Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Cofnod y Trafodion
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Y Pwyllgor Plant, Pobl Ifanc ac Addysg

The Children, Young People and Education Committee

24/05/2017

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Lynne Neagle Bywgraffiad|Biography	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)

Eraill yn bresennol
Others in attendance

Josie Anderson	Uwch-swyddog Polisi a Materion Cyhoeddus, Bliss Senior Policy and Public Affairs Officer, Bliss
Jenny Burns	Arweinydd Prosiect, Mind Cymru Project Leader, Mind Cymru
Sharon Fernandez	Sefydliad yr Ymwelwyr Iechyd Institute of Health Visiting
Sarah Fox	Cynghorwr Polisi Proffesiynol, Coleg Brenhinol y Bydwragedd Professional Policy Advisor, Royal College of Midwives
Dr Jane Hanley	Arbenigwr Iechyd Meddwl Amenedigol, Sefydliad yr Ymwelwyr Iechyd Perinatal Mental Health Specialist, Institute of Health Visiting
Rhiannon Hedge	Uwch-swyddog Polisi ac Ymgyrchoedd, Mind Cymru Senior Policy and Campaigns Officer, Mind Cymru
Yr Athro / Professor Ian Jones	Athro Seiciatreg, Cynghrair Iechyd Meddwl Mamau Professor of Psychiatry, Maternal Mental Health Alliance
Helen Rogers	Cyfarwyddwr, Coleg Brenhinol y Bydwragedd Cymru Director, Royal College of Midwives Wales
Dr Sarah Witcombe-Hayes	Uwch-ymchwilydd Polisi, NSPCC Senior Policy Researcher, NSPCC

Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance

Jon Antoniazzi	Clerc Clerk
Sarah Bartlett	Dirprwy Glerc Deputy Clerk
Rebekah James	Y Gwasanaeth Ymchwil Research Service

Dechreuodd y cyfarfod am 09:33.
The meeting began at 09:33.

Cyflwyniad, Ymddiheuriadau, Dirprwyon a Datgan Buddiannau
Introductions, Apologies, Substitutions and Declarations of Interest

[1] **Lynne Neagle**: Good morning, everyone. Can I welcome you all to the Children, Young People and Education Committee? We've received apologies for absence from Julie Morgan and Hefin David and also Mohammad Asghar. Can I ask whether there are any declarations of interest, please? No.

09:34

Ymchwiliad i Iechyd Meddwl Amenedigol: Sesiwn Dystiolaeth 1
Inquiry into Perinatal Mental Health: Evidence Session 1

[2] **Lynne Neagle:** Item 2, then, is our first evidence session on our inquiry into perinatal mental health. I'm very pleased to welcome the witnesses this morning: Jenny Burns, who is project lead at Mind Cymru; Rhiannon Hedge, who is senior policy and campaigns officer at Mind Cymru; Josie Anderson from Bliss, senior policy and public affairs officer; and Dr Sarah Witcombe-Hayes, who is a senior policy researcher with the NSPCC. Thank you all for coming and thank you, too, for the helpful papers that you provided in advance.

[3] If you're happy, we've got quite a lot of questions, so we'll go straight into questions. If I can start: we know that the Welsh Government wants to improve perinatal mental health services and that was one of the objectives in the 'Together for Mental Health' delivery plan. Can you just give us your sense of how things are going, where we're at and whether we are actually

on target to achieve the kind of change we want to see? I don't know who'd like to start.

[4] **Ms Burns:** Each health board does now have a service, just about—I think the deadline was November last year to be getting going. I think it's been difficult for lots of different reasons. I've got a few reasons here why some have been quicker setting up than others. Team size is one of the things—for example, Cwm Taf has two workers and Cardiff has 17 workers, so there's a big difference there regarding how many people you could see. Another issue, I think, for getting set up quickly is geography. Powys and Betsi Cadwaladr are very rural, so, obviously, the services are going to look different there. Also, I've got here the team lead background, so, depending on their profession, it can then shape their service—what that looks like. Also, there's a lack of perinatal mental health experience in Wales, so when you're trying to put a team together, because we haven't had perinatal services before, hiring people with experience—it's difficult to find.

[5] So, they are coming, and they are working hard and there's a really good feel at the national steering group when we get feedback, but it is taking time to be effective. I don't think that's from lack of enthusiasm or interest—more some of the things that I've mentioned there.

[6] **Lynne Neagle:** Okay, thank you. Does anyone else want to comment on that aspect of things?

[7] **Ms Hedge:** I think something that's missing from the 'Together for Mental Health' delivery plan's focus on perinatal health is around the performance measures—they're not at all outcomes focused. The performance measures in the perinatal section of the delivery plan are just that the services exist and that 10 per cent of new mothers are in contact with community perinatal support. There's nothing in there around whether those services are delivering improved outcomes, or whether people's mental health is improving and they're better able to manage their own mental health. It was great that £1.5 million was invested in those services, but this delivery plan covers up to 2019. And by 2019 we would expect that health boards will be able to evaluate how well those services are improving people's lives and people's mental health. So, if anything's missing, we think it's that focus.

[8] **Lynne Neagle:** Okay.

[9] **Dr Witcombe-Hayes:** NSPCC really welcomes the Welsh Government's strategic approach to improving mental health and well-being for everyone in Wales. We're really pleased to see that one of the core principles under the delivery plan is to ensure that children have the best start in life and parents or carers are helped if they need support. We think that this best start in life is so important because we know that the first 1,000 days are crucial for child development. So, our early experiences affect the development of brain architecture, which provides the foundation for all of our future learning, behaviour and health. Just as a weak foundation compromises the quality and strength of a house, adverse childhood experiences early in life and not meeting a child's needs at this time can impair brain architecture, with negative effects lasting well into adulthood.

[10] We've seen strong evidence from the recent Welsh adverse childhood experiences study that has demonstrated that association between ACEs and a likelihood of adopting health-harming behaviours such as smoking, excessive alcohol consumption, violence, poor mental health and early diagnosis of chronic disease. We also know that the first 1,000 days are when children are more vulnerable to being abused and neglected. So, for example, in England the most recent analysis of serious case reviews, carried out between 2011 and 2014, shows that the largest proportion of cases related to younger children. So, 41 per cent were under a year at the time of death or incident of serious harm, and 43 per cent of those were under three months old. Unfortunately, we don't have comparable analysis of child practice reviews in Wales at the time, so there's a small gap in evidence.

[11] We're also really pleased to see the Welsh Government focus on helping women and their families with perinatal mental health problems. We know that parental mental health problems, which are also an ACE, are a risk factor, because without the right help and support for parents who are experiencing this, children can be vulnerable to experiencing abuse and neglect. That's not to say that having a parental mental health problem in itself indicates a risk of harm to children, but it means that the symptoms parents can experience because of their mental health problem can make that responsive, sensitive and appropriate care for a baby, which is so crucial within the first 1,000 days, really difficult. That's why early help and support is essential for all women and their families experiencing perinatal mental health problems.

[12] We know that this is a problem—a whole body of research suggests that it could be that up to 20 per cent of women experience a perinatal

mental health problem. We know that without the right help and support these problems can have devastating impacts on women, their families and their children. Research shows, for example, that perinatal mental illness is one of the leading causes of death for women during pregnancy and the year after birth, which is a clear indication of how devastating these problems can be for women and their families. But we also know that with the right help and support, it is possible to prevent many of the negative effects that perinatal mental illness can have on mums and babies. But to do this, we need to ensure that all women who are at risk of, or who are experiencing, perinatal mental health problems have access to good-quality specialist support at the earliest opportunity, and that's why the NSPCC have welcomed the recent investment from Welsh Government into perinatal mental health care. It's really positive to see some of the developments in perinatal mental health care in Wales in such a short amount of time, as Jenny has described.

[13] In 2015, when the Maternal Mental Health Alliance did a mapping exercise of specialist services across the UK, it showed that five out of seven health boards in Wales did not have specialist community perinatal mental health provision and there was no longer an accredited mother and baby unit in Wales. Since this time, the funding has meant that other health boards around Wales have begun to develop their specialist services. However, we believe there's a need to understand more about what services are available to determine whether these services are meeting the needs of women across Wales experiencing perinatal mental health illnesses. That's why the NSPCC have joined forces with the National Centre for Mental Health and Mind to work on a research project that can address this gap in knowledge, investigating the provision of services for perinatal mental illness across statutory and voluntary sectors within Wales that provide support to women experiencing a spectrum of perinatal mental health difficulties. We hope that our collaborative project will be really important to this committee, and we'd welcome the opportunity to present our findings to the committee when they're available in March 2018. One of our key recommendations was to ask for a follow-up inquiry, particularly when the health board services are more established and our research is complete, as we feel this will offer a more complete picture of perinatal mental health care in Wales.

[14] **Lynne Neagle:** Thank you very much. Josie.

[15] **Ms Anderson:** I'd just like to add that Bliss really welcomes the 'Together for Mental Health' delivery plan and we were really pleased to see the focus on perinatal mental health. However, one thing we do find a bit

disappointing is that there is no reference specifically to parents whose babies spend time in a neonatal unit, and nor are they considered a high-risk group, despite the fact that research has quite clearly shown that the prevalence of perinatal mental health conditions is much higher in that group. I'm sure we'll touch on that a bit later in questions.

[16] **Lynne Neagle:** Okay. Thank you very much. We know that health boards have had to map their provision and we know that you're having this collaborative project that you've referred to. Could you just tell us a bit more about this project and how you think this will help to inform service delivery in this area?

[17] **Dr Witcombe-Hayes:** As I've already mentioned, it's NSPCC, National Centre for Mental Health and Mind, and we're working together to investigate what services we have in Wales across statutory and voluntary sectors that provide support to women experiencing a spectrum of mental health difficulties. A key aspect of that is to explore what services we have, but also to explore what it's like for women and their partners in Wales to live with and manage these types of illness. We have a few aims within the project: the first is to identify and map out what services are available, both statutory and voluntary; look at whether these services are meeting national standards and recommendations; illustrate examples of best practice in perinatal mental health services; identify where enhancements are needed to better support women and their families experiencing these difficulties; and explore the lived experiences of women and their partners who have had a perinatal mental health problem identified, managed and treated in a Welsh context. So, in order to do that, we're going to be speaking to midwives and health visitors, mental health teams and perinatal mental health teams, third sector organisations delivering services and women and their partners with lived experience. We're hoping that what we find out from this project will help us understand whether mums and their partners are getting the support that they need to manage these types of illnesses. The project started in March this year and it's going to end in March 2018 with, hopefully, a launch event around that sort of time. It's our hope that the project will raise awareness among health professionals and women and their families with lived experience about what provision is out there to access, and it will also help us to identify where the gaps are and where we need better help and support for women and their families. Jenny, I don't know if you have anything you want to add.

09:45

[18] **Ms Burns**: You've said it great.

[19] **Lynne Neagle**: Okay, thank you. John.

[20] **John Griffiths**: I'm interested in the work of the all-Wales perinatal mental health steering group and what involvement you've had in that work, particularly with reference to the task and finish groups.

[21] **Ms Burns**: I've been a part of it since its start, which is January 2016, and it's had a really good, wide representation of each health board, so each health board comes every time. Public health has been funding that—booking the room and the catering that we have with that. We've also had other stakeholders there. The third sector, people with lived experience and other key people—Welsh Government et cetera—have been involved, and it's sort of grown like that. The last time we met, we had 30 people there, so it was a good representation, and everybody—key people from every health board were there.

[22] I think the original aims were to allow each health board to share resources, and to be able to look at, 'Someone's putting this job description together' or 'That will help when we put a job description together'. So that was one of the original aims: to have that sort of community where we could share resources. Also, to put together some national care pathways. This has been a sub-group, which is still on task. It hasn't finished yet, but it is still on task. Putting on a conference, annually: I think we've had two, which have been very successful. A commitment to research—so, the National Centre for Mental Health has been involved in doing large data collection in and around women who are pregnant to be able to use, then, later. And an oversight and recommendations for training. So, those were the aims of the group, and there's been the two sub-committees in training and also in the care pathways, and they are ongoing. I hope that helps a little bit.

[23] **John Griffiths**: I don't know whether we have anything written in terms of the work of the steering group or the task and finish group, Chair, do we?

[24] **Lynne Neagle**: Maybe we could get a note on it, if that would be helpful for the committee.

[25] **John Griffiths**: That might be useful. I don't know whether you might be able to provide anything—?

[26] **Ms Burns**: I can ask for you. The key person is Lisa Kinsella, and she's employed one day a week by public health to facilitate the national steering group. The two chairs are Dr Sue Smith and Professor Ian Jones. [*Interruption*.] I expect so, yes.

[27] **Lynne Neagle**: Thank you. Okay, we'll get a note on that.

[28] **John Griffiths**: Similarly, then, in terms of what's happening in Wales at the moment with the community of practice network—I'd be interested in your involvement in that and whether you think it's leading to improvements in the community specialist services, right across Wales, dealing with perinatal mental health.

[29] **Ms Burns**: Do you want me to comment on that? There was a little bit of confusion as to the difference between the national steering group and the community of practice. The community of practice seems to be the conferences—I think that's what the point is. We've had two a year so far, and I do think they've been a key factor in the success of the health boards putting their perinatal services together. As I've said, it's helped with resource sharing, communicating information and the latest research. There's been a sense of camaraderie when we've had the conferences. People are excited; the health boards are excited that the Government has invested, and therefore want to go forward, and perinatal mental health is now on the agenda. There's a sense of building a team and it's helped the third sector be linked in, and people with lived experience, so it's definitely drawn that in.

