the units when they should.

The question that then arises is whether there ought to be greater provision. When the network looked at delivering effective services, the estimate was that Scotland would probably require around 16 beds; currently, we have 12 beds, so there is a question about whether we need greater provision. NHS Grampian provided us with an update on the number of admissions to the unit that it has had from the north—I think that the number was around nine per year.

That does not fit with our modelling, which would suggest that the numbers might be higher. However, as I mentioned, awareness leads to a greater number of admissions. That brings us to the idea of an options appraisal on whether we ought to create more beds in the north—perhaps a bespoke unit, with at least four beds, because you need a critical number of beds in order to develop the infrastructure, the staffing, the knowledge and the skills—or whether it might be better to build that resource into the existing mother and baby units.

We need a detailed options appraisal and my understanding is that that is coming in early 2022. That will be critical to making a decision about whether we create a new unit in the north or increase provision in the two existing units.

Dr Gleadow-Ware: I echo the comments in Dr Chopra's submission. Members have highlighted that, at times, it can be difficult to admit women to the mother and baby units. Bed availability can be stretched, although it fluctuates over the course of the year. As Dr Chopra highlighted, geographical barriers disproportionately affect women in more remote and rural areas, so careful consideration is required about the location of additional beds.

That feeds back into the staffing, recruitment and retention issue. To have sustainable, safe and effective mother and baby units, we will need a much larger workforce pool of trained specialists—if units are to be created in areas where they do not currently exist.

We appreciate the work that the perinatal and infant mental health programme board is doing on the options appraisal, and as a faculty, we are keen to see the results of it.

09:30

The Convener: Do you have another question, Evelyn?

Evelyn Tweed: Yes, I do. Which areas of perinatal mental health services would also benefit from further investment? My question is for Mary Ross-Davie.

Dr Ross-Davie: Thank you for that question. You will not be surprised to hear me say that we need further investment in universal services and prevention. The focus there is on ensuring that we have a midwifery workforce that is adequate, appropriately trained and supported to do the work.

So often, when there are reports around perinatal mental health, midwifery is sidelined or not centred in the descriptions of what that service could look like. It is key that every health board in Scotland has a specialist perinatal mental health midwife. They are a key link between universal and specialist services and can ensure that those services are able to speak to each other and that any pathways of care are appropriate and relevant. They also have an important role in ensuring training of midwives in the local area and providing midwifery input when women are admitted to mother and baby units or need more specialist care. Unfortunately, that was not a key recommendation in the initial plans for perinatal mental health services. There is a lot to do to ensure that midwifery input is centred.

Throughout the pandemic, midwives have continued to go out in person. Where other services have become virtual, midwives have needed to step into those positions and ensure that support for women with mental health problems is provided in person. That has put a particular stress on the midwifery workforce, but it also demonstrates how key it is that the workforce is adequate and is prepared, trained and supported to provide that care.

Professor Knight: I emphasise the importance of the non-specialist services. A recurrent message that we have identified is the lack of training and understanding of perinatal mental ill health among crisis liaison and home treatment teams. It is important that actions are focused not just on the specialist perinatal mental health teams because many women will be seen initially by a crisis liaison or home treatment team, yet those teams frequently do not understand the rapidity with which mental health can deteriorate in the perinatal period. Too often, symptoms are dismissed, yet women get very ill very quickly.

We also need to ensure that we train our non-specialist teams about the features of perinatal ill health and the need for urgent care of women who have perinatal mental ill health.

Dr Chopra: I echo the points that Mary and Marian have just made and I will make an additional point around the voluntary sector. We need to ensure that statutory services pathways also make reference to where we can have—and people might benefit from—voluntary sector involvement, because that sector is a hugely important part of the puzzle.

Dr Gleadow-Ware: I highlight the role of the specialist professionals, particularly psychiatrists, in supporting universal healthcare professionals to have that specialist awareness, so that they can pick up those vulnerable women who need enhanced support. Those specialist professionals can teach and train intensive home treatment teams, crisis teams, health visitors and general practitioners. We need the investment in order to support them to be a resilient workforce, so that there are benefits across the whole pathway. We need that expert knowledge to be shared, as Professor Knight helpfully highlighted.

The other area that the faculty would like to highlight—which has already been mentioned this morning and probably warrants additional assessment and potential investment—is the care pathways of women who have substance misuse difficulties. Those women have not traditionally fallen within perinatal psychiatric services and, as yet, there is no specific national care pathway for them. Although there are examples of good practice across Scotland, they are by no means implemented across Scotland. Given that those women are at increased risk of maternal death and adverse outcomes for their infants and families, that area warrants attention, particularly considering Scotland’s high rate of deaths due to alcohol and substance misuse.

Evidence has been given on the experience of women who have had loss events. Traditionally, those women have not been part of perinatal services, but perinatal specialist services do have advice to give to universal or voluntary sector pathways on the support that could be provided to those women and where, for example, they might require more specialist perinatal mental health interventions. Many of them might benefit from more universal or voluntary sector support in the first instance.

Those are particular areas of need that might require further attention. We also need to consolidate the work of the existing pathways, because they are still in the very early stages of being robustly implemented across Scotland.

The Convener: Stephanie Callaghan has a supplementary question on that issue.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): Earlier, Professor Knight mentioned the possibility of including babies being removed from mums in the category of baby loss events. Quite high numbers of care-experienced mums lose their babies at or very soon after birth, because they have not had those stable and protective relationships themselves.

The picture on the screen has disappeared; I do not know whether we are still on.

The Convener: We are still on.

Stephanie Callaghan: Quite often, there is a perceived risk of significant harm to the baby. Would it be helpful if we expanded access to mother and baby units so that they can offer support to those mums and help them keep their babies? What other perinatal health services could we look at that might provide positive support to those mums and keep families together?

The Convener: I hope that all the witnesses heard that question. I think that we are having a drop in connectivity from time to time.

Professor Knight, that question was addressed to you. Were you able to hear all that?

Professor Knight: I hope that I heard most of the question; the connection broke up for us a couple of times. If I understood the question, it was about the fact that children are often removed from mothers' care for their own protection, and whether additional support or family support was needed at that stage. Was that the gist of the question?

Stephanie Callaghan: Yes. In particular, it was about the high numbers of care-experienced mums who lose their children at or very close to birth. Would mother and baby unit expansion support that? What other perinatal services could help to keep those babies with their mums?

Professor Knight: I am probably not the best person to comment on mother and baby units. There is a definite pattern: when the children are removed, all focus goes from the mother and she has no support. The decision around child protection is often valid, but the mother is left with no support. In effect, the rug is pulled out from under her feet. She has had intensive support throughout pregnancy, but when the child is removed all support for her goes. For me, the really important gap to fill is ensuring that those women continue to get the support they need, regardless of whether their children are at home with them.

Dr Ross-Davie: There is very patchy provision in Scotland. There are some really great examples of specialist teams where midwives, in conjunction with social work, child protection and health visitors, provide a wraparound service for women who are identified as being particularly vulnerable and where there are concerns around safeguarding. That includes women who are care-experienced or who have severe mental health problems, substance misuse problems or a learning disability.

There is a great team in Fife, but there have been really good examples in the past—such as in the Borders—and those services have not received consistent and sustained funding. Those teams are often seen as a short-term project and the funding is then removed or they need to spend time seeking additional funding. Those specialist teams need to be seen as an integral part of maternity care across Scotland. We should have midwives with particular training and expertise working within multidisciplinary and multi-agency teams to provide support for women and to prevent babies from being removed, where possible. We have certainly seen examples where that has been the case.

If we have those specialist teams, fewer babies need to be removed because the women and families have additional support during pregnancy and in the postnatal period. There are family support workers who are able to go out several times a day during the first weeks and months to provide really focused support, which can lead to safe environments for those babies. However, that support is not provided consistently across the country and does not seem to be factored into the overall maternity policy.

Dr Gleadow-Ware: I echo the points that have just been made. There are certainly examples of good practice. We know, for example, that early intervention and preventative work to prevent relapse of mental health illness can make a big difference. Care co-ordination between midwives, social workers and health visitors is a big part of the work that specialist community perinatal teams do to ensure that there is as much support as possible around women and families to prevent relapse and the impact of that on the infant.

We have also seen areas of good practice in substance misuse such as the prePare team in NHS Lothian. Again, they carry out early preventative work to engage the hardest-to-reach women who have chaotic substance misuse, with input from maternity, health visiting and social care teams. It is an integrated model of care that continues for women through the antenatal and postnatal period. Unfortunately, that model remains the exception rather than the rule.

There is a need to look at the social care supports that the women and their families need, especially parenting support. During the pandemic, statutory services have often had to prioritise the highest-tariff cases, so there has not been scope to do the early and preventative work that could help to ensure that women and their infants remain together.

09:45

I want to highlight a distinction. The mother and baby units that provide acute psychiatric care to women who are acutely mentally unwell and their infants, when there is a clear determination that the mother will be the main carer of the infant, are separate from the mother and baby units that are used when a parenting assessment makes a determination on whether a mother will be able to meet the needs of her infant. In the social care environment in Scotland, those parenting assessment units have generally been moved into more community-based provision and, as I mentioned, the pandemic has significantly challenged that provision. It is important for the committee to understand the distinction between the role and remit of specialist psychiatric mother and baby units and the broader remit of parenting assessment units.

The Convener: Before we delve into the workforce issues that you have all mentioned, I want to ask Mary Ross-Davie a question. We have spoken to parents who have had mental health issues as a result of pregnancy and childbirth, and one of them mentioned that they had support from an additional support midwife during pregnancy, because it was established that she needed that extra care. I was not aware of that previously but, on probing further, I found that additional support midwives are not available throughout Scotland. Is that your experience? Can you shed any light on where such midwives are available? To me, it sounds like good practice to give somebody an additional support midwife when it is known that they will have particular difficulties.

Dr Ross-Davie: Absolutely. Different titles are given to midwives who work in that particular field and provide additional support to women who have been identified as having particular needs. In some areas, those midwives are called SNIPS—special needs in pregnancy service—midwives, and they used to be called sure start midwives, when there was sure start funding. Whatever the title, the vital thing is that we identify the women who have particular support needs and that we provide additional midwifery support to them, from a known midwife.

As Marian Knight mentioned, it is key for women and families who have not had positive experiences in their relationships with health, social care and authority figures that they can build a relationship of trust with the midwife. That is a great point of entry in building a relationship of trust with authority and health figures. It is vital for the midwife to be a consistent presence in providing support during the pregnancy.

