Health, Social Care and Sport Committee

14th Meeting, 2021 (Session 6), Tuesday, 7 December 2021

Inquiry on perinatal mental health

Introduction

1. At its meeting today, the Health, Social Care and Sport Committee will take evidence from two panels of stakeholders as part of its inquiry into perinatal mental health.

Background

2. At its work programme discussion on 5 October 2021, the Health, Social Care and Sport Committee agreed to hold a short inquiry into perinatal mental health.

3. The Committee subsequently agreed that the aim of the inquiry would be to explore the key issues facing new mothers during pregnancy and following the birth of a child that can impact mental health. It will consider aspects such as new mother care, breastfeeding support and specialist training. It will also consider the mental health impacts of bereavement from miscarriage and the death of an infant.

4. The inquiry will also explore opportunities to improve and increase access to perinatal mental health services in Scotland over the next five years and make recommendations for the Scottish Government to help support new parents with their mental health.

Structure of the inquiry

5. The Committee issued a call for evidence on 2 November 2021 which closed on 24 November 2021. The Committee received 103 responses which can be read here: Perinatal Mental Health Inquiry - Scottish Parliament - Citizen Space

6. The Committee's inquiry consists of four sessions in December 2021:

6 December 2021	Private informal engagement event with parents.
7 December 2021	Panel 1: Evidence session with professional organisations and academics. Panel 2: Evidence session with third sector support organisations.

14 December 2021	Evidence session with the Minister for Mental Wellbeing and Social Care and the Chair of the Perinatal and Infant Mental Health Programme Board.

7. The representative from Maternal OCD is only able to attend panel 2 for part of the sessions and has therefore provided additional written evidence in advance. This is attached at Annexe A. The Mental Welfare Commission for Scotland submitted a late response to the Committee's consultation and this has been attached at Annexe B.

Clerks to the Committee

2 December 2021

Annexe A

Maternal OCD

What is Perinatal OCD?

Obsessive Compulsive Disorder is an anxiety disorder characterised by:
a) recurrent, unwelcome thoughts, images, ideas, (obsessions)
b) related behavioural or mental acts (compulsive rituals) to suppress or neutralise the distress or prevent a feared outcome
c) significant functional impairment in a number of domains

Perinatal OCD is OCD during pregnancy and in the postnatal year, with obsessions usually (but not always) revolving around significant fear of harm coming to the infant, with worries frequently focused on accidentally or deliberately harming the child or the child becoming ill. It is important to note that the occasional experience of all of these worries is absolutely normal and indeed very common in mums and mums to be.

How prevalent is perinatal OCD?

Nichole Fairbrother et al recently published a robust study titled 'High Prevalence and Incidence of Obsessive-Compulsive Disorder Among Women Across Pregnancy and the Postpartum' which demonstrated a high prevalence of perinatal OCD - **7% across the whole perinatal period**. This paper was pre-pandemic, so it is likely that even more women are having a hard time.

How can the workforce be supported to provide for women impacted by perinatal OCD

- The British Journal of General Practice produced an article and letter about Perinatal OCD which arose from the lack of understanding by professionals and the consequences of this. There is a clear need for training in recognition and effective treatment of the problem
- Please see here an Article by Dr Fiona Challacombe: '*A hidden problem: consequences of the misdiagnosis of perinatal obsessive compulsive disorder'* which also demonstrates a need for training and support for the workforce.
- Studies show that Cognitive Behaviour Therapy (CBT) works well (Challacombe et al, 2017) and should be accessible for women to support their recovery – effective signposting is vital
- Watch Maternal OCD patron Dr Fiona Challacombe and Maternal OCD Co-founder Maria Bavetta who ran a Facebook live session

How to manage risk and perinatal OCD

- People with OCD do not act on their intrusive thoughts of deliberate harm.
- Veale et al (2009) wrote a Risk Assessment and Management in OCD paper extracts below:

- “A person with OCD can be harmed by an incorrect or unduly lengthy risk assessment, responding with increased doubts and fears about the implications of their intrusive thoughts.”
- “At best this will lead to greater distress, avoidance and compulsive behaviours, and mistrust of health professionals; at worst, to complete decompensation of the patient or break up of the family”

Maternal Mental Health Alliance (MMHA) Make All Care Count Campaign

Maternal OCD is a proud member of the MMHA and supports the Make All Care Count Campaign calling for all women and families across the UK to have equitable access to comprehensive, high-quality PMH care, including and beyond specialist services.