[30] With networks, there's an interesting thing. I think they've got a huge sense of value, but there does need to be resource put in to help those networks continue. I actually think it's probably about a two and a half day a week job to keep that network going, because I do think it's had a tremendous value in helping the health boards put their services together. So that's probably my comment on it. If you've got Lisa or Ian coming to give evidence, they will be able to give you more on that.

[31] **John Griffiths**: So, what you said, latterly, about resources, then, Jenny, would, I guess, back up what the Royal College of Nursing have said, which is that they consider the network to be excellent, but it falls short of an adequately resource managed clinical network, which they see as being developed in England at the current time. Would you agree with that?

[32] **Ms Burns**: Yes, probably. Yes. My project's been very involved in early intervention, so that's probably a better question for Professor Ian Jones. They have been working hard on trying to equip the psychiatrists and that more clinical side. But yes, I probably would agree with that. Yes.

[33] **John Griffiths**: Okay. Thank you.

[34] **Lynne Neagle**: And is that the view of the panel generally—that it would be better to have a managed clinical network?

[35] **Dr Witcombe-Hayes**: I'm not sure I have the expertise to comment. I think Ian would probably have a lot to say about that. But just to say, I also sit on the steering group through the project, so I've been invited to have a standing agenda item where I can update the group on what's happening with the project. They've agreed to officially endorse our research project and act as our steering group, and have been already a fantastic resource for bringing our ideas to the table, really. It makes me feel very confident that our work with the steering group will mean that our research will be a comprehensive and up-to-date overview of what's happening with the perinatal mental health service provision in Wales.

[36] **Lynne Neagle**: Okay. Thank you. Llyr.

[37] **Llyr Gruffydd**: Thank you, Chair. One of the key features of the evidence that we've received so far is around the concerns about the gaps in acute provision, particularly the lack of a mother and baby unit here in Wales. So, could you tell us a little bit about the experiences of women needing access to hospital in this sort of key period? And also, what benefits do you think would come from having a centrally funded mother and baby unit here in Wales?

[38] **Ms Hedge**: I think some of it's fairly obvious. If a service doesn't exist in Wales, inevitably a lot of people are going to have to travel very far. So, usually, Bristol or Birmingham is where people end up. Obviously, there's no guarantee that there'll be a bed there either. So, there are cases where we know people have gone further afield. But Bristol and Birmingham alone from many areas of Wales—that's three and a half hours in a car; longer on public transport. So, we know that people are often faced with the choice of going to a mother and baby unit, remaining with their infant and having all of the benefits of the bonding and attachment period, or getting treated closer to home but having to be separated from their infant. Obviously, travelling far

and remaining with your infant means you're away from your support networks and your family. We have heard from people who have talked about what an extremely difficult choice that was.

[39] Last year we carried out a survey as part of the 'Together for Mental Health' delivery plan consultation period, and a part of that survey focused around perinatal mental health. About 100 people who filled out that survey—there were about 700 in total—had experience of perinatal mental health problems. We do have some responses from people who told us about their experiences. There were some people who talked about having no support whatsoever, some people who talked about having great support, but also they really genuinely told us that they believed that they wouldn't be alive today if they hadn't had the support that they had. Also, there were some experiences that showed how the existence of a service in itself can raise awareness of an issue. If someone knows that something exists, they are more likely to come and seek help. One person told us, 'I think I had psychosis after giving birth. I was too scared to tell anyone, but also no-one noticed'. One person told us that, quite a long time ago, they were sectioned with severe postpartum psychosis, and they received treatment at the old North Wales Hospital. She said, 'This probably saved my life and my family's lives. I find it astonishing that units for mothers and babies don't exist in Wales at all'.

[40] We also spoke to people who needed crisis care during the perinatal period and didn't access hospital, but there were services that supported them. Someone in Pembrokeshire said, 'I was under the obstetrician who helped me access services. The crisis team looked after me during the pregnancy and that was what kept me alive. My GP came to my house without hesitation to treat me, and without that I'm not sure what would have happened'.

[41] So, as we said in our response, we think it's a huge gap that there's no mother and baby unit in Wales, and it's also an accountability issue: that this is a service that the Welsh NHS isn't delivering. So, the Assembly doesn't have much power in holding the Welsh Government to account on the quality of that service if people need it, because it's in England. But also, having one mother and baby unit in Wales isn't necessarily going to deliver good access all over Wales. If we reinstated one in Cardiff, that still doesn't really support women in north, west and mid Wales who would still have long journey times. So, I think, as well as the importance of having something, because something is better than nothing, we also need to look at how that can be

delivered across Wales, but also where people can be treated at home to avoid a crisis.

[42] **Llyr Gruffydd**: Yes, okay. Thank you for that. There was an assertion in our session last week with a number of stakeholders that the previous provision was taken away because of lack of demand. That's been challenged in the evidence we've received, and that there were resourcing and staffing issues as well as low demand amongst the factors that contributed to the withdrawal of the previous provision. But, are you satisfied that we have robust enough data to be able to prove that there is a need, or is there a danger, as was suggested to us last week, that people actually get by and find other ways, and don't necessarily appear in the statistics as needing that provision?

[43] **Ms Burns**: Again, Professor Ian Jones, this is definitely his bag and he's done an enormous about of research on it. But there's an added element to what Rhiannon very aptly said, and that is, having provision right across the spectrum—so you've got early intervention and you've got crisis care at the other side—says, and is the message out to everybody in Wales, 'We stand behind perinatal mental health', rather than, 'Oh, we're just going to do the front end bit.' Well, what about those who are critical and suffer so much? They are there. I think two in 100,000 is the statistics for it, so they do exist. So, not having a whole spectrum of care, just sort of says, 'Well, we like it, it's quite good, but we're not going to do this bit here.' So, it's kind of a stamp of 'We really get behind perinatal mental health.'

[44] **Llyr Gruffydd**: But in order to provide the acute services that we're talking about here, we would probably need more than one centre, then, in Wales—coming back to your point about accessibility.

[45] **Ms Burns**: But it's a start, isn't it?

[46] **Ms Hedge**: It's a start.

[47] **Llyr Gruffydd**: Yes.

[48] **Ms Burns**: I also think it can be a place of learning. So, I mentioned before that we lack experience in Wales in perinatal mental health, and it's a place where your experts can be, like Ian Jones, Sue Smith, et cetera, from Cardiff, and you can have students go in, they can learn, and we can develop and build capacity. So, it's got more than just provision; it's got a lot more, I

think, attached to it than just having three beds.

[49] **Llyr Gruffydd**: But then we're into the realms that you need a certain amount of throughput in order to retain that specialism, so maybe more than one centre in Wales, then—. We're back to that, not quite chicken and egg, but it's a very difficult provision to provide if you're looking for that kind of specialism.

[50] **Ms Burns**: Yes. But I think if it started in Cardiff with a 17-strong team in perinatal service, you've got more than enough people there to be—. And a lot of those did equip the mother and baby unit before. So, I think a creative way of looking at how it could work. We're not talking like a brand spanking new building or anything like that, but something that can work that just endorses that we cover the whole spectrum of perinatal mental health, I think.

[51] **Dr Witcombe-Hayes**: I think—am I able to—?

[52] **Lynne Neagle**: Yes.

[53] **Dr Witcombe-Hayes**: Just to kind of echo what's been said, really. Not having a specialist mother and baby unit in Wales means that many women must be treated on an adult psychiatric ward with no contact with their baby, or treated out of area in England, often very far away from their support systems. I think the key issue is that generic adult psychiatric wards do not have the expertise to care for women experiencing perinatal mental health problems, and this means that women are not receiving the standard of care that they need and that's detrimental to mums, partners and babies. And the real benefits of having a mother and baby unit would be that women in Wales would be able to be admitted for specialist in-patient treatment with their babies, and this means that mums would get access to the specialist assessment, treatment and support they need, whilst having support with mother and infant interactions and attachment, which we know are so crucial in those first 1,000 days to giving children the best start in life. But it is a complicated issue, and as Rhiannon said, having a single mother and baby unit in Wales would not necessarily mean that all women in Wales would have equal access, with some still having to travel very far away.

[54] I know that there's some work going on with the Welsh Health Specialised Services Committee to review in-patient care in Wales at the moment, which I believe is another task and finish group from the all-Wales

perinatal mental health steering group. And their recommendations, which I think are due in the summer, could possibly be really important to this inquiry.

10:00

[55] Hopefully, as part of our research—. Although we don't have findings to share at the moment, we are planning to ask women about the experiences they have with in-patient care. So, our research may be able to offer some evidence to this question, if the committee does a follow-up at any point.

[56] **Lynne Neagle**: Thank you. We are having WHSSC in actually, in a couple of weeks' time, to talk to them about these issues. We've got Darren on this.

[57] **Darren Millar**: It was just a question on this issue of demand, actually. You mentioned that quite a number of mums and babies are having to be sent hundreds of miles away to mother and baby units over the border in England. How many are we talking about?

[58] **Dr Witcombe-Hayes**: I think, probably, WHSSC would be your best people to ask that.

[59] **Darren Millar**: But you don't have any of those figures.

[60] **Dr Witcombe-Hayes**: No. They collect the figures annually.

[61] **Darren Millar**: Okay. And, you also mentioned—I think it was you, Rhiannon—this issue of the difficult choice that mums often face, you know: should I go in as an in-patient to be treated and be separated from my child, or should I just muddle through as best as I possibly can? I can imagine that's a very harrowing choice, but they don't really have a choice, do they? I mean, if they don't want to be separated from their child, and most mums are desperate not to be, then because of this lack of mother and baby units, they're prevented from being able to make a real choice, aren't they? The choice is made for them, effectively, isn't it?

[62] **Ms Hedge**: Yes, definitely. And there's no doubt that there's real suffering involved when it comes to this gap in care, however few people may need this care. I think it's important to note as well that the people who are

seeking help are almost certainly a minority of the people who need help. This is an extremely stigmatised area. We know that mental health is already a very stigmatised area, but also the pressures around women and motherhood and the societal stigma around that as well, in that people regularly tell us that they are really, really fearful that disclosing any perinatal mental health problem will deem them an unfit mother or they will lose their child. A lot of people told us that they were very scared that they would have their child taken away from them, and keeping mothers and babies together in an in-patient unit can assuage some of that fear, because it reassures women that they won't be separated from that infant while they're receiving treatment. But, yes, there is a very severe need in some cases, with issues like postpartum psychosis, which is an urgent issue.

[63] **Darren Millar**: One thing that Llyr suggested in his line of questioning earlier was that the fact that there's a lack of mother and baby units may hide the potential demand for them because patients can't ask to be admitted into one. But I suspect that most mums wouldn't even know about the availability of them elsewhere, would they? I mean, I assume that they just think that the clinicians who care for them give them the best possible care and wouldn't know what the pathway would be, so it's impossible, really, to gauge the demand. But given that there are similar units available over the border in England, I would expect that there may be population-wide studies, which would suggest that a population of around 3 million would require a mother and baby unit bed provision of x number of beds. I mean, surely that sort of bigger picture, in terms of data, is available, isn't it?

[64] **Ms Burns**: It must be. I don't think we're the right group to be asking about the actual data. As I say, I keep referring to poor Professor Ian Jones who is going to have a very long list of questions to be asked of him, but he is your absolute expert and a psychiatrist. I am a clinician, but mostly, we are third sector staff who aren't so involved in the MBU thoughts. It's difficult to say. And no, women don't always have a choice, because they get sectioned, because they're a risk to themselves or their babies. Sometimes, it's not always good for the baby to be kept with the mother because the mother is so unwell, but you need a specialist assessment for that, and therefore, there needs to be that provision here in Wales, as a statement.

[65] **Lynne Neagle**: Thank you. Llyr.

[66] **Llyr Gruffydd**: Yes. I'd like to just ask a few questions about mental health for parents of premature and sick babies, primarily to Bliss, but I'm

sure the others will pitch in as well. In your paper, you say that psychological support on neonatal units in Wales is woefully insufficient and requires urgent attention. We've heard about some of the issues, of course, but could you expand on those comments? Are there any particular issues that have concerned you?

[67] **Ms Anderson**: Yes, of course. I think, to answer this question fully, it's helpful to give a bit of context about the number of parents who have to have their baby admitted to a neonatal unit every year. So, around 2,700 babies every year will be born premature or sick and will need to be cared for in a neonatal unit. There are 11 units in Wales, and parents often have to travel quite far from home. This can automatically create a barrier for them, of not being able to get to their baby and be with their baby for long periods of time. As well as that, research has shown that parents of a baby admitted to a neonatal unit are at greater risk of suffering from a postnatal mental health condition. One piece of research has suggested that mums were up to 40 per cent more likely than the general population to suffer from postnatal depression after their baby had been premature and admitted to a neonatal unit.

[68] Last year, the British Psychological Society published a briefing paper, and they state in that that admission to the neonatal unit 'can have negative psychological consequences' for parents, the baby and the parent-baby relationship, and that parents must have support, particularly with bonding and development of a secure attachment, and also support when they need to make decisions or when bad news is delivered. The importance of psychological support for these parents is recognised in national standards. The all-Wales neonatal standards do say that families should have access to services that include psychiatric and psychological support and the BAPM service standards make it clear that an intensive care unit should provide parents with access to a trained counsellor without delay, from admission. We're hoping that the new updated Welsh neonatal standards will build on that, because, to date, unfortunately, there's not been much reporting against those measures.

[69] So, with all that in mind, our report, which we released last year, showed that only five out of the 11 neonatal units in Wales were able to offer parents any access to psychological support of any kind, either on the neonatal unit or via referral to an outside service. What's particularly concerning is that none of the three intensive care units reported having a dedicated trained mental health worker on site. That is a great concern,

because these units will look after the very sickest babies. They're likely to have the highest rates of bereavement, as well, and parents really need that support.