You are right that that provision is patchy and does not exist in every area. Over the past 10 years at least, the focus has been on trying to have midwives across the service providing universal care, rather than on identifying the benefit of those specialist roles. To provide really high-quality care, midwives who work in those areas need additional training on perinatal mental health, substance misuse and safeguarding. Not every midwife will be able to provide high-quality care in that area. Therefore, let us ensure that we have those specialist services in every health board in Scotland and that we have consistent long-term funding for those services.

The Convener: Thank you. That was really helpful.

Gillian Mackay (Central Scotland) (Green): Are the witnesses satisfied that sufficient long-term workforce planning is taking place to ensure that Scotland has the perinatal mental health workforce that it needs? Perhaps I can start with Mary Ross-Davie.

Dr Ross-Davie: There is a focus on workforce planning, and more work is being carried out to ensure that our workforce planning tools in maternity services are fit for purpose and reflect the direction of travel of those services. The previous tools focused very much on acute care, given that maternity services were generally being provided in obstetric units in maternity hospitals. However, maternity care is now much more than that. It crosses into community care—in fact, it is provided largely in community settings by midwives—and a huge amount of work is also being done in primary care and in conjunction with other services. Improvements are being made in that area, but there is much more to do to ensure that we have the long-term planning that will put the right professionals in the right place.

Since 2011, there has been a huge drop in the number of student midwives in Scotland, and we have been trying to address that situation by ensuring that we have enough student midwives coming through and being trained. There is still an issue to be addressed with regard to attracting student midwives, particularly in the north and in remote and rural areas of Scotland. Only three universities in Scotland provide preregistration midwifery education. In recent years, though, a real opportunity has emerged in Inverness in the form of a pilot project for a shortened programme for student midwives, and we also want Napier University’s new shortened programme to encourage developments in remote and rural areas. I should explain that people who have been nurses in the past can go through that kind of shortened programme to become midwives. There is more to be done, but there are positive green shoots.

The other key factor is to retain the experienced midwives that we already have. Not enough is being done about that. We cannot just have student and newly qualified midwives in the service; we need to retain very experienced midwives by offering them decent working conditions and flexible working opportunities. Again, that is not happening consistently everywhere.

Gillian Mackay: Are the witnesses concerned about workforce morale and wellbeing and the impact on retention? Mary Ross-Davie talked about focusing on both recruitment and retention. Do you feel that, just now, there is too much of a focus on recruitment and not enough on retention?

Dr Chopra: It is important to focus on both.

I would like to talk about some of the commission’s work in that respect. We operate an advice line that professionals, people with lived experience and their families can phone when they have particular issues about their care or about how the 2003 act or other laws are being used. We take about 4,500 phone calls a year, and we get a sense of what is happening both through that and through our visiting and monitoring function. What is coming through is the complexity of what people are working with and a lack of resource.

I will provide some numbers. At the sharper end of the mental health and mental illness continuum, there is usually, year on year, a 5 per cent rise in the number of people who are detained under the 2003 act. Data that we published in July showed that, during the Covid period last year, there was a 10 per cent rise—there was almost a doubling of the number of people with more severe illnesses. That is being echoed in the system with the increase in anxiety and particular conditions, such as eating disorders and obsessive compulsive disorder, that have relevance to the perinatal population, too.

If we place perinatal services in a broader context, we see from the commission's monitoring data and from our advice line that the workforce are experiencing pressures that they have not seen before. That makes it really important for us to see how the 2003 act is being delivered and how care is delivered when the workforce are having particular difficulties.

Yes, it is important to train more people, and recruitment is important. Across the professions in health and social care, we are also looking for compassionate leadership and retention. There will be issues around ensuring that funding goes to the right places, and there is the point that was made earlier about specific perinatal training. Training will need to be broader, so that everyone has experience that they can fit into perinatal pathways.

As well as thinking about capacity, what professionals we have in Scotland and whether they can meet demand, it is important to think about demands on services and whether there are alternative models. People are coming forward with mental health difficulties, and we have to operate with mental illness. Those things sometimes synergise, but they can be quite separate. Someone having a mental health difficulty does not necessarily have a mental illness that requires secondary or tertiary care when it comes to perinatal services. We need to think about alternative models for providing people with the help that they might need. That might include peer support workers, and it could involve positioning within primary care people who might be able to meet the emerging needs as we emerge from the pandemic.

It is a matter of thinking about those wider issues, and that will have a knock-on impact on secondary care and perinatal services.

Dr Gleadow-Ware: I will highlight one point that builds on the points that have been made. Although recruitment in services across Scotland has rapidly expanded over the past 18 months, we need to think about retention and staff wellbeing in order to maintain and expand services. In particular, we need national training pathways, and we need the numbers. We have really benefited from the work that NHS Education for Scotland has done and from the perinatal curricular framework. There are clear educational resources across the different professions and pathways, including for specialist services, but we do not yet have clear, discipline-specific pathways that highlight the number of people we need to train to ensure sufficient numbers, accounting for a drop-off or loss or changes of careers.

In perinatal psychiatry, for example, there are no national perinatal training numbers. At the moment, we are very vulnerable to the added challenges in the mental health workforce, such as in general adult psychiatry, which means that we could lose the gains that we have made.

There is a real need for national training pathways and regional training placements so that the students of today can become the perinatal workforce of tomorrow. At the moment, we do not have those training pathways for Scotland.

Stephanie Callaghan: What impact are workforce issues having on patient care and on the ability of GPs, midwives, health visitors and others to work together effectively as a team? Last night, I spoke to some women who felt as though people all had bits of their jigsaw, but it was not necessarily coming together so that the whole picture could be seen. They found it difficult to get help as a result.

The Convener: Would you like to direct that question to anyone in particular? Perhaps we can go to Mary Ross-Davie initially. If anyone wants to come in on the back of her response, they should use the chat function, and I will take them in turn.

Dr Ross-Davie: I am sure that you will all be aware of what has been described as a crisis in maternity services across the United Kingdom, with the chronic shortages of midwives becoming acute during the pandemic. That has a huge impact on the quality of care that midwives are able to provide. If a midwife is really doing the job of two midwives, they need to cut their cloth accordingly in terms of the length of appointments. With perinatal mental health in particular, it is vital that a midwife has time during an appointment to get to know an individual, so that they can build a rapport and build trust.

10:00

In some respects, the move to some virtual working and the ability to have virtual multidisciplinary team meetings as a result of the pandemic have been of benefit. For instance, I have heard that, during the pandemic, it has been much more possible to get together for a meeting with all the professionals and support people who are involved in a woman's care. The GP, the health visitor, the midwife, the obstetrician and the perinatal mental health team are able to get together on a virtual platform, like the one that we are using now, to hold a planning meeting. There is something of a silver lining in that the pandemic has, on occasion, made multidisciplinary working easier. Nonetheless, it is vital that the time pressures and the pressures around staff shortages are addressed as a matter of urgency.

Dr Chopra made a point about the need to invest in, support and work with voluntary sector organisations, which is vital. It is clear that universal services such as midwifery cannot provide everything, and that we need investment in other areas of support so that we can all work together effectively to provide the right level of care.

Dr Gleadow-Ware: I agree that the pandemic has affected women and their families significantly in terms of the support that they have been able to receive, including informal support such as that provided through antenatal groups and meeting other women for peer support. Voluntary support in particular stopped quite abruptly at times, but fortunately it is restarting now.

As Mary Ross-Davie highlighted, there have been interruptions in continuity of care. In particular, as she described, women have not had as much face-to-face contact with midwives in order to enable them to develop a trusting relationship and to open up on more sensitive topics or particular areas of difficulty that they might be experiencing.

Specialist services have adapted in order to retain as much face-to-face contact as possible. At the start of the pandemic, we were often the only professionals, aside from those in midwifery, who were seeing women regularly. Women have certainly faced challenges with regard to the ease of seeing their GP and whether they are able to make a face-to-face appointment. A lot of information is lost through telephone and video consultations—for example, it can be hard to fully assess the parent-infant relationship.

The pandemic has had a number of impacts, not only on the availability of support, both socially and in the voluntary sector and through statutory and specialist services, but on how that support is delivered. The delivery of support has varied, which has particularly affected women's experiences and has had a knock-on effect on their mental health. Anecdotally, that might be one of the contributing factors in women raising concerns about significant levels of birth trauma, because they have simply not had the continuity of face-to-face care that would have created a buffer against particular trauma that they might have experienced during childbirth.

RCP members have highlighted specific vulnerabilities. As Mary Ross-Davie said, there have been some silver linings. Teams have been nimble in their communication, and we have continued with multidisciplinary and multi-agency care co-ordination, although that has been easier with some professional groups than with others.

Professor Knight: I want to pick up on the role of the GP. Doing all the mental healthcare planning before pregnancy can have a substantial impact. We have not really talked about pre-pregnancy, but we see clear examples in which a GP and mental health services have discussed risk-mitigation strategies pre-pregnancy. That means that all actions can be put in place if a woman's mental health deteriorates during or immediately after pregnancy.

We have lost the GP capacity to think about what happens pre-pregnancy. All too often, we still see the structural biases in pregnancy care, such that women stop medication or are told to stop medication inappropriately. Nobody thinks about the impact that that will have on their mental health; people think only about foetal risk. It is concerning that nobody thinks that women should restart medication post-pregnancy, even if they make it through pregnancy. For me, that is where the GP is a clear linchpin in continuity of care pre-pregnancy, during pregnancy and particularly post-pregnancy.

The Convener: Thank you. We are now going to dig further into training.

Emma Harper (South Scotland) (SNP): Good morning, everybody.

We have heard some really interesting responses so far. Dr Chopra touched a wee bit on training. I am interested in what training is available, what training is being delivered, and what barriers, if any, there are to training. My understanding is that there is a Royal College of General Practitioners perinatal mental health toolkit. Information has also been produced by NES, and there are re-learning modules. I know that the Edinburgh postnatal depression scale is used to assess women once they have delivered a baby. There seems to be so much information out there, so how is it being delivered to health professionals—midwives, GPs and other practitioners?

Dr Chopra: It is a bit of a shame that Selena Gleadow-Ware has had to leave, because I am sure that she would have had plenty to say about the perinatal curricula.

I am familiar with some of the training material that you mentioned, but not with all of it. The NES perinatal mental health curriculum, which I had a look at in the context of some other work that we did, is brilliant. It is really good training that is pitched at various levels; it allows people to determine what training they need and at what level, and it builds gradually. It is exactly the sort of training that is necessary in relation to our earlier point about ensuring that training is made available not just to specialist perinatal mental health services—which I think is a point that the whole panel has echoed—but to general teams, primary care and general mental health services, so that people understand the different risk levels of perinatal times, and the need to refer women to specialist services and get them the support that they need. That is the key point about training that I would like to make.