Overall to note:

- There are no cases of a mum with perinatal OCD harming her baby
- Prevalence is high (7%) but diagnosis is low, so women are falling through the gaps
- CBT is an effective course of treatment & recovery is possible for women with perinatal OCD.

Annexe B

Mental Welfare Commission for Scotland

Information about your organisation

The Mental Welfare Commission for Scotland (the Commission) was originally set up in 1960 under the Mental Health Act and our current powers and duties are set out under the Mental Health (Care and Treatment) Act (2003) and the Adults with Incapacity Act (2000). We carry out our statutory duties by focusing on five main areas of work: visiting people, monitoring the Acts, investigations, providing information and advice, and influencing and challenging.

The Commission's work in relation to perinatal mental health care is primarily in two areas: visiting and, more recently, monitoring. The focus of our work in both areas is on the women who experience severe mental ill health during the perinatal period and who may require care and treatment in hospital, whether informally or under the Mental Health Act. However this requires us to be aware of the context of available care in the community setting and staffing for this.

Mental Health law in Scotland makes provision for mothers with a baby under 12 months old who require inpatient treatment for mental illness to be admitted with their baby if they wish, where this is in the best interests of both mother and infant. Section 24 of the Mental Health (Care and Treatment) (Scotland) Act 2003, 'Services and Accommodation for Mothers' , sets out the legal duties of Health Boards to make this provision for mothers. This legal requirement was broadened in the 2015 Act to reflect that it was not just mothers with post-natal depression who should be afforded this provision but also those with mental illness, personality disorder and/or learning disability

In Scotland there are two regional mental health Mother and Baby Units (MBUs). These specialist six-bed units are based in Glasgow and Livingston.

When the Mental Welfare Commission carried out a national perinatal themed visit in 2015, we found that, during a three month survey, over one third of women (36%, 16 of 44) who were admitted postnatally for mental health care did not receive care with their baby in a specialist MBU, instead receiving this in general adult psychiatry (non-specialist) settings. We found that some women were separated from their baby for prolonged periods. Annual admission data from the MBUs also showed considerable variation in admission rates between health boards.

Perinatal Mental Health Network Scotland (PMHNS), established in early 2017, carried out a national needs assessment exercise during 2017/2018. Their report 'Delivering Effective Services: Needs Assessment and Service Recommendations for Specialist and Universal Perinatal Mental Health Services', published in March 2019, highlighted ongoing geographical variations in access to MBU care. It also confirmed that two NHS boards continued to have no formal arrangement for admitting to one or other MBU.
Confidential enquiries into maternal deaths in the UK continue to highlight the risks of perinatal mental illness and the need for careful risk assessment and specialist

support. Maternal suicide remains the leading cause of death during the first year after pregnancy[1].

PMHNS and the Commission worked to improve the monitoring of perinatal admissions, with the aim of identifying current barriers to MBU care, informing national service development and improving women's access to inpatient perinatal mental health care, wherever they live in Scotland. Progress and challenges in this area are highlighted in the following section.

Q1. How can the Scottish Government improve perinatal mental health services in Scotland, both in the short term and over the next five years?

The Commission welcomes the significant progress made by the Perinatal Mental Health Network and, more recently, the Perinatal and Infant Mental Health Programme Board in improving perinatal mental health services in Scotland. Much of this work and service development has continued despite the challenges of the pandemic.

In our contact with the MBUs we are continuing to hear how this progress and investment is making a difference on the ground. Additional funding to MBUs has enabled increases both in staff numbers and in the breadth of professional expertise available in both units. Examples of this include: increased numbers of mental health nurses and nursery nurses; increased access to psychology, nurse therapy, occupational therapy and social work support. We have also heard of innovative plans to employ the first peer support worker and parent-infant therapist in one of the MBUs.

There do however continue to be challenges, including recruitment (a continued area of concern the Commission is aware of across mental health services in Scotland) and access to specialist perinatal services for women living in remote and rural areas.

There are three specific areas for improvement we would wish to highlight in relation to the Commission's perinatal work:

1) Improving perinatal admission data

   Short term

   Whilst annual MBU admission data is collected by both Mother and Baby Units, it is difficult to establish the number of women who are admitted to general adult mental health wards each year and are not transferred to an MBU. Information is held separately on maternity and mental health datasets, and is not routinely combined to provide these answers.

   The Perinatal Mental Health Network submitted a research proposal to the Public Benefit Privacy Panel for the routine collection of these data-sets going forward to enable an accurate assessment of gaps i.e., the proportion of mothers admitted without their baby. We understand that this application is currently delayed. The Commission are cited on this application.