[70] Comments that we received to our parent's survey and from health professionals to our report last year revealed a real lack of professional support. Two mothers who responded were, very sadly, bereaved, and they weren't able to be referred on to the psychological service; they relied on the support of the nurses. And I must say that all of the comments that we received from parents about psychological support praised the nurses no end for the support they provided. But, nurses are not trained mental health workers, and it's not fair for nurses to carry that burden. The psychological support on a unit is for nurses as well. It can be a harrowing, harrowing job.

[71] **Llyr Gruffydd:** So, do you mind me asking, then, why are the health boards not meeting their obligations in that respect? Is it a lack of trained professionals? Is it a lack of resource or—?

[72] **Ms Anderson:** I think it's a mixture of a lack of resource—there's not the investment into creating roles for those professionals that there needs to be—and also just a lack of awareness, as well, to an extent. So, I had a look through some of the submissions—the written evidence from the health boards—and I noted in there that when they spoke about the professionals that they reached out to, to form their steering groups and to gain opinions on how services should be created, not one of them mentioned consulting with a neonatal professional. I think, generally, in the perinatal mental health arena, neonatal parents aren't really seen as a distinct group with their own distinct needs.

[73] What I do find really welcome in those responses from health boards and the board papers I've seen is their focus on bonding and attachment. But for the parent of a baby in an incubator, that's all the more difficult. Some parents might not be able to hold their baby for days or weeks. They're limited in their interaction, especially if they can't travel, or find it difficult to be with them for long periods of time. So, those parents really do need specialist support to help them build that bonding. We hear frequently from mothers who express feelings of guilt, also of grief, of losing what could have been with their pregnancy, and also feeling afraid to bond with their baby when the future's so uncertain.

[74] So, again, I think health boards do have a role, but, as well as

providing investment in creating it, it's also growing awareness within what they're doing at the moment, to say that neonatal is an important group. If they know a mother has had a baby admitted to the neonatal unit, that should be a marker already that they might need to ask some questions about that.

[75] **Llyr Gruffydd**: Thank you. I'll move on, if I may, because, very often, if the public sector doesn't provide a service, the third sector steps in. Clearly, in this regard, we have a panel of third sector organisations. I was just wondering how well developed is specific perinatal third sector support across Wales. Are there any gaps in provision in that respect?

[76] **Ms Burns**: The joint project that we're doing with the NSPCC is going to reveal more next year, which will be great. Sarah will be hard at work doing that. But, there are some really good examples of good practice across Wales. I'll name a few. Home Start do a great job. Family Action, which is a brand new charity that's come to Wales, it's an English charity and there's a south Wales and a north Wales representative and they are doing perinatal mental health as part of what they're doing. Some local Minds, also. There's a wonderful partnership in north Wales called Aspire, which is social services, Barnardo's and Mind working together with young parents who are pregnant. Advance Brighter Futures, Action for Children—there are more, but those are some of the ones that I've come into contact with.

[77] So, there are some really good examples, but there could always be more. One of the problems with third sector is that projects come and go, depending on the funding. So, thinking about legacy, which is what I'm doing as Two in Mind comes to an end, what are you leaving behind is a really important thing that needs to be thought about at the beginning, before you end. So, those are my thoughts on that.

[78] **Llyr Gruffydd**: Okay, thank you. And as you say, a lot of that information will come through the mapping exercise, but I'm just wondering as well—are you looking at the interrelationship, then, or the joint working between statutory services and the third sector?

[79] **Ms Burns**: Yes, I have got some comments on that, because part of my role within the national steering group is not only to be a third sector voice but also to try and get more joined-up working, because of building capacity. There is quite a difference in how the statutory services engage with the third sector. This is something I've got as a recommendation, really.

I can give an example of a very good one that's working, and that's in north Wales—a charity called Advance Brighter Futures is working very well with the statutory services, and they make direct referrals into Advance Brighter Futures, which has a perinatal group that meet together, and they can offer lots of support, including home visits, swimming groups, cognitive behavioural therapy, et cetera.

[80] However, I'm not going to name them, but there is another perinatal team that refuses to refer into the third sector, and I'm not quite sure why. Partly, I think it's to do with the risk and safeguarding and is the third sector equipped enough—can they handle, if we refer somebody to them—so, they just have a blanket, 'No, we're not doing it'. There's no middle ground. What I have tried to encourage is more of a middle ground. So, instead of saying just, 'Refer or not refer', how about some joint assessments, joint training, invite the third sector in to your multidisciplinary teams, et cetera, and work alongside each other so you build that trust and that relationship.

[81] One of my recommendations is that, as we think about the statutory perinatal mental health services, one of the outcomes is that they have evidence of working with the third sector. If your outcomes are only treating mums and families, you'll never get partnership working. But, if you make an outcome, with evidence of how you have partnered, or how you have worked with the third sector, you will then see that, because outcomes shape the services. So, that's my direct witness, really, of what's going on in the field.

10:15

[82] **Llyr Gruffydd**: Okay, thank you, that's really useful. Thank you for that. Just one briefly from me, then—what services are there then for fathers and wider family members? Because, again, in evidence we had last week, people were saying, 'Well, it's not just me on this journey, my partner, or my husband, or my parents are with me on this journey as well.' Are you confident that there's enough support for those people also, or are they integrated well enough into the support that exists?

[83] **Ms Burns**: There's actually just been a recent report that's come out, which is on the Two in Mind website. I can't remember the reference to it, but if you go to the 'For Professionals' tab on the Two in Mind website, there is a brand new report out about fathers. Mark Williams has been championing that—I think he's probably coming in to give evidence—across Wales. There are a few—. Home Start in Monmouthshire has a specific project

for fathers, but one of the difficulties is engaging men. It's hard enough for a woman to admit, 'Actually, I've got some mental health issues', but for a dad to say, 'Well, I'm not coping either', that's really another step, isn't it? So, to get them to come to a group is really a tall order. So, it's definitely something that needs to be addressed, and people are trying to, but it is a very difficult one to do. Mark Williams is doing a good job at trying to do that. But, you're going to look at it in the project, aren't you?

[84] **Dr Witcombe-Hayes**: Yes. Just to add, that's another element of the project that we're looking at. So, it's kind of mapping what third sector provision looks like in Wales, which is quite tricky, because, quite often, it's difficult to locate, and as Jenny said, the funding ends, so it can disappear. But, we're trying to do that to the best of our ability. We're looking at examples of good practice of integrated working between statutory and voluntary sectors, and highlighting any challenges. So, really asking people what are the difficulties about this and how can we overcome them. And, also asking each of those service providers, 'Do you offer any support for partners, dads, and, if so, what does that look like?' So, hopefully, we will know more shortly.

[85] **Ms Anderson**: Just to add on to that, if I may, I think that reaching dads in a neonatal unit has its own set of barriers, and is also more difficult. Something that is a challenge, particularly for fathers, is having to go back to work when their baby's still in a neonatal unit. That reduces the amount of time they can actually spend visiting, and also makes it harder for professionals to establish contact with them and spend time with them and help them bond with their baby as well. But, dads, from our research, often have no choice but to go back to work due to financial constraints. So, that would be something to take into account when providing support on a unit.

[86] **Llyr Gruffydd**: Thank you.

[87] **Lynne Neagle**: Thank you.

[88] **Ms Burns**: Can I just add one other thing that might be of interest to you? The Maternal Mental Health Alliance—I don't know if you've come across them but they are a UK-wide group that has hundreds of interested parties in perinatal mental health involved with them—have just been refunded for another five years. Comic Relief, which helps fund them, has given them some money to develop some standards—it's difficult to say for the third sector, you can't really say 'guidance'—but, some standards for the

third sector delivering perinatal mental health services. So, at some point, there will be a group of people researching what is out there in the third sector and trying to come up with some agreed guidelines and standards for perinatal services, which may help with statutory services trusting the third sector, and knowing that, okay, they've ticked off 10 things in these standards, and that may help with the relationship. So, that is coming—it's not there yet.

[89] **Lynne Neagle**: Thank you. Okay, we've still got quite a few questions left, so can I appeal for brief questions and brief answers please? Darren.

[90] **Darren Millar**: Yes. I just wanted to follow up very briefly on this issue of third sector provision. You mentioned earlier, Josie, the importance of bonding if a child's in a neonatal unit. One of the things that helps parents to be able to bond is by being able to stay in accommodation very closeby to the hospital, particularly when we've got neonatal units that are far away from where those parents live, those families live. The third sector, it seems to me, are filling that gap at the moment, particularly in north Wales—they've got some accommodation at Ysbyty Glan Clwyd, which is provided. How important is that provision and is it consistently available in other parts of Wales? I don't think it is, is it?

[91] **Ms Anderson**: No. I would say that the provision of facilities like accommodation is absolutely essential to facilitating good care on a neonatal unit—good family-centred care, where parents are partners in their babies' care and are able to spend time and bond with them. It isn't consistent across Wales. I believe our research showed that none of the three intensive care units had enough accommodation to meet standards. There are standards in the all-Wales neonatal network—standards that there should be, as a minimum, one parent accommodation room per intensive care cot—but, again, you're right, the third sector does step in with that. There are some great organisations like Ronald McDonald House Charities and the Sick Children's Trust that also build accommodation, but they're not able to do that at every unit. It is something that has to come partly directly from health boards being willing to invest in those sorts of facilities.

[92] **Darren Millar**: Okay. Jenny, you listed a long number of organisations that were working in perinatal mental health. To what extent is the third sector duplicating each other's work and effort? Could there be a better focus to that, perhaps by sharing responsibilities for parts of the system of support, rather than perhaps providing a whole host of services that five or

six other organisations are also providing?

[93] **Ms Burns:** The third sector is pretty hot on knowing what's going on in their area. Otherwise, they usually don't get the funding. But, as far as providing, 'The statutory service does this bit and the third sector does this bit'—that would be great, but we're not there yet with that.

[94] **Darren Millar:** Just going back to the area that I wanted to question you on— clinical care pathways. You mentioned earlier on, Jenny, that there's a spectrum of support that needs to be put in place, from prevention right through to crisis management, when something goes terribly wrong. You said we're getting better at this prevention side in terms of trying to support people and prevent poor mental health from developing in the first place or putting in support when there are early signs of mental health going a bit awry. What does the pathway look like in Wales? How easy is it for patients to navigate? How familiar are clinicians, nursing staff, et cetera, midwives, with that pathway to ensure that everybody gets the support that they need, at the appropriate time, in the appropriate place, and in a consistent way?

[95] **Ms Burns:** The referral pathway, or the care pathway, as I said before, is coming—the national agreed one. Each health board has designed their own. So, each service, depending—. As I said, there are differences in different areas—geography, et cetera. Powys, for example, isn't going to have a team, they're going to have champions across Powys, because of the geography of it. My dilemma—there is a bit of a dilemma, a little bit—is maternity services, for example, or community mental health, saying, 'Oh, great, we've now got a perinatal mental health service, let's refer them there'. Therefore, the responsibility isn't then taken on, for example, by the midwife or the health visitor, to actually do their part. They can now just signpost—they've got somewhere to signpost. So, I know, at Cwm Taf, for example, there are two people in the perinatal mental health team. They take anybody with low mood, basically. So, they are inundated, because now there's a service to refer them to. Long term, I don't think the perinatal mental health services will cope like that, with that kind of referral criteria.

[96] If you think about the figures, a third of people in Wales—so, a third of mums—. There are about 33,500 babies born every year in Wales. So, a third will have adjustment disorders, so that's about 11,000—that's quite a lot—which could develop into a metal health issue, and 3,500 have a diagnosis of postnatal depression. This comes out of an NSPCC report, 'Prevention in Mind'. It really takes a community to raise a child. So, the recommendation

I've got here is that—again, it's going back to outcomes—if your perinatal mental health service is designed to treat and only treat, then you're going to never cope. I just don't think it'll ever cope; there'll never be enough resources. But, if part of their role is to capacity build—so, that would include training, that would include joint visits, that would include sitting alongside a midwife who's frightened that a mum might say to them, 'Yes, I'm actually depressed', and the midwife goes, 'Oh, what do I do with that?' But if you've got a perinatal team member there to help equip them, then you're going to have a different kind of look in Wales. Rather than a service here and a service here, how about the whole idea of capacity building within all the services? That's the future I would see, and that would be better, efficient use of resources.

[97] **Darren Millar:** So, in terms of where the interventions arise, to what extent is mental health and well-being built into antenatal classes, for example? Is that happening?

[98] **Ms Burns:** Somewhat. Your midwives will be better able to understand this. But, from my experience—. For example, I did training with 20 midwives in the Royal Glamorgan Hospital not so long ago. They wanted to understand how to use Enjoy your Bump, which is a short, brief intervention to help during your pregnancy. It's in and around CBT, but it's got some psychotherapeutic principles in there. All the midwives—there were 20 of them there—said, 'If a woman said to me that she felt like ending her life, I wouldn't know what to do'. That's a fact. So, I coached them through what you would do and left them with a sheet, which they are now going to be putting into their files: 'What would I do if a mum said, "Actually, I don't want to live anymore. I don't want to be pregnant"?' So, that's the kind of thing that the perinatal mental health team could be doing to equip midwifery, health visitors et cetera, to be able to address some of those things front line, rather than just treating.

[99] **Darren Miller:** So, what do they do at the moment? Because presumably mums do say that to them.

[100] **Ms Burns:** They would have referred to community mental health or the new perinatal team.