Dr Ross-Davie: In the past 15 years, we have seen a huge increase in the amount of education on perinatal mental health issues that student midwives receive in their preregistration degree. About 15 years ago, a student midwife might have expected to receive only about three hours of training on perinatal mental health; they can now expect full modules that are focused on perinatal mental health needs. Perinatal mental health is also included in, and woven through, the whole curriculum for the three years.

We have, however, a huge number of midwives in the workforce who did not have that solid grounding in perinatal mental health during their initial education and training, so there is still work to do to ensure that they have a sound understanding of perinatal mental health.

What is difficult about staff shortages is that they reduce the amount of time that midwives are given for continuing professional development. Midwives are expected to undertake CPD in their own time. Ring-fenced time for education throughout a midwife’s career is vital.

I echo the comments on how brilliant the NHS Education for Scotland resources are. They have been in development for a number of years, and the curricular framework addresses different needs for different groups—from those who are providing universal care right up to specialist perinatal mental health workers. A really good system of support and education is provided through NES.

However, the problems are in enabling people to access that education in their work time and in offering support and supervision when they are providing care to women who have significant perinatal mental health problems. That is key to preventing burnout and to ensuring that the care that is provided is high quality and evidence based. NES has done a huge amount of work; I would say that Scotland is ahead of the rest of the UK on that.

Emma Harper: What you have said about education in work time is really important. I probably need to remind everybody that I was a clinical educator before I was an MSP, and provided education to midwives.

It is important that we offer education in work time. Would providing education directly in the workplace, and not expecting people to do continuing professional development away from their workplace, also support retention of the workforce, which you previously mentioned?

Dr Ross-Davie: Yes. We have found models that use such work-based training. The Scottish multiprofessional maternity development programme, which is run by NES, provides clinical skills training for maternity teams. That is done locally but has a nationally accredited high-quality curriculum. We also see that with things such as Practical Obstetric Multi-Professional Training.

However, those tend to focus on obstetric emergencies. It is vital that we have continued training for maternity teams on how to deal with obstetric emergencies such as postpartum haemorrhage and shoulder dystocia, but we should also use that model for other issues including perinatal mental health, substance misuse, and supporting women when there are child protection and safeguarding concerns. That model should be part of the mandatory expected training for midwives and other maternity professionals and support workers.

We need far more clinical educators, such as Emma Harper, out in the service and we need a focus on developing those roles across Scotland.

Sandesh Gulhane (Glasgow) (Con): Emma Harper has just asked about training; on that, my question is about ethnicity. What training is being given to ensure that differences in ethnicity are being picked up, assessed and treated? Speaking as a doctor who was trained in the 2000s, I certainly did not receive such training. I direct that question to Dr Chopra and to Dr Ross-Davie.

Dr Chopra: Committee members may be aware that, in October, the commission published “Racial Inequality and Mental Health in Scotland”, which is a wide-ranging report that looks at racial differences in accessing mental health care and in how people experience use of the Mental Health (Care and Treatment) (Scotland) Act 2003.

The report also talks about the lived experience of people who come from ethnic minority backgrounds and their experience of mental health services. It highlights differences in representation of people in the mental health workforce and in how people progress in mental health services. It also talks about training—there is a whole chapter in which we focus on what sort of training is currently available to people on what we call “cultural competence”.

10:15

We have found that the majority of training is done through learnPro, in an e-module that people are expected to complete. Of the staff who responded to our survey on training around ethnicity and mental health—it did not focus specifically on perinatal mental health—70 per cent said that training does not meet needs. That is because, in 2021, the goalposts have moved; people are much more experienced and understand a lot more about how ethnicity and race impact on healthcare.

The training that is currently delivered through most health boards in Scotland—we focused on health boards—comprises a module that survey respondents considered to be inadequate to meet needs. We have recommended that the Scottish Government considers asking NES to provide more bespoke modules.

We have also spoken about the need for specific modules that focus on meeting the needs of asylum seekers and refugees in primary care and secondary care, so that they are not retraumatised by having to tell their story several times.

The commission has undertaken a lot of work around racial inequality and mental health. I would be happy to send the committee a link to the report and to address any questions that arise from it.

On perinatal mental health specifically, I go back to the NES module. The NES curriculum for perinatal mental health contains a section on culture and meeting the needs of people who come from different cultures and ethnicities. It is brilliant, because it shows, at various levels, what sort of competencies practitioners might want to achieve to enable them to meet people’s needs. At the most basic level, that might involve having an understanding of someone’s background. The level above that might be about use of advocacy and interpreters—knowing how to use interpreters well is a specialism in itself. The level above that might be about understanding the power dynamics that take place in a clinical interaction when people come from different backgrounds, and how the interaction develops accordingly.

I welcome the question. We need to do a lot of work as we build back fairer and create more equitable access to all parts of our services.

The Convener: We would definitely like to see the report, because it will inform our wider work on mental health. Thank you for offering to send it to the committee.

Gillian Mackay wants to come in on training.

Gillian Mackay: When a woman is pregnant or has recently given birth, she will be in contact with a range of health professionals, which potentially creates a lot of opportunities to identify whether she is struggling. Are the witnesses confident that staff have the training to take up those opportunities? For example, are primary care teams, in particular, equipped to identify perinatal mental health issues?

Dr Ross-Davie: As we discussed earlier, there are real opportunities in Scotland, given the resources that we now have for raising awareness about perinatal mental health, which are suitable for people in primary care and midwifery and for other health professionals.

The issues, as I have rehearsed today, are that we need time for people to do the training, enough staff to do it effectively and systems of care that enable health professionals to build relationships. At present, the answer to your question is no—we do not have all that in place. We do not have the staffing, the opportunities for education and support or the systems of care that would enable us to maximise what we want to do in order to identify women who are struggling and offer them adequate support.

What midwives, health visitors, GPs and so on find difficult is when a woman discloses—in conversations around, say, the Edinburgh postnatal depression scale, which was mentioned earlier—that she is struggling, but even though they know that there is a problem, there is nowhere to refer her to be seen quickly and to get the support that she needs. As a result, midwives and health visitors very often feel as though they are left trying to meet the care and support needs of a person who actually needs more specialist support.

I would like to go back to the previous question about ethnicity and the impacts on maternity outcomes. Professor Knight will be able to talk about this very eloquently, but we know from the MBRRACE-UK report that black women are four times more likely to die in childbirth or in the postnatal period. Women from ethnic minorities face huge inequities with regard to outcomes from maternity services, and we in the RCM are seeking to address that by providing much more focused education and training for student midwives and midwives on racial disparities and their impact on maternity and perinatal mental health care.

There is much to be done on that in Scotland. We know from recent reports that ethnicity is not being adequately recorded in the antenatal period, which means that we are unable to identify adequately the disparities. We need to improve recording of the conversations that are being had and we need to improve the confidence of professionals in talking about race and ethnicity and addressing their own unconscious bias. There is a huge training need across Scotland in that respect.

Professor Knight: I will pick up on the previous point. It is really important to recognise how complex service users find the whole maternity care system. The pattern that we see in the women who die by suicide is that they have had multiple contacts with different individuals. They might have seen the GP, have been to the emergency department and have seen a health visitor with concerning symptoms that have been either normalised or dismissed, and no one has recognised the overall pattern.

As they say, it takes only one person—but there still needs to be that one person who knows an individual well enough to recognise the deteriorating pattern of symptoms. That could be the GP or the midwife, but we have also seen fantastic examples of health visitors being the linchpin in ensuring that women get the care that they need. We need to ensure that that one person exists.

On ethnicity, when we look at what has affected care of black women who die, we find that there has been a lack of individualised care, a lack of recognition of cultural nuances and a lack of recognition of the woman as an individual, which would have ensured that she got the care that she needed.

It also needs to be recognised that no one size fits all. For me, the main message with regard to perinatal health pathways is that no one solution will ever be right for every woman. We have to ensure that, whatever an individual woman's needs, she is able to negotiate the parts of the pathway and her symptoms are not normalised by every person whom she meets as she goes along it.

Dr Chopra: In responding to the question, I think that it might be helpful if I reiterate the point that was made right at the beginning of the session about the need for clear and explicit pathways, which is one of the things that is highlighted in the MBRRACE-UK report.

Notwithstanding the need for nuance and the need to individualise care, one thing that would help everyone is clear and explicit pathways into perinatal mental health services at all the different levels. That would mitigate some of the uncertainty and would allow universalism, whilst allowing for nuance. It would be great if every health board had very clear pathways all the way from primary care, to secondary care into perinatal care and mother and baby units.

We made that point in our evidence on service level agreements. That should happen so that when someone needs specialist care in an in-patient facility, there is no questioning or misunderstanding about where they need to go—the right pathway for them is there, which should be patient centred and nuanced. Clear and explicit pathways going right back to the beginning would make a huge difference.

The Convener: We are rapidly running out of time. I want to address some of the issues that have come up as a result of Covid-19. We heard a substantial amount of testimony from mothers and fathers around that.

Carol Mochan (South Scotland) (Lab): As the convener said, last night we heard from several people with lived experience and it was striking that, although we are all affected by the effects of Covid-19, for the mothers and fathers in this category there are some major things that we need to address right now and going forward. Does the panel have any advice on the return to services that seem very different across Scotland? What things might need to be put in place to support this group of people in the next year or so?

The Convener: One of the things that we found out last night was that the impact of not being able to have partners accompanying women to antenatal classes throughout the pregnancy and being there during the birth was acute.

Professor Knight: I was just going to reflect on what we saw in the initial phase of the pandemic, when face-to-face services and mental health services were not recognised as having the priority that they needed. We had women whose appointments were cancelled because of the pandemic and who were subsequently, two months later, sent letters with leaflets providing advice.

The thresholds that were being imposed were so high. I vividly remember one letter, which said,

> "We don't care for women who are not acutely mentally ill".

That was despite that the fact that the woman had known long-term mental health problems. Sadly, she took her life two weeks later.

There did not seem to be a recognition that we cannot do everything remotely. There needs to be a triage system. Even if we continue with some remote consultations, we have to recognise that, particularly with mental health, there will be a need to offer on-going face-to-face services. We have to ensure that mental health services are prioritised in the return to face-to-face consultation and that it is not assumed that it can all be done remotely. For me, that is the most important thing.