[1] MBRRACE-UK_Maternal_Report_2021_-_Lay_Summary_v10.pdf (ox.ac.uk)

Until we have accurate national data, we cannot know the full extent of current unmet need. Currently it is not possible to know whether women living in certain areas are disadvantaged in relation to MBU access. We know that there continues to be a significant variation in admission rates to the MBUs from across NHS boards (when compared with birth data), but we do not know if women from these NHS boards are being admitted to local inpatient services for perinatal mental health care, or are not being admitted at all. Additional factors which may contribute to these inequities, such as economic deprivation, may also be impacting on access.

Once approved and underway, this work will enable comprehensive data to be collated by the PMHN and future monitoring to be carried out with a high degree of accuracy.

2) Equity of access to MBU care

Following discussions with PMHNS, the Commission undertook a period of national perinatal admission monitoring between April 2019 – March 2021. The aim was to provide further information about women who were being admitted to general adult acute wards for mental health care in the year following childbirth and were not receiving specialist inpatient care with their baby in an MBU. The aim was to carry out this monitoring while longer term plans for future monitoring were undertaken by the network as above.

During this 2 year period, we asked all acute inpatient mental health wards across Scotland to inform us when a woman who had a baby under 12 months old was admitted to their care. We then asked clinicians to complete and return a monitoring form.

In total, we were notified of 30 women who were admitted to acute adult mental health wards during this 24 month period. We received completed monitoring forms for 25 women.

We suspect this represents under-reporting, but until comparative data is available, the true number of perinatal admissions to general adult wards during this period cannot be verified. We are also mindful that there were significant pressures on services during the pandemic that might have prevented them from participating in this monitoring.

Our data has not yet been published, but key findings include:

- 19 of the 25 women, were thought to pose a risk to their own safety and five were considered to pose a potential risk to their baby.
- 24 of the 25 women were reported to have at least one “red flag” symptom (a risk indicator highlighted in the report ‘Saving Lives, Improving Mothers’ Care 2015’).
- Only 9 of the 25 women were subsequently admitted to an MBU
- Reasons for non-admission to MBU echoed the findings of our previous perinatal themed visit:

- MBU referral not being made by the treating psychiatrist
- Lack of awareness among staff of MBU admission criteria or the benefits of specialist perinatal admission.
- Women being offered admission but declining this due to separation from family (especially when there were other children at home) and distance from the MBU. In some cases women resident in neighbouring NHS Boards (to the MBU) felt it was still too far.
- MBU admission not being offered due to the baby's age (eg nearing 1 year and potential risks to infant on ward)

Both MBUs have been helpful in continuing to share annual MBU admission data with the Commission. This shows the number of MBU admissions each year by health board. The trends highlighted in our themed visit report (reflecting 2012-2015 data) and by PMHNS in their 2017 Needs Assessment Report[2] continue, with markedly higher MBU admission rates for women who live in Lothian and Greater Glasgow and Clyde, where the MBUs are hosted. As the PMHNS suggested in their report, this "*may be a reflection of improved detection, local awareness of the service or ease of access for women and families."*

To improve equity in access to MBU care for women going forward, the Commission would recommend:

Short term

- Formal arrangements for admitting to an MBU
  The Commission is advised that two health boards in Scotland (NHS Grampian and NHS Forth Valley) continue to have no service level agreement with either MBU. This has been the status quo for over five years, despite recommendations to address this. Although the MBU teams work together to prioritise admissions based on clinical need, it remains that women resident in these two health board areas may not have the same equity of access to MBU care as women living in other areas, particularly at times when demand for beds is high.

Longer term

- Maximising perinatal knowledge among non-specialist mental health staff
  Excellent NES Perinatal mental health modules have been developed in recent years and are freely accessible. Improving perinatal knowledge and skills among health staff may help ensure women who meet the criteria for MBU admission are offered this.

3) Improving specialist Community Perinatal Support

We have been very encouraged by recent developments in the establishment / expansion of specialist community perinatal mental services across NHS boards

[2] https://www.pmhn.scot.nhs.uk/wp-content/uploads/2019/03/PMHN-Needs-Assessment-Report.pdf

in Scotland. This has been supported and funded by the Programme Board, following recommendations from the needs assessment carried out by PMHNS. While this will be a long term process of service improvement, we would endorse the following:

Short term

- Inreach support for women admitted to general adult wards for perinatal care
  As discussed above, some women who require admission for acute perinatal mental health care, actively choose to receive this inpatient care locally and not in a regional MBU. Specialist perinatal expertise is nonetheless essential. With the establishment of local specialist community services, we would recommend a focus of this support extends to women who are admitted locally for inpatient perinatal care. The skills and expertise of community perinatal specialists supporting inpatient colleagues in this context is also likely to be invaluable.