[101] **Darren Millar:** So, we need to build some resilience into the midwifery teams, in particular, that are at the front line and the health visitor teams that are working directly with the mums. Then, when they signpost in—

obviously they don't want to be signposting into a crisis service if there's no crisis—but if it's something that they can't handle themselves, what happens at the moment?

[102] **Ms Burns**: Well, the perinatal mental health teams should be perhaps dealing with the more unwell mothers, rather than dealing with everybody. So, rather than just shifting all the responsibility to them—which I don't think they'll ever cope with—it's actually building capacity within those front-line staff who meet families all the time. As I say, there are 35,500 babies being born—. Did I just misquote that? That's right isn't it? There are 35,500 babies being born and all those front-line staff are going to be in contact with those families. The perinatal services will never cope long term, so they've got to have, I think, an outcome measure—again, that shape-shift service—that is helping build capacity within those front-line family services. And social care as well.

[103] **Lynne Neagle**: Darren, I want to move on, if possible. Quickly, please.

[104] **Darren Millar**: One important question though, and that is timeliness of intervention. Obviously, if someone is referred onto the perinatal mental health team—if their capacity isn't right and the appropriate referrals aren't necessarily being made, people might have to wait a long time to have an intervention. So, what are the waiting times like at the moment?

[105] **Ms Burns**: It's hard to comment on that. Each health board will have a different aspect for that. But, you're only pregnant for nine months, so you can't wait too long, can you? Do you know what I mean?

[106] **Darren Millar**: But also, post the birth as well, what are those waiting times like?

[107] **Ms Burns**: It's patchy.

[108] **Darren Millar**: Is that data that's collated, for example? You mentioned outcomes earlier on.

[109] **Ms Burns**: I don't know—[*Inaudible.*]

[110] **Lynne Neagle**: These are probably questions for the health boards when we have them in.

[111] **Ms Burns**: We haven't quite got there. They're quite new teams, you see.

[112] **Lynne Neagle**: Obviously, Darren has taken you into the issue of training. Are there any other issues that you think the committee should be aware of in relation to training that we ought to be flagging up as part of this inquiry? Clearly, there are issues that you've highlighted with training for midwives and front-line staff. Is there anything else that we should be aware of?

[113] **Ms Anderson**: I think, from my perspective, when it comes to the end of the neonatal state, there are usually two main pathways. Most babies will be discharged home and some will sadly die. But the parents' journey obviously doesn't stop at the neonatal doors. It carries on, either into the community or coping with their loss. I would say that after the neonatal doors needs to be looked at as well. So, how will those community services be equipped to deal with parents who've been in a hospital for six months? Who is coming out to visit the mum who doesn't have her baby and the dad who doesn't have his baby anymore? I think that needs to be looked at as well.

10:30

[114] **Lynne Neagle**: Okay. Can I just ask one final question, then, because we are practically out of time? How do you think the Healthy Child Wales programme is impacting on support for people who are having mental health problems after birth?

[115] **Ms Burns**: It's an interesting one, because it's brand new, as of last year, and it's only for, really, the generic services, isn't it? I'm not a health visitor, so it's hard to comment, probably, on that, although I think it's been well thought through and put together, and there was a launch at the health visitors' conference last year. The gap I see is that Flying Start don't have to adhere to it—they are encouraged to, but they don't have to. So, you've still got this divide of Flying Start and generic services, and I think there could be a little bit more blending there.

[116] **Lynne Neagle**: Okay.

[117] **Dr Witcombe-Hayes**: I don't have specific information about how the Healthy Child Wales programme has impacted on families, but we welcome

the programme and the increase in contact between health visitors and children in the early years. We also support the Welsh Government's Flying Start programme, which delivers intensive support in the first 1,000 days in certain geographical areas. I think that what concerns us is that early intervention for parents struggling to meet a child's needs may not be available outside of those Flying Start areas, and it's for this reason that we would recommend that the committee scrutinises the Healthy Child Wales programme, particularly how it's being resourced, how the current workforce is being supported and trained to deliver the programme's aims, how it delivers early intervention outside of Flying Start areas and how this is joined up with perinatal mental health services.

[118] **Lynne Neagle:** Okay, thank you very much. We've come to the end of our time, so can I just thank you for coming this morning and for answering all of our questions? I think it's been a really helpful, informative session, so thank you very much. You will be sent a transcript in due course to check for accuracy. Thank you again. The committee will break until 10:40.

Gohiriwyd y cyfarfod rhwng 10:32 a 10:40.
The meeting adjourned between 10:32 and 10:40.

Ymchwiliad i Iechyd Meddwl Amenedigol: Sesiwn Dystiolaeth 2
Inquiry into Perinatal Mental Health: Evidence Session 2

[119] **Lynne Neagle:** Can I welcome everybody back to item 3, our second evidence session this morning on our inquiry? I'm very pleased to welcome our next panel of witnesses, who are: Helen Rogers, director at the Royal College of Midwives Wales; Sarah Fox, professional adviser at the Royal College of Midwives; Jane Hanley, who is a perinatal mental health specialist at the Institute of Health Visiting; and Sharon Fernandez, who is also from the Institute of Health Visiting. So, thank you very much for your attendance this morning, and for the papers that you provided in advance. If you're happy, we'll go straight into questions. I've got questions from Michelle Brown first.

[120] **Michelle Brown:** Good morning, everyone. I just wanted to ask what your experience is of specialist perinatal services in the community. How accessible are they? Is it patchy? What's the coverage like across Wales? Are you able to inform us a little bit about that, please?

[121] **Ms Fox:** From a maternity services point of view, there's really been a

significant shift in the last 12 to 24 months since the investment from the Welsh Government in perinatal mental health services, which, I think it's fair to say, has transformed the potential for midwives to refer to specialist mental health services in the community. Each health board has their own individual pathways, and that means that midwives within health boards will know for their own individual health boards what that referral pathway is. That can cause challenges when you're talking about cross-boundary working, and some midwives will have women from different health board geographical areas. I know that there's some work towards all-Wales care pathways, and I think that we should see that as a very positive move, because that, I think, will help individual clinicians to be absolutely clear on what is available for all women and prevent the potential of having different levels of service provision dependent on where you live and which health board you are receiving care from.

[122] **Dr Hanley:** I would agree with Sarah that it is relatively new, really. And for access for mothers across Wales, there's not consistency at the moment. But people are working towards that, so that when the pathways are established—and ideally, an all-Wales pathway is the way forward—there should be no doubt about where mothers go, when and how, and the appropriateness of the referral.

[123] **Ms Fox:** I think we shouldn't underestimate the fact that, prior to the investment of money, there really was virtually no service available. So, it is relatively early days, but it's very welcome and a huge benefit that the injection of money has enabled these services to be established.

[124] **Lynne Neagle:** And as far as you're aware, all the health boards have got in place what they were meant to have in place by October 2016, even though it's early days, yes?

[125] **Ms Fox:** From a maternity point of view—a midwifery point of view—all services weren't up and running fully by October 2016, but my understanding is that they are now.

[126] **Lynne Neagle:** Okay. Michelle.

[127] **Michelle Brown:** Just one more. On our table at the roundtable discussions last week, there seemed to be—well, my perception certainly was that there seemed to be a difficulty and delay in identifying that mothers have perinatal mental health issues. Do you think the new pathways that are

being introduced will help with that?

10:45

[128] **Dr Hanley:** I think one of the fundamental advantages to having this investment is that women will be now assessed much more thoroughly than they have been in the past. I think prior to the investment it was an intuition or instinct that—health visitors are very skilled, and midwives are very skilled, I'm not taking away that, but actually now knowing what to do and looking at the evidence of other screening and assessment programmes, it's much more rigorous to be able to assess in a much more formal way. And then you will always miss because you've got to be intelligent and skilled and knowledgeable to able to assess. Mothers are also skilled, intelligent and knowledgeable, and if they don't want you to know that they're not well then they have the means to do that. And we still have the stigma, whether we like it or not, about the babies being taken into care, should they admit to it, so in lots of ways it may not be the fault of the health professional but indeed the ingenuity of the mother in lots of ways.

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

[130] **Ms Fox:** And for the pathway to be as effective as it can possibly be, and give women the best possible service and care and nurturing that they need, we need to be really joined up in how that pathway works. There's a real challenge with perinatal mental health services in my opinion: that we don't we see it as maternity services asking routine questions or health visitors asking routine questions. A woman triggers on those questions and she is referred to a separate perinatal mental health community service, which may be of an excellent standard, but working separately, I think we lose some of the benefits that women would gain by having a more joined-up service. So, it's a real challenge to ensure that we haven't got separate referral areas, that we all work together to have the knowledge and the confidence and the expertise to enhance the woman's care. So, from a maternity point of view, midwives haven't had a lot of experience of being involved in the care of women with perinatal mental health issues, and my concern is, in the future, if we're just referring them to a separate service,

that they won't be able to build up that confidence, that ability, those skills in that area. So, obviously, we want to see perinatal specialist mental health midwives working as part of the service and being able to work between the two areas to build up that confidence and that knowledge.

[131] **Ms Fernandez:** I think, in my experience as a health visitor, it became part of my everyday role. It wasn't seen as a specialist role. You're building and developing on universal work. The introduction of the Healthy Child Wales Programme and the Flying Start programme make it a part of your everyday business and I think, as you say, with the right training and supervision, and knowing that you can refer on if necessary, that that can only be a good thing for all women in Wales.

[132] **Lynne Neagle:** Thank you. Michelle, do you want to go on to workforce?

[133] **Michelle Brown:** Yes. What's your experience of—? Putting it bluntly, do we have enough staff to cater for the potential need in the community?

[134] **Ms Fox:** I think that the investment in money over the last few years has created the capacity to care for women from maternity services who need community perinatal mental health care at the current time. It may be that we almost—. We need to be careful about how we define care, and care isn't necessarily an appointment within a certain amount of time and treatment within a certain amount. It's a whole package of care, and as I've previously touched on there, there's a challenge to that in terms of ensuring all the services work in collaboration and that package of care is the right thing for the woman.

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

[136] **Dr Hanley:** I think, also, perinatal mental health is becoming a very attractive area now, in terms of when you're talking about recruiting. People,

as Sharon said, prior to this, were doing the work themselves and not having the acknowledgement—certainly in terms of time and resources. So, what we've now created—the Welsh Government has now created—is a resource that is extremely welcome, and I'm sure people will find that they can develop it and take it to a much higher level as well than, perhaps, our counterparts in England and Scotland, because there is the capacity there for not only referrals—and I'm looking at the different types of referrals that would go there—but for research too, and development, and taking it to different levels. So, yes, I think that it will attract a lot of people and a lot of people with a firm interest in perinatal mental illness.

[137] **Ms Rogers:** I think we also have to recognise that, certainly from a midwifery perspective, it's only relatively recently that the role of the midwife has been acknowledged in perinatal mental health. For a long time, it was seen that our only role was to refer, and a lot of effort was put into getting the questions into the hand-held notes, and as previous evidence has shown, the midwives, then, were in a position that they didn't—. If somebody said, 'Yes, I've got a problem', they didn't know what to do with it. And partly because of the funding and partly because midwives have been shouting quite loudly over the last few years, our role is much more recognised than it has been in the past, and we are reaching out to other groups that perhaps would not be our natural allies. We are working in a much more multiprofessional fashion. We've just run an all-Wales perinatal mental health conference with Public Health Wales, but that has taken time, and I think if you went out to the service and asked midwives what their role is, they would say, 'We are frustrated because we're just seen as those who refer, and we're not seen as part of the solution.' And I think when you're looking at, 'Do we have the capacity? Do we have the staff?', we have the staff but we don't always recognise their role in perinatal mental health.

[138] **Lynne Neagle:** Okay, thank you. Before I bring Llyr in, can I just clarify something you just said? You said that it's in the hand-held notes, so women are asked now whether there is an existing mental health issue, so what you're saying is it goes in the notes, but nothing is done with that, because midwives don't have the skills and the training to deal with that.

[139] **Ms Rogers:** They have some skills and they have some training, but I think, as Jenny Burns said earlier, if a midwife is faced with a woman who says, 'I'm suicidal', there is genuine fear that they don't know what to do with that woman, so the questions are in the hand-held notes. Some training was put in place, but there is still much more work to be done around that,

so that the service is not overwhelmed, because there are lots of things that the midwives could do at that point other than refer.

[140] **Lynne Neagle:** Okay, thank you. Llyr.

[141] **Llyr Gruffydd:** I just wanted to pick up on a point that Sarah Fox made about co-operation and co-ordination, and people coming together—service providers coming together. There was a key concern in a lot of the evidence that we received last week in our stakeholder event around the fact that there were so many people providing different aspects of services. I mean, there was the GP, the health visitor, community mental health team, perinatal, and the cry, really, was, 'I just wanted one person to take control, to take the lead', because there were multiple assessments and all this, really. Is that something that you recognise as a weakness, and can you reassure us that something is happening to try and maybe offer that better co-ordination? Is there a designated lead person within a broader team? Because, clearly, there was a concern from the evidence that we have that that was lacking.

[142] **Dr Hanley:** I think it's always been the health visitor who's taken the lead in terms of perinatal mental health, and has done the referrals to the GP, has done the referrals to the psychiatry team, and has also liaised with the midwife. In fact, when I was working as a health visitor, that was a very tight liaison that we had, and we worked together. So, the mother saw the midwife, she saw me, saw the GP, and then went into the services, but was never lost to the services either. I think that was always a major concern: that a mother went into the psychiatric services, never to be seen again. But that doesn't happen. The health visitor is certainly there for three and a half or four years, so the continuity of care is there and they can monitor that mother should she relapse or should she have any difficulties. So, we relied very heavily on the midwives for the background information, and then it was a health visitor who took charge.