As you have highlighted, family support is crucial for women who have mental health problems and who need advocates because of their complex background. Ensuring the ability of others to be with those women is also very important.

Dr Ross-Davie: I am pleased to hear that the committee has heard the direct testimonies of women and families of their experiences of giving birth during the pandemic. We, too, have heard extremely distressing stories from women who have given birth during the pandemic about their sense of isolation, their loneliness and their difficulties in accessing care from health professionals and those more informal sources of support that come from antenatal support groups and classes and postnatal support groups.

10:30

In the past, those elements of maternity provision have been undersupported and underappreciated, and they have been seen as a “nice to have”. When there are midwifery shortages and pressures on the service, antenatal classes are one of the first things to go or be pulled back from. One key lesson from the pandemic is that those support and education classes—both antenatal and postnatal—are not just nice to have but are a key part of the provision of decent, supportive services during the perinatal period.

What we have been able to do during the pandemic is to rapidly instigate more virtual appointments. Through the Near Me programme, we have been able to provide virtual antenatal clinic appointments. There have been positive elements to that.

However, it is key that we do not become reliant on those virtual appointments because, as mentioned earlier, it is very difficult for health professionals to pick up on some of the non-verbal cues and nuance in virtual appointments. If someone is not wanting to open up and give things away, it can be much more difficult to get beneath the veneer in a virtual appointment, not least because many women do not have access to good wi-fi of the kind that we are experiencing today and good data availability. Often, a virtual appointment will revert to a crackly mobile phone consultation in which the professional will not be able to pick up on those issues.

As was mentioned earlier, it is important to be able to pick up on the relationship between the mother and baby in those early postnatal days. Postpartum care has often been described as the Cinderella element of maternity services. It is so important that we have skilled midwives going into the home regularly in those first days after the birth and that that is carried on by health visitors, to support the development of that relationship and pick up on how the woman is doing. We cannot just pop in and out or have the odd telephone call. Postnatal, postpartum services are vital—they are not just a “nice to have”. Those services need investment and adequate staffing.

On the role of partners, the situation has been hugely distressing for women. It has become the norm in maternity services over the past few years that partners are there at every scan and antenatal appointment and throughout the induction process, labour and birth. We have had open visiting on postnatal wards in maternity services for many years now and that has become an expectation.

During all parts of the pandemic, maternity services have focused very hard on ensuring that partners were able to be there during active labour and birth. That was always there. However, it meant that some women who had a longer induction process on the antenatal ward did not have their partners with them at all times and there were women who attended scans at which they received bad news when their partners were not with them.

We have been able to recognise that partners are part of the care team and that maternity services should see themselves as providing care for the family. Hopefully, we will ring those changes and return as rapidly as we can to having partners present throughout the journey.

Dr Chopra: I echo those points. In its intelligence gathering, the commission has heard very clearly about the isolation that people have experienced throughout the pandemic. In a practical sense, we have also heard about the difficulties that it has caused in relation to discharge planning from mother and baby units, as well as on leave. The impact of people getting the virus and then potentially coming back means that it is more difficult to organise leave. I was pleased to hear that the emphasis on partners included fathers, because they have experienced that same sense of isolation.

All that said, there is an opportunity to think about how we adapt to the new normal. The idea that we are going to go back to some sort of old normal seems increasingly distant. We may experience further variants and further disruption, but we ought to be thinking about how we build back fairer and how we adapt our system.

Virtual appointments offer the opportunity to build choice into the system. Rather than having an approach in which either it is face to face or it is virtual, wherever possible we should give people the choice as to how they want to accept those aspects of their care that can be delivered on different platforms. I want to emphasise the centrality of choice and the opportunity that living through this difficult period has provided us.

The Convener: Thank you. I am sure that we could easily go on for another hour, but we have run out of time. What you have told us has been hugely helpful and valuable. Thank you very much for your time. We will take a short break to allow the next panel to come in.

10:37

Meeting suspended.

10:45

On resuming—

The Convener: Welcome back, everyone. We continue item 2 with a second evidence session with stakeholders as part of our inquiry into perinatal mental health. I welcome Cat Berry, who is the group facilitator and volunteer co-ordinator of Juno Perinatal Mental Health Support; Joanne Smith, who is the chair of Maternal Mental Health Scotland; Dr Fiona Challacombe, who is the patron of Maternal OCD; and Clea Harmer, who is the chief executive of the Stillbirth and Neonatal Death Society, known as Sands.

I would like to go to each witness in turn with my opening question. What role does your group play in supporting women and their families during the perinatal period? I do not know whether you watched the earlier session, in which we heard clinicians and academics reference the third sector many times.

Cat Berry (Juno Perinatal Mental Health Support): Hello. I am from Juno. We are a purely volunteer-led organisation. We run support groups for women in the perinatal period, which is anything from conception up until when their child is about two years old. We run general support groups online and face to face. Obviously, we have not been able to run the face-to-face groups during the pandemic, so we had to come up with an online solution. That has worked quite well, so we have continued with that approach. We have brought back a face-to-face group, too.

We are purposefully unfunded. We realise that funding can be not only given but taken away. We do not want to be dependent on funding for it then to be taken away. Women need support in the perinatal period permanently, full stop. We have had to find a way to survive and keep going, whatever Government we have and whatever its policies are.

We have two types of support group. We have our general support groups, which, for example, cover prenatal anxiety, postnatal anxiety and postnatal depression. We also cover obsessive compulsive disorders, although that is less common in our groups. We have a birth trauma group, which, unfortunately, we have not been able to bring back after the pandemic, but we desperately want to do that.

Our general group is facilitated by trained peer support facilitators, whereas our birth trauma group is facilitated by professionals who are not just trauma informed but trauma skilled. That group also has a slightly different structure.

We have two separate groups because, having run groups since 2015, we realise that having a woman with prenatal anxiety and a woman with postnatal PTSD in the same room is not a good match. Both women need to be supported in a very different way, separately.

We have identified three themes that existed before the pandemic but which have been exacerbated by it. The first is isolation, which has been greatly exacerbated during the pandemic, particularly because of the shortage of NHS and third sector services, but also because friends and family were not allowed to visit during the full lockdown. You know how it is—when you have a small baby, you need as much help as you can get, and it just was not there. A lot of women were extremely isolated.

The second theme is birth trauma. There was a massive rise in birth trauma before the pandemic, but that has been exacerbated during the pandemic. Again, less support being available has led to more cases of PTSD.

The third theme is lack of support. It is a recurring theme that has also been exacerbated during the pandemic.

I will go into those themes in more detail later on, but those are the three that we have identified.

The Convener: Thank you. That is very helpful. My colleagues will probably come back to quite a few of the issues that you have brought up.

Joanne Smith (Maternal Mental Health Scotland): Hi, everyone. I am the chair of Maternal Mental Health Scotland, which is a coalition of statutory services, third sector services and women with lived experience of perinatal mental illness. Our role is to come together to provide a strong collective voice to campaign for prioritisation of and increased investment in perinatal and infant mental health services.

We are run entirely by volunteers. We have evolved over a decade from a professional group—a clinical forum—into a significant lobby operation. I hope that we, as an organisation that is run entirely by volunteers, offer a distinct overview of some of the intertwined issues that face statutory services, the third sector and care support groups.

Our aim is to create a continuum of pathways of support for families, from family support through to specialist care. That is a massively ambitious aim, but we believe that it is the right ambition to have. We have strong foundations to build on in Scotland.

The Convener: Thank you.

Dr Fiona Challacombe (Maternal OCD): Good morning. I am representing the charity Maternal OCD, which was set up by two women with lived experience of maternal OCD to raise awareness of what is a very common condition. I am a clinical academic at King’s College London, and I am lucky enough to be patron of the charity.

Over the past 10 years, we have worked to raise awareness of the issue among women and professionals, and it is no longer a lesser-known condition, which was a key barrier. Research shows that it is a very common presentation in pregnancy, particularly in the postnatal period. It is characterised by intrusive thoughts of harm coming to the infant and sometimes by horrible intrusive thoughts of deliberately harming the baby, which are obviously very distressing for women and can be misunderstood.

It is really important that a good understanding is obtained of what is a common condition that can present across all aspects of the perinatal pathway, from primary care right up to MBU specialist care level.

Maternal OCD has done a wonderful job in assisting the development of training for professionals and in disseminating information to those such as GPs, who might be the first point of contact for women with this horrible disorder. It has also facilitated peer support groups, alongside the national charity OCD Action, which has continued to run specialist groups for women throughout the pandemic.

The Convener: Is the nature of maternal OCD a barrier to women seeking mental health support, because they are worried about the consequences of admitting to some of their challenges as a result of having those intrusive thoughts?

Dr Challacombe: Yes. All perinatal mental health issues carry a stigma in relation to disclosure, but it is clear that there are additional issues of potential misunderstanding, inappropriate risk assessments and, sometimes, very inappropriate treatments, so educating professionals on the right questions to ask to ascertain whether someone has OCD or another problem is crucial and has a potentially huge preventative function. We have treatments that work well for OCD, so it is important to disseminate that information. There has been a lot of discussion about workforce training, but sending the message that there is effective help that should be available to all women is key. Thank you for raising that point.

The Convener: Thank you for clarifying.

Clea Harmer (Stillbirth and Neonatal Death Society): Sands offers support to anybody who has been affected by the death of a baby, which includes pregnancy loss and baby death. I thank the committee for recognising the fact that bereaved parents have specific and different needs. They have often been overlooked, so it is wonderful that you are recognising that.

We offer support to parents across Scotland through a range of channels, including group support face to face or via Zoom, and we have specialist Scotland groups. We increasingly offer support digitally through online community Facebook pages, Instagram and Messenger. People reach out to us in lots of different ways, so it is important to recognise not only that different channels work for different people but that different levels of support are needed.

Although we provide support and a level of counselling, many parents go on to experience severe mental health issues such as PTSD, depression and complex grief, but we do not support people who need specialist psychological or psychiatric help. It would be interesting to further discuss that gap, because it is important that parents are able to access the support that they need.

We work with healthcare professionals to provide the training and resources that they need to provide bereavement care, although that has been challenging during the pandemic. It is incredibly important that parents are supported in the first days and hours after the death of a baby. That support is often given by midwives, but it can be given by a range of professionals, and it is important that those professionals also get the support that they need. In a nutshell, that is what we do.