Longer term

- Supporting women living in remote and rural areas
  Focussing particularly on establishing access to specialist perinatal mental health services for women and families living in remote and rural areas, dependent on the needs of the local population.
  As described below, there have also been benefits in the use of digital technology in healthcare during the pandemic, but this must be person-centred and the Commission supports the view that patients having a choice in how they would like to access health support.

Q2. How has the COVID-19 pandemic impacted on the mental health of new mothers and the support available to them during the perinatal period?

The Commission carries out routine visits to the Mother and Baby Units in Scotland every few years. The majority of our 2020 visit programme had to be postponed due to Covid-19, but we maintained contact with services during this time to monitor the impact of the pandemic. We visited the West of Scotland MBU in November 2021 and will be visiting the MBU in St John's Hospital, Livingston in 2022. The areas below have been highlighted during our contact with the MBUs during the pandemic:

1. Potential impacts on access to care and pathways to admission

Early in the pandemic, we heard that women were presenting with more severe post-partum illness at the point of their admission to MBU. This mirrored a picture being reported to us more widely from acute inpatient mental health services across Scotland. It was not clear whether early detection and swift assessment of acute mental illness in the community (in primary and/or secondary care) was being affected by reduced access to services, particularly during the first lockdown.

Restricted visiting by community midwives and health visitors, reductions in face to face assessments by both GPs and community mental health teams were themes that were discussed with us.

In addition, ordinary support networks for new mothers, such as family contact, informal post-natal 'meet ups' or more formalised community supports such as mother and baby groups and services provided by thirds sector organisations were also significantly impacted by Covid-19. Increased isolation and reduced support may have further disadvantaged women already struggling with their mental health at home.

2. MBU bed occupancy
   During the first lockdown we heard that bed occupancy remained high on both MBUs. Through our monitoring we came across individual cases where women had not been able to access MBU admission at the point of referral (in one instance due to a unit being temporarily closed to admissions due to Covid, and in another instance, due to no bed availability across the two units).

   During our recent visit to the West of Scotland MBU, we heard that bed occupancy remains around 100%. The MBU at St Johns has reported more capacity recently. We are aware that the MBU teams continue to work closely, providing 'out of area' admissions for women needing an MBU bed whenever possible when required.

3. Impact on family contact during MBU admissions
   Restrictions on hospital visiting due to Covid had an impact on many women, their partners and families during their time in hospital. We heard this was particularly challenging for families who lived at a greater distance from the MBUs. It was suggested to us that in individual cases, reduced contact with family may have had an impact in 'slowing recovery'.

   Whilst the staff teams supported partners visiting wherever possible, and when it was safe to do so, we were told that families were sometimes separated for long periods. Improved access to video technology was promoted to enable 'keeping in touch' and was welcomed by many families. However we heard that for some women who were severely unwell, this caused additional stress. Ensuring families have the technology and internet access to enable this contact is also an important consideration.

   Both MBUs have reported family contact and visiting has much improved since the last lockdown.

4. Impact on discharge planning,
   We were told that arrangements for discharge planning, which normally involve women having passes at home prior to discharge, were not possible early in the pandemic. The normal practice of graduated home passes enables women to adjust to returning home with their babies, whilst ensuring discharge is safe and supported. Both MBUs told us that due to Covid, admissions were sometimes longer than they might ordinarily have been. Particularly early in the pandemic, discharge was only considered after women achieved a prolonged period of stability on the unit.

   There was concern that this particularly affected women living in remote and rural areas, where there was less community support available on discharge. While this

'frustrating' for women and their families, we were told that generally there was understanding and acceptance of the rationale for caution.

5. Benefits of technology
   In addition to facilitating contact between women and their families during admission, staff from both MBUs have continued to tell us about the benefits of the increased use of technology during the pandemic. These include:

   - Use of MS Teams to hold virtual meetings with community services:
     - Improved communication with services in women's home areas from the point of admission.
     - Improved attendance at discharge planning meetings from across primary and secondary care, social work and third sector organisations. Particular benefit for services at a distance from MBU.
   - Additional support for women on discharge
     Eg Nursery nurses offering post-discharge support groups via 'Zoom' and videoconferencing support for women and their families from the MBU team in the early stages of discharge.

   Both units, while having to make significant changes to their services have had time to reflect and view changes as opportunities for new ways of working (e.g feedback from mothers in relation to online support group hosted by nursery nurses from one unit was hugely welcomed).