[143] **Ms Fernandez:** I think what you there alluded to is that relationship between the practitioner and the parent. You know it's imperative. In practice, I would spend a lot of time working with mums, listening, because often that's all that was needed, and that maybe once, maybe more. On the times that you would then need to refer on, it's because it was felt, together, that what you were doing wasn't enough. So, you would have built up a relationship of trust, and then they would trust that your judgment was right to refer to the GP and get extra support, whether that might be medication or referral on to the local mental health counsellor or community mental health

service. But again, from a Powys perspective, because I'm health visitor lead in Powys, we have been building on the universal services, so very much working with what midwifery and health visiting are doing—again, every day—and making them the point of call for the parents and encouraging them to do the listening work rather than referring straight on. Because we don't really need to be doing that on most occasions.

[144] **Llyr Gruffydd**: Okay, thank you.

[145] **Lynne Neagle**: Okay, thank you. Darren, on the clinical—

[146] **Darren Millar**: Yes. You've touched on some of the clinical pathways that are there at the moment and the need to build some more resilience, if you like, into the midwifery and health visitor teams. Can I just check with you: when you said that, within the questions, there are questions about mental health, Helen, that are asked to mums, they're about pre-existing conditions, are they, or about changes in people's mental health?

[147] **Ms Rogers**: They're about family history and pre-existing conditions.

[148] **Darren Millar**: It's about family history.

[149] **Ms Rogers**: Yes, but it is an opportunity for a woman to also flag up, and it's an opportunity for the midwife to have that conversation.

[150] **Darren Millar**: Yes, and to what extent is pre-existing mental health, or the prospect of potential mental health problems, featuring in antenatal classes these days?

[151] **Ms Fox**: There's no clear format for each antenatal class. They won't all sit the same. It very much depends on the leader of that class. Sometimes, that's midwives, and sometimes that's third sector groups. So, it depends on their criteria. Anecdotally, I can tell you it is touched upon, but in any great depth would depend on the individual leader of those sessions.

[152] **Darren Millar**: Because it sort of really starts there, doesn't it, in terms of putting some hedges of protection in place, if you like, as well, then, as sort of building on the interaction that the midwifery teams and health visitor teams have with the individual parents?

[153] **Ms Fox**: I agree it's an opportunity but, unfortunately, as a percentage

of all women birthing, probably fewer than 20 per cent go to antenatal classes.

[154] **Darren Millar:** Is that right? Okay.

[155] **Ms Fox:** On paper, some of the most high-risk individuals of having perinatal mental health problems or ill health are in the demographic that are the least likely to attend. Now, all women—well, virtually all women will receive antenatal care from their midwife, which is why the routine enquiry is such a valuable tool, if it's delivered well and with confidence in opening up a conversation. Because as you've already heard, perinatal mental health has been almost an area of shame for many women. So, if it becomes more of the normal care that women receive, part of the normal conversations that they have with their midwife, who they know and trust, it will enhance, I think, women's opportunities to open up and discuss.

[156] **Darren Millar:** So, it's going to take some time to build a bit more resilience into the midwifery teams. Some training has obviously taken place, and some health boards appear to be further down the line with supporting their midwives and health visitors to be able to give that support than others, but, clearly, there will always come a point where someone may have to make a referral on to someone who is more of a specialist. What sort of time lag, then, appears for the mum who is being referred before they're properly assessed, seen to, given appropriate support or interventions? Do you have any data on that, or information that you're able to share?

11:00

[157] **Ms Fox:** So, each individual health board, from an antenatal referral point of view, will have their own timelines. So, in ABMU, for example, they will look after the referral is assessed, and appointments are sent out within seven days, antenatally. But this service has been up and running in its entirety for weeks, so we are in its infancy. And, because each health board has their own individual pathways, I'm sure there are differences in each of the health boards.

[158] **Darren Millar:** Okay.

[159] **Ms Fox:** It will be really helpful to all, I think—most importantly the service users—to have a clear, all-Wales target of what is appropriate and what can be achieved.

[160] **Darren Millar**: And what do you think is appropriate and should be achieved? You said you get a letter out within seven days. That doesn't mean you get—

[161] **Ms Fox**: Well, I think it's a phone call in ABMU, but yes.

[162] **Darren Millar**: So, what do you think is appropriate and should be achieved? If we were to suggest a target to the Government, what should it be? The clock's ticking with an impending birth, isn't it, so—.

[163] **Ms Rogers**: I think some of that will depend on the severity of the situation—

[164] **Darren Millar**: Yes, of course.

[165] **Ms Rogers**: You need to take that into account.

[166] **Darren Millar**: But, presumably, if you've got this resilience in at a lower level, you're only going to be passing on the ones that really do need passing on, with a higher level of need, aren't you? So, what sort of timescale do you think is appropriate—two weeks, a week, a month?

[167] **Dr Hanley**: I think when we're talking about mild to moderate then it can come under the remit of the health visitor, as Sharon said. They can have listening visits, and those listening visits will be monitored for four to six weeks. Four weeks is the average that they will argue for the therapeutic interventions—but, obviously, that depends on the mother as much as the health professional—and then to have a look again at how that mother is progressing, and if that mother is not progressing then she will be referred onto the psychiatric secondary services or to the third sector, depending. And it does depend, as has been said, on the capacity of those services to be able to see that mother at that time. Eighteen months has been quoted for IAPT services in the past, and, certainly, when I was somewhere the other day it was at least a 12-month waiting list for referral to a counselling service. So, it's patchy, but at least it's far better than it was perhaps two years ago when you were awaiting an appointment.

[168] **Darren Millar**: It's still a very long delay, isn't it?

[169] **Dr Hanley**: It is, yes.

[170] **Darren Millar**: And just in terms of mums who are under 18, they're obviously having to be referred into a different service, almost, with CAMHS services. To what extent are they given an advantage or disadvantage because of that? Does that relationship work well with health visitor teams?

[171] **Dr Hanley**: I'm not sure about the waiting time, again, for the CAMHS services. Again, that could be patchy too, but in the meantime that mother is supported. She is having all the services available and she is having all the direction that she needs. It's just for that extra support. And that is always available, also: a telephone call to an appropriate service.

[172] **Darren Millar**: But, with the new perinatal mental health teams, to what extent do they have exposure to CAMHS experience, if you like, so that they can use that as and when it might be required? Is that featuring at all in those services at the moment?

[173] **Ms Fox**: I don't know the details of job descriptions of appointments into perinatal mental health teams, I don't know if part of the criteria for the jobs is previous experience of CAMHS services. You would hope that, if you are providing a service for all women having babies, and knowing that some of those referrals are going to be under 18s, then there would be experience. But 'I don't know' is the answer.

[174] **Lynne Neagle**: Can I just ask the health visitors in relation to CAMHS—you said that if a woman under 18 was referred into CAMHS you weren't aware what the waiting time is, and everyone on this committee will tell you that it's not easy to get into the CAMHS system. Do you provide any additional support, then, to women who are under 18? Or is it just the usual kind of support that you've referred to, the listening visit? Or is there any additional input, given that there are issues with CAMHS?

[175] **Ms Fernandez**: I've been reflecting on this and, actually, in my 14 years of practice, I've never worked with a mum who is under 18 with postnatal depression or anxiety, which is very bizarre. But, as a practitioner, what I would be doing is ensuring that I provide the level of support needed, because it's about the unique needs of that mum. And that obviously varies, depending on what they're wanting from us, but I would say that the practitioner would be holding—the health visitor would be holding—that mum until the relevant services can provide the support that's needed.

[176] **Lynne Neagle**: And that would be however much support they needed, then, even if it was a visit every few days, or every week.

[177] **Ms Fernandez**: Absolutely. And, again, I'm talking from a Powys perspective—we have taken a different approach. So, our service consists of nursery nurses—so, the midwives and health visitors are assessing on a regular basis, they would offer the listening visit, and then they're making a referral and delegating work to the nursery nurse, so then the nursery nurse may go in and do some support.

[178] **Lynne Neagle**: Okay, thank you. Llyr.

[179] **Llyr Gruffydd**: Yes. I just wanted to ask about dual diagnosis, because the Royal College of Psychiatrists has suggested that there's often a significant delay in getting the appropriate treatment for perinatal mental health illnesses if the mother has a dual diagnosis—alcohol or substance misuse, learning disability, that kind of thing—and they say that that's likely in part due to a lack of knowledge and confidence from front-line healthcare professionals. Is that a fair assessment, do you think? I see you nodding.

[180] **Dr Hanley**: Well, I think self-medication comes into it, and, very often, the dual diagnosis is because they're self-medicating because of the depression, or because of the anxiety. It's very difficult to unpick it, but, again, it's not impossible to do, and we are at a new stage, whereby people are going to be much more aware of the impact that alcohol and drugs have on mental health and illness. So, new avenues will be open. So, although it's not great at the moment, there certainly is scope for future development.

[181] **Llyr Gruffydd**: Okay. Yes, sorry.

[182] **Ms Fox**: Sorry. There are many specialist services in maternity, so, for example, most health boards would have a substance misuse/alcohol misuse specialist team to care in pregnancy. When I was talking about the separation of the teams, this is an ideal opportunity for someone from the specialist perinatal mental health team to join that service and provide almost a multidisciplinary team-type approach to a woman who is clearly at a significantly higher risk of perinatal mental health issues. So, that, I think, is the opportunity in the future. I don't see that happening in Wales at the current time, but there's the opportunity for us to really think about a joined-up approach and ensuring that perinatal mental health support and care and knowledge and expertise is involved in all of the layers of maternity

care.

[183] **Llyr Gruffydd**: So, what will it take for us to get there, then? Is it simply resources?

[184] **Ms Rogers**: No, I don't think it is. At the moment, if you have a high-risk woman, say, who has a cardiac condition, she will be looked after by the obstetrician, she will be looked after by the cardiac team, and she will have a named midwife. Every woman will have a midwife. So, it's about having that joined-up thinking, it's about saying, 'This woman presents and there are risk flags there, so who needs to be involved?' I think, sometimes, we give care in silos and we think we're the only ones who are giving care and it's a bit like if a pregnant woman is admitted to an orthopaedic ward because she's got a broken leg. The orthopaedic people want to send her back to maternity because she's pregnant, and the maternity people are saying, 'No, it's the leg that's the problem at the moment', but she still needs that maternity support. So, it is about working out what's the key thing that needs looking after at the moment, but that doesn't mean that the rest of the team disappears. So, it's about good use of resources; it doesn't necessarily mean that we need additional resources.

[185] **Llyr Gruffydd**: And that, therefore, primarily, is the responsibility of the health boards to ensure that it happens. Okay. The Royal College of Nursing say that women's mental health should be given parity of esteem with physical health. I presume that you agree with that, although I'll stand corrected if not, but, if you do, how can we take this forward?

[186] **Ms Fox**: We've made a great start. It's not just about money, but money makes a difference. I don't think you can underestimate that. We've had a significant investment in services and my belief is that it's transformed the opportunities for women to get the specialist care that they need in pregnancy and postnatally. However, when you consider the number of personnel, the number of training opportunities, the investment in their training in the first place and ongoing continual professional development of all the physical knowledge of ill health, as opposed to mental ill health and well-being, it is completely disproportionate. So, I think we almost need a bottom-up approach now, looking at every aspect of career training and development and the networks out there, to ensure that it has the profile that it needs, because it hasn't. It's starting to improve, but it hasn't for such a long time that we have clinicians in practice who just have had years of experience of virtually no information, knowledge, confidence building to be

able to deliver care in this area.

[187] **Llyr Gruffydd**: Thank you.

[188] **Lynne Neagle**: Thank you. John.

[189] **John Griffiths**: I wanted to ask about your involvement in the community in practice network, and whether you believe it's achieving improvements to the specialised perinatal mental health services in the community.

[190] **Ms Rogers**: From the Royal College of Midwives's perspective, we have very little involvement, and I think that stems back to it not being widely recognised that midwives have a role in perinatal mental health. So, I think it's been a struggle to get involved. Therefore, it would be difficult for us to say how effective that network is.

[191] **Dr Hanley**: Sorry, could you just clarify what you mean by 'community network'?

[192] **John Griffiths**: There's a network in place that links organisations working in perinatal mental health services in the community, and we want to get a view, really, of how involved you've been, or not, and whether it is really improving those specialised perinatal mental health services in the community, or not.

[193] **Dr Hanley**: I'm going to ask you to come in on that one.

[194] **Ms Fernandez**: I have been a member, and I have been a member for some time. I think what I felt was, maybe, again, health visiting wasn't recognised, but I have been persistent and I've continued to go in. There are a few health visitors who go along. It is very much about specialists. It is very much about psychiatry, CPNs, and that's absolutely fair enough, but I do feel that there needs to be representation from all the services from the very beginning, from the very mild-to-moderate right through, going forward.

[195] **John Griffiths**: So, do you think, then, all of you, that midwives and health visitors should have more of a role in the network, more of an involvement? Would that make sense from your point of view?

[196] **Ms Rogers**: Yes, and, to be fair to the network, I don't think it's a

question of, 'We must keep these people out'. I think it's a question of not fully understanding each other's roles, and we could be accused of the same around our psychiatry colleagues. So, it's because, historically, we've all worked in isolation, and that's to no-one's credit. We've dealt with pregnant women, and psychiatrists have dealt with pregnant women who have mental health issues, and a lot of work has been done by a lot of very good individuals to get people around tables together. Every so often, I think it's just that people forget that there are other professionals out there, such as midwives and health visitors. I think the all-Wales perinatal mental health steering group was a good example, because, initially, there were no midwives on there whatsoever. There are now, so that is a step forward.