The Convener: Colleagues will want to ask a range of questions, but I remind them that Dr Challacombe has to leave at 11:30, so if they have questions on OCD, there is a window of half an hour to ask them. If they do not get the chance to ask a question, we can get in touch with Dr Challacombe after the meeting.

Stephanie Callaghan: My question is for Joanne Smith. You spoke about the fact that you cover the third sector as well as statutory services. I am interested in the evidence that we got from women about the importance of the third sector’s role. They spoke about Home-Start and peer support. As Gillian Mackay picked up on, there is sometimes a worry about being too honest and up front with health professionals because of what the consequences of that could be. There are fears about the mum being taken away from their baby or the baby being taken away from their mum. The women felt that peer support gave a bit of trust on either side and allowed them to feel much more comfortable in being open.

11:00

I have experience in providing breastfeeding support as a volunteer peer supporter, and the midwife who led that work said that how mums speak to her in her midwife role is very different from how they speak to her when she does peer support.

Is the third sector picking up services that our NHS boards should be delivering? Where does the balance lie? In addition, what can our NHS boards learn from third sector organisations?

Joanne Smith: That is a critical point. Organisations such as Home-Start, which you mentioned, Aberlour and CrossReach have been providing perinatal mental health support in communities for decades—they were probably doing that before we referred to it in those terms. They bring a huge amount of specialism and expertise, and there is no question but that their position within communities, alongside families, means that they are able to identify risk early and to intervene appropriately, often preventing problems from escalating and, therefore, stripping out the demand for specialist services. They play a critical role.

Often, our specialist services take a very clinical view of social and emotional wellbeing, and people do not necessarily identify with some of the clinical terminology that is used by those services. Having local third sector services available means that women can overcome some of the pressing barriers to disclosing that they might be struggling through misery at a critical life stage.

The role of the third sector is critical. The managed clinical network's report "Delivering Effective Services" concluded that short-term funding for third sector services had meant that well-established community services were sometimes unable to be sustained—we are losing some local specialism and expertise because of short-term funding structures. That is obviously hugely problematic in that it increases demand for crisis services further down the line.

It is probably worth saying that we agree with the approach of prioritising investment in specialist services. I understand that that is the right thing to do. However, of the £50 million that has been invested by the perinatal and infant mental health programme board, only £2.3 million has been earmarked for the third sector. There were 95 applications for that fund, but only 16 organisations were successful in securing funding. That indicates that the third sector is willing to provide local support. If we can get it right, we will drive the shift towards prevention to which we in Scotland have long aspired. However, current national investment is not sufficient to provide that sustainable long-term third sector offer.

You are absolutely right. We cannot overstate the role of the third sector, and it is critical that we recognise and respect its role in the spectrum of support that women need, which runs from support for women with low or moderate need right up to specialist care.

The Convener: Sandesh Gulhane has a question. I have just realised that there is a request to speak in the chat box from Cat Berry. Sandesh, can you hang on for a second? I will come first to Cat and then come to you.

Cat Berry: The Lothian perinatal collaborative has done a lot of work recently to join up third sector organisations—in particular, Juno, CrossReach, Home-Start UK, Dads Rock, Fathers Network Scotland and a few others. If we have a more joined-up approach to communicating and working with the NHS, those mums and families who are currently falling through the service net will not fall through it quite so much.

Even before the pandemic, we noticed that the women we see at Juno were on very long NHS waiting lists not just for cognitive behavioural therapy or eye movement desensitisation and reprocessing treatment through the NHS, but to see other third-sector organisations that provide counselling. The waiting list to get one-to-one support from third sector organisations is about four or five months. For the NHS, it is much longer—it is up to a year at the moment.

We try not to have a waiting list, and we are able to see people when they come to us, but it is a difficult situation. I know that various NHS departments are working on recruiting more psychologists and counsellors, which I hope will plug the gap and enable the waiting lists to be not quite so long, but that is a real problem at the moment.

The more we can see people at the time when they need it, rather than making them wait and wait, the better. It is best to see people early, when their condition is much more treatable. If they have to wait, their condition get worse.

Make Birth Better is using our birth trauma group model as a best practice model, and it features in Make Birth Better's handbook that NHS midwives are using. We are trying to join up a bit more with the NHS to bring the model into the NHS, but, of course, that needs funding as well.

The Convener: Thank you. I now hand over to Sandesh Gulhane.

Sandesh Gulhane: That works quite well for me, convener, because my question is for Cat

Berry. You have talked about birth trauma. We went through a very difficult birth with my first child and the support really was not there. Although we all recognise that it is the woman who goes through birth trauma, the men and partners also suffer—I suffered—trauma through difficult births. What support is in place not only from your organisation, but from other health boards for the partners of women going through birth trauma?

Cat Berry: That is a really important question, because birth trauma can happen to partners and dads as well, but that is not really talked about or recognised. It is very traumatic when the person you love most is going through something absolutely horrific and, as a partner, you have no control over it and no way to help them.

It is important to say that it is possible to have a traumatic birth without it leading to PTSD if the right support is in place. It is also possible to have a textbook, totally normal birth and for it to lead to PTSD in the mother and the father or partner. However, a traumatic birth leads to PTSD if the right support is not in place. The really crucial point is that PTSD is preventable in those circumstances with the right support. At the moment, that support is not in place, which is why we are seeing a rise in PTSD.

I know that the third sector organisation Dads Rock, which already sets up groups for dads, has been looking at providing birth trauma groups. However, such groups do not require the straightforward peer support that Juno and Dads Rock are able to provide; they require professionals to facilitate them.

There is no specific NHS treatment for birth trauma. Kirsten Coull and Melanie Gunning are doing a lot of work behind the scenes to create a structure for that, and money has been put into providing more trauma-skilled workers, who are able to treat people on the NHS either one to one or in groups. However, that takes time, and for parents who are experiencing birth trauma and PTSD now, it is not coming soon enough.

I hope that that answers your question.

The Convener: I call Paul O’Kane.

Paul O’Kane: We have heard about the work that is being done and the huge support that is being provided by the third sector, and I am keen to hear your thoughts about the sustainability of third sector organisations. The perinatal and infant mental health fund, which was launched in May 2020, has provided £665,000 to support 16 organisations. Is that fund providing the sustainability that is needed, or do we need to go further and find other ways of mainlining that funding? I direct that to Clea Harmer, and to Cat Berry, if we have time.

Clea Harmer: The funding is undoubtedly appreciated by and helpful to the third sector. However, there is work to do if the sector is to be an acknowledged part of the referral pathways. I would simply highlight, especially with regard to bereaved parents, the National Bereavement Care Pathway, which is funded by the Scottish Government and which we lead on. The bit of the pathway in hospitals is funded really well, but when midwives, obstetricians and neonatologists try to refer people back into the community, they find that things start to go wrong, because the funding has not established the same structure in the community. If that could be more formalised, as it now is for the hospital element of the bereavement care pathway, and if there were a similar structure in the community, that would prevent parents and families from falling through the gaps.

At the moment, it is incredibly difficult to provide enough support and services for everybody. The geographical challenges, and the diversity and the different needs of the groups that we are trying to reach, mean that it is a struggle to be there for everyone in every part of Scotland. A commitment to funding the third sector to provide a safe and secure structure everywhere would be good for parents.

The Convener: I will come to Joanne Smith.

Joanne Smith: Thank you for the very helpful question. Prioritising investment in perinatal mental health has been hugely beneficial to third sector organisations, but it is worth saying that we are trying to achieve a really ambitious culture shift. That is a huge task that will require investing in and expanding the workforce across all tiers of the health sector and the third sector. I suppose that we need to start where we can have the biggest impact.

11:15

The third sector fund is a one-off fund. Funds like that cannot deliver the cultural shift that is required to integrate services and to move practice towards prevention. The Scottish Government has committed £500 million to a whole family wellbeing fund. That is an advance, but the funding is a one-off; it is not recurring.

There is an interesting commitment in the programme for government to redirect 5 per cent of the community health and social care budget towards preventative services. That could be an interesting way of embedding support for third sector services in universal funding streams, which would make those services more secure and would begin to build the integrated health and social care partnership that we in Scotland have long aspired to.

In its current form, the fund is not sufficient, especially after the pandemic has significantly increased need.

Cat Berry: I absolutely agree with Joanne Smith that prevention is important, particularly with regards to birth trauma. Third sector organisations can support the NHS in treating birth trauma. Unfortunately, third sector organisations that deal with birth trauma are spread out very patchily across Scotland. We have a tried and tested model, and we can work with the NHS to ensure that that model is followed, but the NHS should be providing that support.

Regarding the prevention of birth trauma, in 2019, one of my colleagues, Dr Jenny Patterson, wrote a paper called “Traumatised Midwives; Traumatised Women”. She found that the biggest cause of PTSD in birthing women was a lack of care from midwives, because midwives were so stretched. That has become worse during the pandemic.

We saw the march for midwives last month. We have heard awful stories about midwives being unable to look after their own basic human needs. They do not have time to go to the loo or to have a lunch break, and they are covering other people’s shifts. There are not enough staff. If those midwives cannot even look after their own needs, how are they meant to look after the needs of birthing people? The support that is needed for birthing people is not in place, and that is leading to a lot of PTSD.

The Convener: Emma Harper will delve further into the support for women who are vulnerable or at risk.

Emma Harper: The Mental Health Foundation recommends in its submission that

> “the development of perinatal mental health services be equality-proofed”

to reduce the social inequalities that may prevent pregnant and postnatal women from experiencing good mental health. Where do you think the gaps are in the delivery of perinatal mental health, especially in relation to at-risk or vulnerable women.

The Convener: Anyone who wants to start off should raise their hand or use the chat box to highlight that they want to come in.

Joanne Smith: That is a really important question. We do not understand enough about that issue. We have heard from others today that we do not have sufficiently disaggregated data about who is accessing our specialist services. We do not really know how inclusive and accessible the services are; we need to get better at that.

In my full-time role with NSPCC Scotland, we did an incremental health needs assessment in NHS Lanarkshire. There were some interesting findings about women accessing specialist perinatal mental health services. The areas with the lowest number of vulnerable pregnancies had the highest number of successful referrals to specialist services. Conversely, the areas with the highest number of vulnerable pregnancies had the fewest successful referrals to specialist services. The picture is complex, but it indicates that there is an inverse care law at play in perinatal mental health services.

It may be that social class or race could undermine a woman’s ability to access specialist support. I am sure that there is a range of reasons for that, but we wonder about the woman’s ability to describe her difficulties in a way that resonates with medical professionals, and about whether that increases the likelihood that that woman will be able to access specialist support. It is a complex issue.