[197] **John Griffiths:** Just allied to that, one of the issues we're also concerned with is whether there's a case for a managed clinical network in Wales. Do you think that there is? Maybe it's not so easy for you to form a view, given the lack of involvement you've had, but would that be a step forward?

[198] **Ms Rogers:** It could be a step forward. One of the examples that we have is the maternity network, and that's been established for about three years now. That is jointly chaired by a midwife and an obstetrician, and it has all of those who are involved in maternity care on that group. It's growing, it's learning, and one of its sub-groups deals primarily with stillbirth, and a lot of work has come out of that, including the safer pregnancy campaign with 1,000 Lives Wales. So, that is a good example of where we've moved forward and where we have very good multiprofessional working. So, a managed network could be useful as well.

11:15

[199] **John Griffiths:** Okay, thanks for that. Moving on then, in terms of postnatal depression and anxiety and the extent to which they go undetected, we have a statistic that states that the Royal College of Paediatrics and Child Health estimate that as many as half of those cases of postnatal depression or anxiety do go undetected. Do you share that concern? Would you have any evidence that you could furnish the committee with to support your view?

[200] **Dr Hanley:** It is the case that cases go undetected, and for a variety of reasons. That might be the lack of knowledge on the part of the practitioner, or that the pathways are unclear. It's multifactorial. Also, as I said, the fact

that you can get the mother being resistant to any kind of assessment, because of the fear of her child being taken into care. That is a real problem, and does present itself on a national scale.

[201] Again, I think we've alluded to the fact that it's a new area for some, perinatal mental health and illness, and the prerequisites for detecting it have not been there in the past probably as much as they will be in the future. So, although there has been a lack in the past—really it's only in the last couple of years that we're talking of the investment of money in the services being provided, so the mothers you would have talked to in those previous years will have been in a different set of care, if you like. So, yes, in the past, but hopefully not in the future, and for all the reasons that have been laid out today, that the services are there now, whereas they weren't previously.

[202] **Ms Fox:** From a midwifery perspective, postnatal care has always been the least well-resourced area of maternity care, and there's always been a challenge for midwives and midwifery support workers to deliver quality care at the level they would want to. In order to support women, to have a relationship with women whereby you would recognise postnatal depression at its earliest stages, you need continuity of carer, you need to have a reasonable number of visits, you need to have built up a trusting relationship with your midwife, and that is very challenging to do in the current structure of maternity services. So, there are some challenges for midwives to be able to deliver the best possible support to women, and it wouldn't surprise me that many women, unfortunately, who have postnatal depression aren't immediately offered the care that they need from the midwifery perspective.

[203] **Ms Rogers:** I think you also meet more and more young women these days who are having babies and have moved away from family networks. Their husbands and partners go back to work very quickly. They're often in isolated homes on huge housing estates. If you're feeling a little down, you're much more likely to feel that way if there's no support mechanism there. Coupled with that, it's unusual for a midwife to visit a woman past 10 days postnatal now, unless there's specific need, and she may only see her three times in those 10 days. And it may not be the same midwife. So, there are huge issues around that emotional support, and it's not seen as something that is important. As long as, postnatally, the mother is physically well, and the baby is physically well, and you're not picking up any major problems, then the psychological needs are often the last thing that people can think about. That's not because people don't care about them; it's down

to the fact that there is little time and poor resources. And, as Sarah said, postnatal care is not given the priority that it should be.

[204] **Ms Fox:** It's a sad irony as well that certain postnatal anxiety disorders can sometimes result from birth experiences. So, sometimes, our service has created the postnatal mental health issues, and we know that where there's good debriefing services from clinicians that women trust and know, you can, at the earlier stage, intervene and support women to not go on and progress and get some of the anxiety disorders that we see. So, it's a real challenge.

[205] **John Griffiths:** So, these are issues essentially for the health boards and the Welsh Government at a Wales-wide level, because that's where the resource allocation is decided and prioritisation is made.

[206] **Ms Fernandez:** I think as part of the Healthy Child Wales programme now and the Flying Start core programme, we will see a difference. There's an expectation that all mums are asked about their emotional health and well-being at specific periods throughout the early weeks and months, and even antenatally. So, I think that will make a difference. And, also, up until last year, I think, most people focused on depression. People hear about postnatal depression, everybody knows about that, but anxiety wasn't given. Now, we're asking people to ask both about depression and anxiety. So, I feel that we will be giving mothers and fathers the opportunity to share with us how they're feeling.

[207] **John Griffiths:** As part of Flying Start?

[208] **Ms Fernandez:** As part of both the Healthy Child Wales programme and the Flying Start core programme, all mums should be asked about their emotional health and well-being.

[209] **John Griffiths:** Yes. So, between them, they would cover everyone.

[210] **Ms Fernandez:** Absolutely. The whole of Wales.

[211] **John Griffiths:** Okay.

[212] **Lynne Neagle:** But you've raised in your evidence the fact that you don't think mothers are being asked at the right time.

[213] **Dr Hanley**: No, I wouldn't say that at all. I'd say, previously, I think the mothers that will have been asked for that survey will have been in a previous time. No, absolutely, now, the emphasis is on asking mothers in the antenatal period about anxiety and depression, and in the postnatal period.

[214] **John Griffiths**: Okay. Could I just ask this one, Chair? Just in terms of the importance of support services being available for fathers, partners and family, how important is that, and are there real gaps there?

[215] **Dr Hanley**: It's vitally important. I think we're recognising much more in recent months even the role of the father and how the mother's mental health can have an influence on the father's mental health, and how the father's mental illness can have an influence on the child. So, there are very real issues around involving the father in everything. Whether it's practical, again, it comes down to resource issues, it comes down to accessibility, if the father is available. Certainly, you have paternity leave now, so it should be better than it is. But, certainly, the research is showing that there is a significant percentage of men who are now suffering from depression and anxiety in the postnatal period, as opposed to the antenatal period.

[216] **Lynne Neagle**: Llyr.

[217] **Llyr Gruffydd**: I will pick it up later. I think it'll come up later, actually.

[218] **Lynne Neagle**: Okay. Can I just go back to what you said about the timescales? Your paper does say that it is good practice to assess at six weeks and three to four months, but that the guidance currently is only to do a formal assessment at six months. That's your paper.

[219] **Dr Hanley**: Yes, it is, and I've been corrected on that too, by Sharon, because that's been revised now with the universal Healthy Child programme, so the times are actually different on that paper now.

[220] **Lynne Neagle**: Okay. So, that's changed. Great. Thank you. John, are you—

[221] **John Griffiths**: I'm fine, thank you, Chair.

[222] **Lynne Neagle**: Michelle.

[223] **Michelle Brown**: Thank you, Chair. You've emphasised the role that

midwives and health visitors have in identifying perinatal mental health issues. Are you happy that midwives and health visitors have sufficient training to identify those issues, and do they have the time to?

[224] **Ms Fox:** I think that midwives have the training to ask the routine questions that are asked of them, and I think that the midwives have the training in understanding their health board pathway of care. What I think would be optimal is if there were more training to enable midwives to support the specialist perinatal mental health services in their care of women with identified issues, because there will be some women who perhaps wouldn't need referral to a specialist service, if a level of care could be provided by the midwife. And there will be some women who do need a referral, but that referral will be more effective if the midwife is able to support the care that that woman is receiving through that specialist service. I think midwives currently aren't receiving training in that area.

[225] **Dr Hanley:** The health visitors of Wales—[*Inaudible*.]—19 of them [correction: 19 areas of Flying Start] have received training in perinatal mental health and listening visits, and indeed, some of that training has been rolled out across parts of mid Wales and south Wales too. But the emphasis has always been, 'This is just awareness raising' and there needs to be more in-depth training, definitely, to support practitioners to know what they can do for mothers. The model of training has been spread out.

[226] **Lynne Neagle:** Did you say 19 or 90?

[227] **Dr Hanley:** Nineteen.

[228] **Lynne Neagle:** One, nine?

[229] **Dr Hanley:** Yes. Areas of Flying Start, yes. Again, not every Flying Start practitioner was able to attend because, again, the moneys were allocated and were to be spent within that, I think it was a three-month period, so it was very difficult, as you can imagine, to get staff to attend those courses. But there has been training rolled out. You may be familiar with the Institute of Health Visiting training that's now been rolled out across England. It's a 'train the trainer' course, so the numbers of health visitors in England who have been trained are quite significant.

[230] **Lynne Neagle:** Llyr on this.

[231] **Llyr Gruffydd**: On training more generally, and not specifically on this.

[232] **Lynne Neagle**: Okay. Michelle, did you want to pick up on that?

[233] **Michelle Brown**: You were talking about England there and what the situation is. How many health visitors, approximately, do we have in Wales? How many of those have had perinatal training?

[234] **Ms Fernandez**: I would suggest that moneys came from Flying Start and all the Flying Start areas received perinatal mental health training. Generic may be different—not everywhere may have received that.

[235] **Ms Fox**: Can I just add that, in the last month, there's been a very successful conference held, which was a partnership between the Royal College of Midwives and the community of practice? Two-hundred people were able to attend this conference, where there was a raising of awareness and knowledge and the actions of midwives and other healthcare professionals. It was massively oversubscribed and I think that illustrates that there is a desire out there from midwives to enhance their knowledge and expertise in this area. They are actively searching for opportunities to do that.

[236] **Dr Hanley**: Perhaps I should also add that, two years ago, there was a very successful international conference on perinatal mental health and, again, that was oversubscribed. It was a three-day conference and we had experts from all across the world, who were giving their knowledge.

[237] **Ms Rogers**: You asked about whether midwives have the time and I think the reality is that we need to make the time. The midwives are there postnatally. They are there for that initial debrief, whether it's very simple or whether it's more in-depth. They have that relationship with the woman. I think they are key professionals, so I think we have to enable them to get properly trained and to have the time to do that because we simply can't refer every single woman, just because we can't deal with them. We need to refer them based on clinical need.

[238] **Ms Fernandez**: I would absolutely agree with that. Time is such an issue and people may use it as a barrier; practitioners may use it as a barrier because it will generate work. But what I say to colleagues and myself is: if you invest that time earlier, you will save time later on.

[239] **Lynne Neagle**: Llyr and then Darren.

[240] **Llyr Gruffydd**: Yes. Again, I'm referring back to what some people told us last week in our stakeholder event. Some people didn't feel that there was enough information out there about what medication you could take and still safely breastfeed. I'm just wondering, as people working on the front line, whether you've picked up a significant number of people who are on medication who are concerned about this, because some of the evidence that we received suggested that GPs very often weren't too sure actually, and there was reference to even a pharmacist in one hospital who really didn't know whether you could and there was conflicting advice from different professionals. Is that something that you're picking up as a concern?

[241] **Ms Fernandez**: I think that's definitely something that needs more work. Again, in Powys, we've rolled out the GP toolkit, which is an excellent resource, to be distributed to the GPs, but we need to be working with pharmacies as well to ensure that everybody understands—not just GPs, but the midwives and the health visitors—because they can advocate, then, on a mother's behalf. Yes, you do hear stories where breastfeeding, unfortunately, has been discontinued because they've been told that they need to stop in order to take medication and that simply isn't true.

11:30

[242] **Llyr Gruffydd**: Needlessly.

[243] **Dr Hanley**: Yes, as a precaution.

[244] **Ms Rogers**: I think people always err on the side of caution.

[245] **Ms Fox**: It's very, very difficult, isn't it? Because the trials are not being undertaken on whether women breastfeeding can safely—you won't recruit into those sorts of studies. So, robust evidence to support women in their choices is very hard to come across. It's very difficult for women to hear, 'We're not absolutely sure, we think it's probably safe.' Unfortunately, for most medications, no matter how much knowledge you've got, that is unfortunately what you need to feed back to women. That's a really difficult responsibility for them. So, I am sure there's a slight lack of knowledge, but even the very knowledgeable may come across as if they're not sure, because of the evidence base, and I don't think that that evidence base will change.

[246] **Llyr Gruffydd**: Okay. Thank you.

[247] **Lynne Neagle**: Darren, on this.

[248] **Darren Millar**: Yes, just in terms of the listening visits and things, obviously, that's going to require more time from midwives—everybody's accepted that. So, even if they're not being referred onto the perinatal mental health teams, which we've accepted aren't big enough in some places at the moment because they're not fully developed, they're still fledgling, then we're still going to need a bigger midwifery workforce, aren't we? Because if they've got to spend more time with the mums—.

[249] **Ms Rogers**: Jane alluded to the fact that nursery nurses have a role to play in perinatal mental health, so do maternity support workers. I think it's important to recognise initially what are the needs of the woman and then work with the team that's available. We have had a 40 per cent increase in our student midwifery commissioning numbers this year, which is very welcome, and that will go some way to ensuring that we have more midwives in the system. I could be at five more committees and, every time, I'm going to be saying, yes, midwives are going to have to have more time to do this and, yes, we're going to need more midwives to do it. That is a fact of life.

[250] **Darren Miller**: Has there been any estimate of the total number, in terms of the workforce, that will be required to deliver the new services, with midwives, maternity support workers, nursery workers, et cetera?

[251] **Ms Rogers**: Midwives have a workforce planning tool, which Welsh Government supports.

[252] **Darren Miller**: So, has this been taken into account within that tool—that's the question.

[253] **Ms Rogers**: Not this specifically. I think one of the reasons why we would want a specialist midwife in each of the health boards is because they can take on some of that leadership and some of that helping midwives with training and assessment to see what exactly their involvement needs to be. But there hasn't been any workforce analysis, as far as I know of, just to take into account this.

[254] **Darren Millar**: A final brief question, and it's just on the initial midwifery training—you've mentioned there's been a 40 per cent increase in

new midwife training places coming in, which is great.