I think that we professionals are guilty of assuming that, for a woman who is experiencing mental health difficulties alongside other adversities such as substance misuse or material deprivation, we will address the mental health issues if we remove those wider adversities. That is true in many cases. However, it is also true that women who experience disadvantage can have long-standing mental health difficulties that are further exacerbated by the arrival of a new baby. Those women deserve access to specialist mental health care but in many cases they do not receive it because their mental health difficulties co-exist alongside other adversities.

There is an issue with the accessibility of specialist services. Who is able to access specialist support, and why? That warrants more research to help us understand the local picture in Scotland.

Cat Berry: Two categories of at-risk and vulnerable women are being missed. The first is women who have a history of rape or sexual abuse. A birthing woman may not feel comfortable disclosing her sexual history to a midwife in front of her partner or husband. Childbirth should be a wonderful and joyful occasion of bringing new life into the world. We see women for whom the sensation of giving birth causes flashbacks to a previous rape. The cervix is pummelled during childbirth. I will not go into the issue because it is really depressing, but that really important aspect is not being addressed.

I wonder whether there could be a protocol under which midwives would ask those questions separately from the partner so that they are prepared and can provide adequate support, particularly when it comes to invasive examinations. Informed consent is also really important, because women who have been raped or sexually abused in the past might be retriggered by invasive examinations by staff without adequate informed consent for why they are performing them.

The other group of parents to consider are those who are going through miscarriage or stillbirth. I know that it has been publicised a little bit in the news, but the Scottish Government has promised to introduce specialist baby loss units for parents who are going through miscarriage and stillbirth. In reality, though, the NHS has said that the units will not be implemented until 2024.

I want to make this really clear: at the moment, parents who go to hospital in the knowledge that they will have a stillbirth or who have to get to hospital because they are going through miscarriage are told beforehand that, when they press the buzzer at the door, they will be greeted by a specialist bereavement midwife. That is not happening. They are actually pressing the buzzer to the maternity ward, and they are then greeted at the door by happy fathers with balloons saying, “Congratulations” or “Welcome to the world”. They have to run a gauntlet of balloons, teddies and all these things saying “Congratulations”. It is not fair; in fact, it is really inhumane for parents who are already going through the trauma of losing a baby to have to go through that added trauma. It is like putting salt on the wound.

People should not have to go through a stillbirth or miscarriage in a ward next door to parents giving birth to perfectly healthy babies. The problem is easy to solve, and I do not know why it is taking until 2024 to do so. It could be solved much earlier than that, and I ask the Scottish Government to please introduce the units earlier before more people suffer.

The Convener: Sandesh Gulhane wants to pick up on that point.

Sandesh Gulhane: I did my training at Glasgow royal infirmary, and I know from my time in the maternity and obstetrics unit that there is a separate area—a sort of closed unit—for mothers who experience stillbirth, to ensure that they do not see other people’s happiness. Would it be appropriate to roll out that kind of separate unit that sits a bit further away from the main ward?

Cat Berry: Absolutely. Dedicated baby loss units are vital, because parents who are going through the process of losing a baby should not have to do so in the same wards as parents having a normal healthy childbirth. There needs to be a separate entrance, for a start, but we need a completely separate baby loss unit for parents who are going through miscarriage and stillbirth. I am sure that Sands will have an opinion on the subject, too.

The Convener: I was just about to come to Clea Harmer.

Clea Harmer: Cat Berry has described the issues beautifully. That is what the national bereavement care pathway is about. Some hospitals already have bereavement suites and separate areas, and the idea was that the national bereavement care pathway would be rolled out throughout Scotland. That coincided with the start of the pandemic, and one problem during the pandemic has been that a lot of rooms have had to be redeployed and used in different ways.

11:30

It has been frustrating that the pathway has not been prioritised and put back on track. It makes an enormous difference to parents not only to have the space to give birth but to have the space to be with their baby, make memories and take the time that they need afterwards. That was very difficult during the pandemic. Compassionate care was difficult, because everyone was wearing personal protective equipment. A lot of good intentions and plans were put on hold. It is really important that, instead of being seen as extras and nice to have, those plans are prioritised as part of getting back to normal.

To go back to an earlier question, I want to say something about the gaps in services. In one sense, you can say that any parent whose baby has died is vulnerable but, as I am sure you know, the groups that are at high risk are those that are classed as vulnerable, such as those in deprived areas. We know that domestic abuse is associated with increased risk of miscarriage and stillbirth. As I am sure the committee heard from MBRRACE earlier, certain groups—black babies and Asian babies—are, shockingly, also much more likely to die.

The fact that all those groups find it difficult to access support, particularly after the death of a baby, combines with the fact that there is very little understanding of what support is needed after a baby has died. That is despite the number of people who are affected. One in four pregnancies ends in miscarriage and 14 babies die every day in the UK. It is a massive hidden problem.

We have quotes from parents who have been told that their thoughts were “unhelpful” and that they needed “to get over it.” Some were told that they had

> “not lost a loved one.”

Some were told to come back to the hospital where their baby had died to seek psychological support. Others had to wait a long time for support. One mother said:

> "I walked out of hospital and no one ever contacted me! Only a letter from the GP with congratulations and dates to bring my deceased baby for jabs and check-ups. I called for some counselling but was told I'd have to wait 6 months. I got no support."

Endlessly, there are gaps for bereaved parents, because they are invisible a lot of the time. Those who are in groups that are more at risk are also invisible, so it is a kind of double issue. There are massive gaps for those poor parents, which need to be filled.

The Convener: While you were talking, it occurred to me that one of my colleagues, Angela Crawley MP, is campaigning for paid miscarriage leave. I assume that Sands fully supports that.

Clea Harmer: Absolutely. We are supporting Angela Crawley and working with her on that. The very least that we can do as a society is to give parents that space. You never get over the death of a baby or the loss of a pregnancy, but it is crucial to be given the time and space that you need to start on that journey. It is so important that society holds those parents, at a time when they need to be held more than any other. We are 100 per cent behind what Angela Crawley is doing.

Dr Challacombe: We need to understand more about the inequalities, and the groups where special consideration is needed in terms of the buildings, what help is available and how that is presented. I want to emphasise the importance of embedding experts by experience and service users in the design of any services and training, and of that being an on-going dynamic process.

The Convener: We have specific questions on training, but Emma Harper has a supplementary question before we move on to that.

Emma Harper: It is distressing to hear about what is happening in relation to access for support to deal with bereavement and stillbirth. I had a thought about new Scots who come here and end up going through NHS Scotland. What work is being done, or needs to be done, to support new Scots whose first language is not English and who have babies in our country?

The Convener: Crucially, they are without family networks as well.

Emma Harper: Yes—without family networks to support them.

The Convener: Do any of our colleagues want to come in on that? Shall we go to Joanne Smith first?

Joanne Smith: I do not know if I am best placed to answer that. I will just reflect on the barriers to access—we need to do a lot more work on those. I acknowledge that the programme board is making efforts to understand equality and diversity in service design, through the creation of an evaluability and equalities framework. That work has not progressed at the pace that we would have liked, but that is not surprising, given Covid and a global pandemic.

There are huge issues in our national care service with the services not necessarily meeting the needs of the women who would most benefit from them. A range of third sector groups such as the Amma Birth Companions project, which you may have heard from, are doing important work to break down some of the barriers and ensure that women can access local pathways to care. However, the reality is that large groups of women will not be able to access special support, because help-seeking behaviour and self-care are learned behaviours.

We cannot just assume that people are able to access the support. If the referral pathway starts with the GP, for example, we assume that people are seeking help from the GP or would proactively contact their local practitioner, but we know that very often that is not the case, especially in more marginalised groups. Therefore, we need reach-out services and the step up, step down services to support families and bridge the gap to the community support that we currently offer and also help them to tap into the specialist care.

Fiona Challacombe raises an important point. We are expanding our specialist capacity, which is a significant advance, but we cannot currently be confident that the expansion will benefit the women who are in greatest need and managing the most complex range of traumas. We have ambitions to get better at that, but it has not been prioritised. We certainly need to do a lot more in that area.

Clea Harmer: I want to flag up the importance of translators. It is often highly inappropriate, if a baby has died, for a family member or a member of the community to be involved. We have a lot of instances where children have to be the translator and tell their mother that the baby has died, which is clearly totally inappropriate. There are also instances in which the community may have a different perception of either mental health illnesses or baby death, so the community member is not the right person to translate and support the mother.

It is crucial to have a supportive translator who understands the issues—either baby death or perinatal mental health issues—and can not only translate but support the mother in a person-centred way. It is agonising to see children having to act as translators. There can sometimes be community norms or the community might expect mothers or parents to respond in ways that are not always helpful.

Cat Berry: I echo that point about the need for translators. The cultural changes that new Scots face make it more important than ever to provide easy access to those services. In an ideal world, we would have a 24-hour helpline, run by the NHS, that parents could call, and it would not cost them anything. There would be a translator if necessary and parents could report any concerns, such as their baby not sleeping. They could report smaller things before they build up into bigger ones, because social services get involved in bigger things. As people's health conditions get worse, they become more afraid that their baby might be taken away. That is compounded for people who speak a different language.

We need something from the ground upwards. It should be acceptable for all parents to ask for help for even the smallest things. Parents who are new Scots do not necessarily have their aunts, uncles and grandparents around them. They do not have that free childcare. They need an extra layer of support so that they can ask those questions. Someone who is having a baby for the first time is not necessarily taught how to look after it. There should be a simple phone line for people to ask questions before their issues turn into bigger problems. I know that that would cost money, but it is something to think about.

The Convener: We are going to delve into workforce training.

Stephanie Callaghan: A lot of women find that breastfeeding has a huge impact on their mental health. There is a need for support so that women can make informed choices about their individual circumstances. A skilled hands-on approach is important, with the right support from health professionals. What workforce training is needed to provide the practical support that women need with breastfeeding?

The Convener: Please raise your hand if you want to come in on that. The issue has been flagged up to us. We have heard that infant feeding can be a trigger for mental health issues if support is not there. Joanne Smith, can we come to you first?

Joanne Smith: I do not lead on that area. To be honest, I am not well placed to answer that question. We are a membership organisation. I will defer to someone else.

The Convener: That is fine. Cat Berry would like to come in.

11:45

Cat Berry: From our volunteers who are seeing women every week, we hear about the disjoint between the narrative that "breast is best" and that formula feeding is not quite as good, and the fact that the right support is not really there for breastfeeding.

Breastfeeding is not easy, particularly if your child has tongue-tie—in fact, it is not easy even in the easiest of circumstances. There definitely needs to be more support for it, but the narrative also needs to be slightly changed. Is it not the case that "fed is best"? As long as your baby is fed and thriving, does it actually matter how that happens? There is so much judgment and shaming around the issue. Is it not more important to look after the mother's welfare so that she can choose whether to breast or bottle feed?

Dr Challacombe: I second those comments. It is a very emotive issue for most parents, and whatever ideals or wishes might be involved, parents need to be supported in their situation. For many of us, the matter might not fall directly within our remit, but we certainly see the consequences, with women feeling very guilty about making this or that choice, particularly where there might also be interaction with medication issues. If we had non-stigmatising education and support from professionals and other services that are in contact with women, that would help women to make the best decision for the situation that they are in, be it breastfeeding, bottle feeding or a combination of the two. We need to support women in what can be a difficult and a physically and emotionally exhausting issue.

The Convener: Stephanie, do you have another question?

Stephanie Callaghan: No, but I want to thank the panel for those answers. I realise that none of the witnesses necessarily has particular expertise in the area.

I absolutely agree that a happy mum means a happy baby, and supporting mums in making the right choices for their circumstances must be right at the top of the list. However, I want to point out that there is huge evidence of the benefits of breastfeeding not just for babies but right through to adulthood.

Gillian Mackay: What role could health visitors and midwives play in prevention and in proactively identifying people who are at risk of developing perinatal mental health problems? Do they have the training that they need in that respect? Perhaps we can hear from Cat Berry first.

The Convener: Joanne Smith would like to come in, too, so we will hear from her first, if that is okay.

Joanne Smith: The upskilling of the primary care workforce is a really critical first step in building and embedding these specialist services locally, and training not just for health visitors but for GPs, midwives and maternity staff can assist with early identification of these issues. It is critical that we have that local specialism. Because of the universality of these services, appropriate and timely referrals can be secured and admissions for in-patient care—and, to be frank, maternal deaths—can be reduced. We really need to prioritise the training of primary care staff in our training plans.

Our ambitions in Scotland are incredible and far reaching, but we need to cut our cloth accordingly and think about where we can make the biggest impact. Getting primary care and local specialism right could drive up standards across the pathways, so it is important to prioritise that.

There is good work under way, with great efforts to develop online modules, but everyone agrees that that is not happening at the scale or pace recommended by the "Delivering Effective Services" report. We must expand the workforce across all the tiers and invest in the right level of specialism within the workforce. That is critical to stripping out the demand for crisis-led services and preventing the year-on-year toll of maternal suicide that we see in the MBRRACE report.

Cat Berry: Midwives, GPs and health visitors have a massive role in the prevention of those conditions and in identifying them when they come up.

This is important. One thing that happened during the pandemic was that antenatal classes were cut and went online. Antenatal classes are important in educating parents about what is going to happen, and they can be used to prevent birth trauma. Much as we love the National Childbirth Trust, it has a certain agenda for antenatal classes, with vaginal birth and breastfeeding being thought best.

It is important that the NHS is able to provide antenatal classes, too, so that parents are shown the hospital environment and are given all the different scenarios that might come up. A woman might have a vaginal birth, but complications do sometimes happen. She might need forceps or an emergency caesarean section. Forewarned is forearmed in all situations. If someone is not prepared for a situation, that can lead to trauma, and antenatal classes have a role in preventing birth trauma.

Preventative measures can also be in place during the birth. That can include having enough staff on duty at the time or enough staff who are trained in how to pick up on certain vulnerabilities or to spot women or men who are more at risk. I mentioned Dr Jenny Patterson's report "Traumatised Midwives; Traumatised Women". If the basic human needs of midwives are not being adequately supported, how can they possibly support birthing parents? That can have a massive impact on perinatal mental health conditions.

Someone should come in straight after the birth to ask how it went and how the mum or dad is doing, but that is not really happening at the moment. Someone asks whether baby is all right or whether baby is thriving. A lot of women who have just given birth tell me that, while they are pregnant, they are wrapped in cotton wool. Then, as soon as they have the baby, it is suddenly all about the baby and not about the mum. Suddenly, all the focus is on the baby.

Before the pandemic, the six-week check-ups by GPs were already not really happening properly, and they have not been happening during the pandemic. GPs are so squeezed at the moment that, when the six-week check-ups do happen, they tend to be all about the baby and not about the mum. Questions such as, "How is your birth injury doing?", "How did the birth go?" and "How is your mental health?" are not being asked at the moment, although they should be asked.

Health visitors, too, are short staffed at the moment. We are hearing from a lot of women who attend Juno groups that, when they phone the health visitor, the health visitor is not getting back to them. When they do get back to them, the women are being given a maximum of five or 10 minutes, and it is generally all about the baby. Women are not being given adequate time for questions such as, "How are you, mum?" to be asked and for them to answer. Unfortunately, it comes down to the same thing. It is a shortage of staff and people not being adequately trained in perinatal mental health.

Dr Challacombe: I have a point to add through a perinatal OCD lens, which is that health visitors have a crucial role to play in many areas but particularly in that area. We know from the background literature that the postnatal period, particularly around six to eight weeks, is when the prevalence of mental health issues—lots of intrusive thoughts, for example—is really high. There is an opportunity there for lots of normalising information. The role of the health visitor is key—it is a non-stigmatising service. Someone might go there to check out something about their baby but the health visitor can have eyes on the mum as well, before they get to the point at which mental health services need to be engaged, with all that that entails. Health visitors, as a profession, need as much support as we can give them, because they are so well placed to offer appropriate normalising or signposting where it is needed.

Clea Harmer: There are some areas in which additional training might be helpful. For example, healthcare professionals could be trained to identify the difference between someone who is grieving and someone who has gone beyond grief and needs further specialist help. Grief is a very natural response to the isolating bereavement when your baby dies, but there is a point at which you may need more specialist help. That is often missed—it is easier to think, "Ah well, it's normal to be sad, so we're not going to provide any more help." That kind of training would be really important.

I suggest wider training for all healthcare professionals in how to offer bereavement care after pregnancy loss and baby death. Although midwives and special bereavement midwives are brilliant at it, families often come in through accident and emergency, gynaecology wards or the community, and the care that they get there is not compassionate or good enough.

Another area is those who are pregnant after loss, which is a particularly difficult time. Again, it would be really helpful if health visitors, who often support mothers who are pregnant or who have a new baby after loss, were able to understand the anxiety—literally from minute to minute and from day to day—that mothers have about their baby.

Finally, going back to an earlier conversation, I suggest there should be training in looking out for the needs of men—fathers and partners—because men are often unable to acknowledge their feelings after a baby has died. They feel that they have to be the strong one and that they should not need to seek support. In a survey that we did a couple of years ago, 62 per cent of men reported feeling suicidal because they were unable to say how devastated they felt and that they needed support. In those four areas, training would be really useful.

The Convener: Thank you. That is very helpful. We will move on to talk about particular challenges due to the pandemic.

12:00

Evelyn Tweed: Good afternoon, panel. We are in a really difficult period just now, with the pandemic, and we have heard a lot of evidence about how it has affected women. Have there been significant regional variations in the return to face-to-face services? As we move forward, dealing with new variants and so on, how can we provide the most effective service, whether it be virtual or face to face? I would like to direct that question to Cat Berry.

Cat Berry: I might not be the right person to answer it. As Juno is very much based in Edinburgh, I can speak only for that area. I can say that, even in Edinburgh, the return of face-to-face services has been patchy, but someone else might be better placed to answer that question.

Joanne Smith: As a membership organisation, Maternal Mental Health Scotland has a geographical spread across the country, and, in the early stages of lockdown, we surveyed local perinatal mental health teams as well as women's and peer support groups to gauge how well national policy was being implemented locally and how it was being experienced by women. It is fair to say that, initially, there was a buffer, with perinatal mental health services being prioritised by the Scottish Government and therefore protected from some of the worst effects that we have seen in the workforce in England and elsewhere.

However, although there was prioritisation in policy terms, local implementation was unsurprisingly variable, with some areas able to make a smooth transition to online support and to deliver their contacts virtually more or less to the same level of quality. However, we have heard from women that, in other areas, contacts were as limited as a text message. Although that would still be recorded as a contact, it does not provide any meaningful support to women.

That sort of variability exists. We need to go beyond what the data are telling us has happened during the pandemic, because the transition to online support has been experienced in a variable way by women in different parts of the country. The offer of such support is irresistible in many ways to professionals, some women and local budget holders, and it works in some areas, but in many areas it is not sufficient, particularly when there are child protection concerns. Staff such as health visitors are critical in the front-line identification and surveillance of vulnerable families and children, and some of that richness of insight has been lost with the move online.

That said, it is becoming a significant part of the health offer to women. My plea, therefore, is that any decisions about moving online be based on the best available evidence.

Clea Harmer: The pandemic has obviously affected the way in which bereavement care is offered, which, in turn, affects people's perinatal mental health. One of the things that we have heard most, both from those who have been affected by baby death during the pandemic and from those who have become pregnant after loss, is that partners have not been able to attend appointments and scans. That has caused enormous stress, and we have picked up quite a lot of mental health issues off the back of it.

The Government has encouraged all health boards to allow partners back into rooms, but that encouragement has been implemented in very different ways in different boards. We have heard that, in some areas, partners have been welcomed back in, whereas, in others, that sort of thing is still not easy to achieve. It makes a big difference if you hear the news that your baby has died on your own or if you have to attend appointments on your own. I just wanted to flag up the fact that the situation feels very variable. Obviously, though, staff are incredibly stretched, and it depends on the state of the health board as well as on what kind of rooms they have available.

The Convener: Thank you. We will move on to a question from David Torrance about access to services. David, I know that you have been having problems with your internet, but I hope that it will hold up.

David Torrance (Kirkcaldy) (SNP): Thank you, convener. Good afternoon, panel members. We have heard about variations in local services, but “Delivering Effective Services” acknowledges the issue of timescales for perinatal mental health services. Are the current timescales adequate? That question is for Joanne Smith.

Joanne Smith: The situation is variable across the country. I think that it is recognised that the current definition—from pre-birth to 12 months—is not sufficient, because mental health difficulties can arise at any time around the birth of a baby. My understanding is that the timescales are being reviewed and that the divergence across health boards is going to be reduced.