[255] **Ms Rogers**: From September.

[256] **Darren Millar**: To what extent does mental health feature in that initial training for midwives?

[257] **Ms Rogers**: It is covered in the curriculum.

[258] **Darren Millar**: Sufficiently well, or does that need to change?

[259] **Ms Rogers**: 'Sufficiently well'—I think it probably is for students. You're not going to be able to train a student to 100 per cent in everything. It is covered. I think one of the challenges is around—just with training of midwives and health visitors—we've tended to focus on awareness training with a view to referral. So, we need to do more than that if we're actually going to get these professionals to be more active in the looking after and treatment of women.

[260] **Darren Millar**: So, it does need to change, both for midwives and health visitors, in terms of that initial training.

[261] **Ms Rogers**: I think it could change.

[262] **Darren Millar**: Thanks.

[263] **Lynne Neagle**: Okay, final questions then from Llyr on the mother and baby unit.

[264] **Llyr Gruffydd**: There seems to be a huge gaping hole in provision with us not having a mother and baby unit here in Wales. Now, I'd imagine that you would wish to see one. Maybe you could tell us what the benefits, you think, would be of having a centrally funded mother and baby unit in Wales.

[265] **Dr Hanley**: I'd like to see several. I'd like to see them all over the country.

[266] **Llyr Gruffydd**: Well, and that. Then, I was going to ask: do you think that one is sufficient? Is it practical to demand more than one? How do you see it rolling out?

[267] **Dr Hanley**: I think it's practical to do two. When we're talking about the physical aspects—if you're talking about somebody with diabetes, they have diabetes specialists, they have diabetes clinics, and yet we don't have any such facility for perinatal mental illness. The fact is that the mother is separated from her baby when she goes into any psychiatric hospital currently, and we know for a fact that that is damaging both for the mother and the infant. It makes perfect sense that they both be treated together in a unit—not necessarily a hospital, but certainly to have the specialist care to ensure quick recovery.

[268] **Llyr Gruffydd**: One has to question, therefore, why did we lose the unit back in 2013? The point was made at the time that there were issues around resources and staffing. Low demand was another point, although I think we've touched on this in our previous session—that maybe the data don't actually capture everyone who would require that kind of service.

[269] **Dr Hanley**: And accessibility, when you're talking about the distances that people have to travel.

[270] **Llyr Gruffydd**: So, why is it that we don't have the service then?

[271] **Dr Hanley**: I suspect it's resources. That's what we were told—that the finances weren't available for it. I suppose it was at a time too when perinatal mental illness didn't have the influence that it does now. The time is right now. It prematurely closed, perhaps, as you rightly say, for those reasons. But the time is right. I've known women who have suffered from puerperal psychosis and I've known women who have committed suicide—all preventable deaths and all preventable escalation of illnesses, if they'd only had the appropriate care at the right time.

[272] **Llyr Gruffydd**: Yes, thank you.

[273] **Ms Fox**: I think we all acknowledge that acute admission to a mental health facility is not appropriate for women who have just birthed or are within a year of birthing their baby. There are profound implications at that moment and ongoing implications for mental health in the future. It is a challenge, geography. One mother and baby unit in Cardiff—you could argue, if you lived in Wrexham, you'd be better off in Liverpool than coming down to Cardiff.

[274] We know that women need to stay with their babies. The college's

view is that no woman should be separated from her baby unless clinically indicated. But they also need to be near their family as well. So, it needs to be really carefully thought out, because I fear that the Cardiff unit may have been susceptible to closure because it was an isolated unit and perhaps the thought wasn't put into it before that was rolled out. If we are choosing to invest in this area, which I think needs investment, we need to think very carefully about location and facilities to be able to make it really work. These women are so vulnerable that we need to make it work really well for them.

[275] We estimate that between 50 and 70 women a year will have acute postnatal psychosis that will require an in-patient admission—require it. Regardless of how great your community perinatal mental health care is—and it is starting to be great—you will still need acute admission for this number of women in Wales, or about, at the moment. WHSSC suggest that fewer than five have been going to mother and baby units each year for the last three years, which suggests there are between 45 and 65 women, which isn't a massive number, but they are very vulnerable women who are in in-patient facilities where, at best, they've got a small waiting room to spend a short amount of time with their baby and family. That can't be acceptable, can it, in a gold-standard service?

[276] **Ms Rogers:** The other thing to consider is that the staff, if there is a mother and baby unit, are very up to date, that they're trained, and that they have the resources as well. So, it's not just about bricks and mortar or a bed—it's about the whole service and that the service is there to benefit these extremely vulnerable women—and not just so we say, 'We've got a mother and baby unit'.

[277] **Llyr Gruffydd:** Thanks.

[278] **Lynne Neagle:** Okay, thank you very much. We have come to the end of our time, so can I thank you all for attending this morning and answering all our questions? You will be sent a transcript to check for accuracy in due course. Thank you again for your time, the committee's found it very informative. Thank you very much.

11:40

Ymchwiliad i Iechyd Meddwl Amenedigol: Sesiwn Dystiolaeth 3
Inquiry into Perinatal Mental Health: Evidence Session 3

[279] **Lynne Neagle**: Can I welcome everyone, then, to our final evidence session this morning? I particularly welcome Professor Ian Jones, who is here representing the Maternal Mental Health Alliance. Thank you very much for attending. Are you happy for us to go straight into questions?

[280] **Professor Jones**: Fantastic, thank you. Yes.

[281] **Lynne Neagle**: The Maternal Mental Health Alliance's campaign 'Everyone's Business' calls for all women in the UK who experience perinatal mental health problems to receive the care they and their families need, at the time that they need it. Can you just tell us how you think Wales is doing, according to that prescription?

[282] **Professor Jones**: Well, I think, historically, this has been an area where Wales hasn't done very well. One of the things that the Maternal Mental Health Alliance has done, which has been a particularly effective way of campaigning, actually, was to look across the UK and produce maps with a red, amber, green colour-coded system to see how the health boards in Wales, the trusts in England, were meeting the NICE guidelines' levels of services. When those maps were first done in Wales, we didn't do particularly well. There were only Cardiff and Vale and parts of Abertawe Bro Morgannwg University Local Health Board that had anything that was other than red—there was some amber on the map. Saying that, I think a very important point to make upfront in my evidence is that I was incredibly pleased and encouraged by the response that the Welsh Government made, for the money that came through as a consequential from the money that was promised in England to be dedicated to be spent on maternal mental health services.

[283] The other thing I would say, actually, that I think the Welsh Government should be very proud of, and it says something, I think, about our health systems in Wales compared to England, is that, although the money was promised much earlier in England, when the money came through to Wales, it was promised, there was a plan, health boards put in plans as to how they wanted to spend it, and money was spent directly on employing people in the health boards that were delivering treatment to women much, much quicker than in England. That's started to happen in England now, but the bureaucracy there has been such that it's taken far, far longer for the money to be spent at the coalface. Historically, we have been

behind the curve, I think, in Wales, compared to the UK as a whole. I think there are some signs of encouragement, and you'll have heard already about some of the developments made, but I think there are some issues that remain with the way that the money has been spent. A couple of issues—. Am I okay to go on?

[284] **Lynne Neagle**: Yes, of course. Yes.

[285] **Professor Jones**: One is that, quite rightly, a decision needed to be made about how the new money coming in was spent, and a decision was made, and I think this was right as well, that it shouldn't just go to pay for services that are currently being delivered. So, what that meant is that—. We had that postcode lottery in Wales, where in some parts of Wales women did have access to specialist services and specialist care but others didn't. The new money that came in—and the decision was made to do that based on the number of deliveries in each health board, which I think, again, was a sensible way of doing that—meant that there was an increase in the services, or there will be an increase in the services, everywhere. But to those that had, more was added, and to those that didn't have, some was added. So, it meant that, while we've improved things, hopefully—we will see over the next year or so if things have improved across Wales—we still have that lack of parity across Wales. There's still a lottery in what services you get, with some services. I think Cardiff and Vale's community service, as an example, is a very excellently staffed and delivered service, now. But in other parts of Wales where they were starting from nothing, it's more difficult. So, that's an issue for us, I think.

11:45

[286] And then, the other big issue for us in Wales, still, is the whole issue of mother and baby unit bed provision, which I'm sure we'll come on to and discuss. So, I think, summarising that—and I've probably waffled on a bit long in that answer—historically, we've been behind the game. I think it's been excellent that we've had the new investment, but there's still work to do.

[287] **Lynne Neagle**: And is the alliance actively monitoring the impact, now, of that funding in Wales, and would it be your intention to produce a new map showing how Wales is doing?

[288] **Professor Jones**: Yes. I think the plans are, across the UK, for us to

repeat that mapping exercise, probably at the end of the year—it may be into next year—to give opportunities. I think what is very demotivating for local services as well is to not see the improvements that have been made recognised in that. There are a couple of implications. One is doing the mapping at the right time to make sure that you've captured the improvements that have been made. But also to get it right, as well, is really important, because you don't want to be misrepresenting what's happening on the ground.

[289] On that—and I know that you heard from Sarah Witcombe-Hayes this morning from the NSPCC—the NSPCC, along with Mind Cymru and the National Centre for Mental Health that I'm the director of in Wales has a project over the next year where we're doing some much more in-depth work to try and map the situation and try and widen it a little bit from what the Maternal Mental Health Alliance campaign Everyone's Business maps focused on, which was specialist provision, and try and get some idea of some of the other provision that's happening across Wales. Particularly, the desire is to look a little bit at what's happening in the third sector across Wales as well. So, the plan is for us to publish that report in March or April next year. That will be a real benefit for us to really take a look at what the improvement has been with the new money coming in—as I say, I'm so chuffed and proud that we decided to do that in Wales—but actually, to look at that reality of what postcode lottery remains and what lack of parity across the health boards there is.

[290] **Lynne Neagle**: Okay, thank you very much. John.

[291] **John Griffiths**: I'd like to ask about the quality standards that we should have in providing perinatal mental health services, and if you could provide the committee with a view of the clinical guidance and standards that exist right across the services, including the NICE and royal college recommendations.

[292] **Professor Jones**: I think the advantage that we have is that I don't think, in Wales, we need to reinvent the wheel here. I think there's a huge amount of work being done by august bodies like NICE that have looked at the evidence base and set the standards, and I think that's the criteria we should be judging by. As far as individual services are concerned, there's also the accreditation operations done by the CCQI hosted by the Royal College of Psychiatrists, which I think is something that would be incredibly beneficial. That started off accrediting mother and baby unit services, but

has moved in recent years to also accredit community services in perinatal as well. I think that would be a huge advantage if the Wales health boards bought into having that.

[293] I know that, from services that have participated in that process, such as the Cardiff and Vale service, it is a fantastically cost-effective way of really benchmarking yourself against the standards that are set by the services, the peers, around the country. As I say, I think there's a real danger that we try and do things that reinvent what's happening, and probably, that's a theme that we can come back to if we discuss training and things later. But we should take advantage of those.

[294] There are issues for specialist services like perinatal mental health and other areas of medicine where there's one team, one psychiatrist, one lead clinician doing something in an area. If you don't join together and monitor yourself against your peers doing this on a national, Wales-wide or UK-wide basis, there's a danger that you go away and develop your services in a way that's peculiar and a little bit different. So, I think there are real, real benefits in that.

[295] **John Griffiths**: I think you told us earlier, in terms of meeting the standards and providing the services, that, perhaps, Wales has been a little behind other parts of the UK, but investment, hopefully, is allowing us to catch up. Would that be a fair summary?

[296] **Professor Jones**: Yes, I think we're catching up. Actually, if you can remember the way that the money was announced in England for perinatal services, it was done in two tranches. When the money was allocated in Wales, I actually worked out that per head, per delivery, we were ahead of the game at that stage in the money that was being promised. But with the further new money that's been promised in England, we've probably at about 50 per cent now of what's been promised. Of course, that's what's been promised. There's still a huge issue in England about whether that money can be delivered, because I think the complexities of the English health system mean that, as far as I can see, the Government can tell the CCGs and give the money, but the CCGs can spend it on whatever they want. So, I think the system in Wales seems to be much better in that regard—that when the Welsh Government says, 'This is money for you to do this,' health boards have to get on and do that, which is good.

[297] So, I think there is still a bit of a disparity in the funding that's gone

in. And, of course, the other thing that's happening in England is that the mother and baby unit provision across England has been looked at, with three or four, I think, new mother and baby units now in the process of being built. We're still probably a little bit behind the game, but I think, actually, that this is an area where we could lead the UK in Wales. I think it's an area where we have fantastic academic—from our centre and others—involvement. We have amazing practitioners—incredibly keen, I think. I sat in the gallery earlier, and the previous speakers were telling you about the amazing attendance that we've had at our community of practice meetings. There's a real interest in Wales, and I think it's an area that Wales could really not just lead the UK in, but actually lead the world in, and we could really have gold-standard services here that the world would look to.

[298] **John Griffiths**: Sure. Of course, resource and staff are always limited. I think the committee would be interested if you have any ideas you might share with us as to how more, perhaps, can be made of those limited resources than is currently the case. Are there any obvious areas where we could achieve more with that resource with more intelligent use?

[299] **Professor Jones**: I think a big issue for me is that, as we develop the specialist services, which are one aspect of the pathway that's needed for women—I'm sure you've been hearing from the midwives and health visitors already this morning about the importance across the pathway—developing those specialist services in the right way, as services that are given the remit not just to deliver care to women with severe mental illness or that severe end of that spectrum, which is undoubtedly important, but, actually, given the remit, as well, of training, of looking at the pathway across to working with colleagues in midwifery. We're developing specialist midwives in this area, with health visitors, to really be the hub, if you like, that improves the whole pathway of care. So, I think there's a big issue about doing things right, giving the specialist teams the right guide about what they're there to do.