Timely and appropriate care is absolutely critical. Getting it right in the early years is well recognised as being the most efficient and cost-effective way of smoothing out problems across the life course. A wealth of policy in Scotland recognises that, so we have very strong foundations to build on, but there are significant issues around our ability to adhere to timescales that have been exacerbated by the pandemic. We have long-standing issues around recruitment and retention, which you have heard about in relation to the universal services workforce. Those have been exacerbated by both Covid and Brexit putting an undue strain on universal services. So, although there have been advances and although specific timescales have been introduced around these newly created special services, there is a risk that that fragile progress will be swept away by the demands that we are seeing for our statutory and universal services.

Timescales are important, but they do not exist in a vacuum. We have to think about the ability of our universal services to intervene at appropriate and timely points and to provide appropriate and timely care. Otherwise, our advances in specialist care and the timescales that are closely related to it will not have the impact that we hope to see.

The Convener: David, are you happy to leave it there so that we can move on to other members’ questions, or do you want to come back in?

David Torrance: I have one more question and it is for Clea Harmer. What impact has the national bereavement care pathway Scotland project had so far on increasing bereavement care and reducing local and national inequalities?

Clea Harmer: The idea was to implement the pathway initially in three pilot areas that would become early adopters. Those areas made a very good start, but they had only a couple of months before going into lockdown and the pandemic. The survey feedback that we were already receiving then and which we have continued to receive, from both healthcare professionals and parents, shows that the experience of bereavement care was greatly increased.

Because of the pandemic, we are moving from using pilot areas to encouraging all health boards to consider implementing as many of the nine bereavement care standards that are part of the pathway as they can. If we wait and continue to use pilot areas as we go in and out of different waves of pandemic, parents outside those areas will not get the benefit that we can see that parents in the pilot areas have had. It clearly makes a difference. The issues around workforce numbers and the space or room, all of which have been affected by the pandemic, are very real. We have spent much of the past six months or so supporting staff for whom it is very traumatising if they cannot provide the care to a bereaved parent that they want to provide.

The pandemic has had a terrible effect on lots of people, but holding on to those nine standards and doing the best that you can with them all has started to make a difference for parents in Scotland.

The Convener: This is a good opportunity for me to ask a question that my colleague Sue Webber wanted to ask. Poor Sue has completely lost her voice, but I will be her voice today. Sue wanted to ask Clea Harmer whether it is normal practice in Scotland to have a symbol, such as a butterfly symbol, on the file of mothers who have had previous baby loss. Is that happening throughout Scotland?

Clea Harmer: You are absolutely right—in fact, it is a Sands teardrop that goes on the notes, which indicates that there has been a previous baby death or pregnancy loss. That means that the parent does not need to tell their story again and again.

The butterflies are important for twin loss. In cases in which one twin lives and one dies, the butterfly is used on the cot to show anyone who comes up and sees the beautiful baby that there was another baby who died. The butterfly is incredibly important, because there are so many difficulties with the joy and grief of one baby living and one baby dying.

We are experiencing some challenges with electronic records, and we trying to work with BadgerNet and the various other electronic systems so that there can be a red flag. That does not seem to be working as well across the board, so we are carrying on pushing it through. The flag needs to be there before you even say the first thing to a parent, so that the tone and the approach of the conversations with parents are right.

The Convener: Thank you for clarifying. Our final questions are from Stephanie Callaghan on public awareness of the services that the third sector groups provide.

Stephanie Callaghan: What gaps exist in the information that is provided by NHS Scotland and the Scottish Government on perinatal mental health? I am not sure who wants to come in on that question.

The Convener: Perhaps the witnesses could raise their hand if they want to come in, and I will look at the chat box to see whether anyone wants to follow up. I do not want to put anyone on the spot—volunteers are always better.

Clea Harmer: Signposting is clearly important, but it is confusing at the moment. If you were looking for the right support, for which a lot of people go online, whether after baby death or just for perinatal mental health support—[*Inaudible*.]—if you are not feeling like going through lots of information any way. There is a key role for midwives and health visitors to help with accurate signposting. Otherwise, it feels as though you are battling yourself to try to find whatever available support is right for you. The kindest thing that we can do is to help people find the information that they need. Upskilling midwives and health visitors so that they can signpost correctly would be enormously helpful.

12:15

Joanne Smith: I think that we are quite good at providing information on perinatal mental health. When the pandemic hit, the programme board set up a virtual rapid response hub to ensure that women had timely and appropriate information and that they were being signposted to the available services.

Although we are very good at providing information, the difficulty is that we have insufficient levels of service on the ground. The perinatal and antenatal health fund that was made available to the third sector is providing support in eight of the 13 health boards. There remain large parts of Scotland where women cannot access specialist support. I am sure that you have heard a lot about the fact that people in the north-east are particularly disadvantaged, for example. We hear harrowing stories about women who need to access specialist care but are unable to do so because it is hundreds of miles away, and they have other children and financial barriers, and they do not have social support.

We also hear about fathers camping in tents near mother and baby units, because they are hundreds of miles from their home and they do not have the money to do anything else. We have the family support fund, but there are questions about the equity of it, as it is £500 and, if someone lives hundreds of miles away, their expenses to stay in or around the mother and baby unit are significant.

As I say, we are quite good at information. It is always helpful to have it there, and we appreciate the effort that is being made to provide it. What is important, however, is to have services to refer women on to at what is a critical life stage.

The Convener: As you were speaking there, I was thinking about people in island communities, who have an added issue. We do not have any island representatives here.

Cat Berry: I echo the point about island communities, as the third sector organisations are not there. A lot of the work that we do in Edinburgh is signposting. We have a long list of local—[*Interruption*.] Sorry—that is my cat making a noise in the background.

The Convener: Cat’s cat!

Cat Berry: Yes—the other cat.

We have a long list of local and national services on our website to signpost people to. However, even that is patchy, because funding comes and goes, and it is a job to keep the list up to date. Within the NHS there could be a good opportunity for health visitors—[*Interruption*.] Sorry—the cat. Health visitors could impart a lot of that information. Nationally, the information could be kept up to date somewhere, I suppose. I know that various organisations such as Health in Mind are trying to keep things up to date, and I wonder whether there could be some collaboration with the NHS on that—I do not know.

Stephanie Callaghan: Thank you for those answers, and I will follow on from that. When I was speaking to women, I found that the third sector services that they got were excellent, and they were a massive help and support to them. The biggest issue that they seemed to have was that that support came a bit too late and a bit too far down the line. That seemed to be down to the information and guidance. The health professionals did not necessarily know about the local organisations that were best placed to help the women.

The women also made a point about some of the literature that they get, which has terminology that is outdated or a bit insensitive; it talks about “baby blues” and so on, which made them less likely to seek help, as they felt that that undermined how they were feeling.

How can third sector and NHS services be improved from that point of view, so that we get mums to the people who can offer the best support as quickly as possible? Maybe the national virtual hub is the way forward, as was said earlier.

The Convener: As that is the last question, I would like to hear everyone’s thoughts on the subject.

Joanne Smith: I think that that gets to the heart of the issue. Individual women have very distinct needs and it is important that we have a suite of services that can support women, families and babies in a way that meets their requirements.

Terminology is an issue. In Scotland, we have aspired to create a multi-agency approach to supporting families, which is absolutely the right thing to do, but it is complicated. We must begin to break down some of the professional barriers between health and social care, and to create space for meaningful collaboration and meaningful integration so that women experience a seamless service response rather than not feeling at home in any one of the services that are offered. If our services are not meeting the needs of women, they are not fit for purpose.

The collaboration that we aspire to bring about will not happen on its own. We need to incentivise that, perhaps through the use of shared budgets. Multi-agency training is also helpful in that respect, and in some areas, co-location of services might be appropriate to ensure that women get the wraparound care that they need and deserve.

The NSPCC in Scotland has developed an integrated multi-agency infant mental health service, which is provided by seconded NHS staff, social work staff and third sector staff. That has been tested for 10 years in Glasgow through a randomised controlled trial. We await the publication of the findings of that in the next two years.

That is an exciting example of how meaningful multi-agency services can work in practice. It is necessary to create the space for different professional groups to develop a shared language and a shared culture, and to operate using the same thresholds and terminology, which is an issue that you mentioned.

It is complicated work, but there are great examples of it happening throughout Scotland. I refer you to the work of the infant mental health implementation and advisory group. There is real ambition to create specialist systems around families rather than any one type of care. We need to look at the best available evidence and be ambitious in our ask to create local specialist systems that offer the best possible support to families, because we know that the return on the investment is massive.

Dr Challacombe: To come back to the basics, the maternity experience is a time when women and families are in contact with services. It is also a time of increased risk and prevalence of a wide range of mental health problems. In that respect, it represents a huge opportunity, because we know that a huge percentage of women and partners will experience difficulties. Information needs to be provided and the wheels need to start turning at a very early stage. There is a great opportunity for prevention and early intervention, which, as has been said, makes such a difference. It is crucial that information about what services are available locally is available right from the get-go and is kept updated. All the thinking that is being done today will feed into that.

Clea Harmer: I think that the hub idea is fantastic, because there needs to be a central place where everything is so that healthcare professionals and parents and families can find it easily.

There is also something about knowing what is happening in the very local area. Alongside a national hub, there needs to be a way of sharing what is happening on the ground—in particular, in some of the Highlands and Islands communities. We have groups in Shetland and various other islands. I was talking with one of them yesterday about how distressed its members are that people still do not know that they are there, offering face-to-face support, on the islands. Healthcare professionals need to know what is happening and what is available in their patch, very locally, as well as having the bigger picture across Scotland.

Cat Berry: Early intervention is key. Some mental health difficulties are preventable; that requires changes win the NHS—more trained staff and a more joined-up approach between departments and between the NHS and the third sector organisations.

Another thing, which came up at a birth trauma working group that I was at recently with third sector organisations and the NHS, is that birthing people can, up to a point, forgive the NHS for being short staffed, but at the end of the day, when someone is going through a very traumatic thing, they need people to be kind to them. The people around them who are stressed and not able to look after their own basic needs will tend to take things out on others. Kindness costs nothing. Dr Jenny Patterson and Make Birth Better talked in their reports about kindness and compassion. Those are key, as well as employing more trained staff.

The Convener: I thank you all so much for your time and for the help that you have given us in looking at the issues from your perspectives. That is the end of that session and of our meeting.

At our next meeting, on 14 December, the committee will take further evidence on perinatal mental health and will undertake stage 2 proceedings on the Transvaginal Mesh Removal (Cost Reimbursement) (Scotland) Bill.

That concludes the public part of our meeting.

12:28

Meeting continued in private until 12:47.

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