[300] There's actually, I think, in this area, a real myth, sometimes—it's not often articulated in quite this way, but it's often propagated—that if we get the general support of women right, if we deal with the milder end of the spectrum, that that will in some way prevent the development of severe illness. There's no evidence for that at all. The evidence is that, whatever we do, a certain number, a proportion of women—it's a very predictable proportion of women, actually, based on the epidemiology—will develop severe episodes of illness and need that very highly specialised, severe end

of the spectrum mother and baby unit care, and will need that specialist perinatal psychiatry and nursing, with the expertise in that area. But I think how they view their role more widely is really important.

[301] **John Griffiths**: Okay. Thanks very much.

[302] **Lynne Neagle**: Thank you. Michelle.

[303] **Michelle Brown**: Thank you, Chair. I was absolutely horrified last week in the roundtable discussions to discover that we have no inpatient facility in Wales for mothers with perinatal health issues. I was equally concerned to hear that the facilities that they seem to be directed to were in places like Bristol, Birmingham and Liverpool. Now, I appreciate that we have geographical problems in Wales, but why do we have no inpatient facilities in Wales? What can we do to put those in place?

[304] **Professor Jones**: I think it's a big issue, and I think it's one of the big issues that remains for us to solve in Wales. I think women in small numbers are going out of the country to as far away as London, Manchester, Birmingham, Nottingham and other units. But I think sometimes, when there are discussions about the need for a mother and baby unit, those small numbers are the numbers that they're coming up with. I think in the last year it's even been fewer than five women who have gone out of Wales. But those are the tip of a very big iceberg, because what we know, from some work that's been done in Public Health Wales, is that around 1 in 600 women delivering in Wales are admitted in that postpartum period not to a specialist mother and baby unit, but they're admitted without their baby to a general adult facility. That is very much consistent with all the epidemiology we know and where this has been looked at throughout the world.

[305] So, I think we can be confident about the numbers of women who are currently being admitted. A few are going outside to England to mother and baby units. But you can imagine the difficulties in that, to say to a family, 'Actually, we think you need to come into hospital and the only way that you can do that with your baby is that you go to north London'. Then there are difficulties of sorting out the finances—and then there needs to be a bed in these units, and they're often full. So, much more often women are being admitted, and that translates into numbers of about 60 to 80 women or something in Wales that are being admitted, in Wales, to general adult wards without their baby.

[306] The other thing, I think, to bear in mind with those numbers is that that doesn't take account of those women who perhaps, ideally, because of the severity of their illness, should have been admitted, but because there's no facility for them to be admitted with their baby, perhaps a more risky option is taken. The decision is for them to stay at home when perhaps the best option would be to be admitted. So, I think it's no doubt that there's need, and the need in Wales is no different to wherever else this has been looked at throughout the world. When Public Health Wales looked at those figures for me, I was very reassured that that's exactly what the epidemiological figures were. So, I don't think we need to do any more work to try and find out what the need is. We just have that information.

[307] Answering the question on why we don't have that, I think there were issues with the very small three-baby unit that we had in Cardiff, with the way it was set up and financed, and some misunderstandings about who could access it. I think there are issues about the geography we have in Wales as well, where the population of Wales—. If it was all like the west midlands or something, you could plonk a mother and baby unit in the middle that could serve the whole population and that would work. Does a unit somewhere on the M4 corridor—? Is that the right place for people in Bangor and north Wales to be able to access care? I don't know. What probably is the case is that there would be enough deliveries in that south Wales M4 corridor to have a unit based somewhere there, a six-bedded unit, something like that, that would look—and then decisions would need to be made then about other parts of Wales. And one of the things I think, just coming back to something that we talked about before, is, with the new developments in England, and new units being set up there, and one going to be placed in the north-west of the country, it might be that this is the right time for Wales to have conversations about having beds bought into a unit that covered north Wales and the north-west, for example.

12:00

[308] The other thing I think is that, in other areas of medicine, when people are severely ill the understanding is that people may need to travel to receive the best and the specialist care. I think that's something that we need to address in this area as well, that, when we're talking about the women—this one in 600 women—who need admission in the postpartum period, we're talking about some of the most severe episodes of psychiatric illness that we see in mental health services. These women are incredibly unwell, and really do need that specialist and that in-patient care. If it was a severe

neurological, neurosurgical procedure that they needed, or neurocardiac, the expectation would be that they may have to—. The expectation is that that cannot be delivered by every health board in every locality. And I think, when we're dealing with that level of severity and that need for that specialist care, we do need to have that conversation with services and with the public, in order to deliver the specialist care that's needed. It may be that a certain amount of travelling—not travelling from, you know, Llanelli to west London; that, to me, is not acceptable, but within Wales.

[309] So, it's difficult. I can understand the geographical challenges that we have, but because something is difficult it doesn't mean that we should throw our hands up, give up and not do it. I think we need to find solutions in Wales that are appropriate for the Welsh context that meet those difficulties, but mean that, wherever a woman is delivering in Wales, if she develops that incredibly serious and severe episodes of illness that we're talking about with postpartum psychosis and these conditions, she has access to that specialist care that she needs.

[310] **Michelle Brown:** So, do you foresee a situation where we're going to become increasingly reliant on facilities for mothers and babies in England?

[311] **Professor Jones:** I think that's one thing that should be on the table to be considered, yes. I think, for example, if a decision for Wales was locating the unit in Bridgend or Swansea, it might be that for women that live in Wrexham, Bangor, then a nearer unit that was an English unit might be a better solution. It may be that the decisions—. And actually talking to women with lived experience of these conditions through Action on Postpartum Psychosis, which I'm involved with, and also through the Welsh Health Specialised Services Committee, which is looking at this at the moment, the women who are sitting on that, the women themselves, say, 'Look, I would have been very happy, my family would be happy, for me to go wherever in Wales to get the treatment I needed.' So, I think that's a discussion that's needed. But I think, from my perspective, it's an example of how, for specialist areas like this, thinking about linking up with developments on a UK-wide basis may be beneficial for us.

[312] **Michelle Brown:** So, ultimately, a mother with postpartum psychosis or another serious acute mental health issue living in somewhere like Anglesey or Bangor, travelling to, say, Manchester, for argument's sake, for in-patient care—. That's, what, a two-hour trip each way. Don't you think we should be focusing on getting a facility, and understanding the demand across and

getting the right facilities within Wales, because the journey time and the separation from the family has got to exacerbate the mental health issues that these women are suffering.

[313] **Professor Jones**: I think there are issues that need to be considered about the size of unit, in that the model that happened when I started training in mental health in the 1990s was that each in-patient unit used to have one bedroom at the end of the ward that had some teddy-bear wallpaper on the wall and there was a cot in pieces under one of the beds, and that was the facility to admit. Very, very strongly, the opinion is now that those are not ideal, those are dangerous, and you need the minimum number of beds so that you can develop that expertise and do that.

[314] So, I think the solution for me would not be to go back to a situation where we had one-bedded or two-bedded units in each of the health boards because I think that isn't consistent with the high quality of care that is needed. I do think that some difficult discussions need to happen and some difficult decisions need to be made about what the potential solutions are. But what you need are units that have—. I think that generally in the field it's recognised that, in order to deliver what needs to be delivered in a cohesive way, you need to have a five-bedded or six-bedded unit. That is the minimum size that makes sense. So, yes. It's not easy.

[315] **Lynne Neagle**: Thank you. Llyr.

[316] **Llyr Gruffydd**: Yes. Thank you, Chair. The Royal College of Psychiatrists have suggested that there's often a significant delay in seeking and receiving appropriate treatment for perinatal mental health illnesses if the mother has a dual diagnosis—so, drug and alcohol issues or whatever. They say that that's slightly, in part, down to a lack of knowledge and confidence from front-line healthcare professionals. Is that a fair assessment? Is that a situation that you recognise?

[317] **Professor Jones**: My take on that would be that that is an issue not just for perinatal mental health care, but for dual diagnosis patients generally. I think there are some issues about the way that services have developed and there are issues across the UK in that respect, with services being taken out of the health service and put into the private sector, being de-medicalised, I think, which is an issue. So, I think there are big problems there. I think that one of the big problems is that perinatal mental health services, as with other mental health services, often haven't had the training in drug and

alcohol, or don't consider that to be part of the—. And, actually, what we know from the confidential inquiries into maternal death is that one of the major predictors of maternal suicide is significant drug and alcohol problems in the mothers. I think it's a difficult area and I recognise that very much to be a problem and what the solutions are, I think, are more unclear.

[318] **Llyr Gruffydd**: But, initially then, clearly, more training is one area that you'd expect to see being developed.

[319] **Professor Jones**: Yes.

[320] **Llyr Gruffydd**: Okay. I'll move on to the third sector, if I may. Now, clearly, it has a very important role, particularly when there are deficiencies in the services, maybe, being provided by the public sector—the third sector very often picks up the pieces, but has certainly an important role to play. I'm sure you'd be aware, and maybe you could share with us, some examples of good practice, where the third sector is actually supporting the statutory services out there and the way they interrelate as well.

[321] **Professor Jones**: Yes, I think we've got some fantastic examples in Wales, actually. I think you've heard from Jenny Burns—this morning I think she was coming along, wasn't she—and the Two in Mind programme that Mind have done. I think there are some fantastic examples of support groups around Wales. Even at the severe end of illness spectrum, these episodes—the postpartum psychosis episodes that I was talking about earlier that are some of the most severe illnesses seen in psychiatry—. Although, maybe sometimes services deal with those in the acute phase, when women are very unwell and very psychotic and need—. I'm involved with a charity called Action on Postpartum Psychosis that does some fantastic work supporting both women and their partners and their families through the whole journey that they have in coming to terms, actually—because in at least 50 per cent of cases these significant episodes are the first episode of illness that a woman has experienced. To have that episode at that time, where joy is the expectation for a new mother, can be devastating to her self-image. So, the third sector organisations—Action on Postpartum Psychosis, for example—do amazing work in addition to what statutory services provide, what the NHS provides, in helping, supporting, providing information, providing support and really helping women through what can be an incredibly long journey following recovery from the acute phase of the illness in that recovery period when they're coming to terms with that.

[322] **Llyr Gruffydd**: And is there enough being done to join up the statutory and the voluntary work that's happening out there?

[323] **Professor Jones**: I think more could always be done. I think one of the good things about the project that I referred to earlier, which NSPCC and ourselves and the National Centre for Mental Health and Mind are doing, is it's trying to map that across Wales and trying to work out what's available, not just as far as specialist perinatal mental health services are concerned, which the Maternal Mental Health Alliance has mapped, but actually more widely. So, yes, I've been a trustee—I'm a very big believer that there's a massive role—. I've been very involved with Bipolar UK as well in this area. I think these are huge roles that these organisations can bring. Funding is a big issue. The work that APP has done has been funded with money from Comic Relief and from the lottery, but there are always difficulties in maintaining that.

[324] **Llyr Gruffydd**: Thank you.

[325] **Lynne Neagle**: Thank you. Michelle.

[326] **Michelle Brown**: Thank you, Chair. The committee's heard a lot of evidence about the importance of the mother-child bond, especially in the early years. Coming back to the conversation we had earlier about in-patient mother and baby facilities in Wales, and the lack of those facilities, don't you think the expectation and almost sort of safety net of being able to send mothers across the border—. They're basically being faced with a choice, aren't they, at the moment? They can go in-patient, relatively close to their family right now and be separated—

[327] **Lynne Neagle**: Michelle, we have moved on from the mother and baby unit now. We're dealing with general issues of attachment and bonding, which is also about community support. So, if we could deal with that, please.

[328] **Professor Jones**: So, what's the question?

[329] **Michelle Brown**: The question is, then: given the lack of in-patient mother and baby units, what support is there in the community to care for the needs of these mothers? Perhaps they're mothers who have to be separated from the babies—what support structures are there to help them through that, because it's going to exacerbate their own problems?

[330] **Professor Jones:** I think it's a really important—. I'm sure that you've received evidence and people talking to this committee have highlighted the work of the London School of Economics, which published a report a couple of years ago now, 18 months ago, which showed that, for each year cohort of women with perinatal mental health conditions in the UK, it cost the country £8.1 billion, and the majority of that was the impact that it has on the child. My perspective, very much, is that it's very important that across the board—from primary care through maternity services through health visiting through mental health services and to specialist mental health services—that the relationship of the mother and the baby is part of something that's looked at, that's assessed, that's supported.

[331] I also feel very strongly that the best way to deal with some of those potential issues is to get the right treatment to the mother at the right time and get her as well as she can be as quickly as possible. Now, we know from research that that doesn't always solve those underlying problems of attachment, and, undoubtedly, in some cases, there is a need for very specialised psychological therapies to address those issues. I think it's really important that that's put in context, though, because, actually, this is potentially an area as well than can really increase stigma for women, which you've heard about already. I think that it's really important for us in clinical services and in research not to give the impression that women are toxic for their babies, because the vast, vast majority of mothers—even those with mental health problems and even those with mental illness—recover and have a fantastic relationship with their baby.

12:15

[332] Undoubtedly, there is a small proportion that does need specialist care, and I think that's lacking—that specialist infant mental health approach is something that is lacking—but I think it's really important to see it as only being important for a proportion of women. Actually, it's the work that midwives do, that health visitors do, that general practitioners do and that services do to support women into developing that bond and that relationship with their baby that's really important. As I say, coming back to it, the best thing that we can do for the majority of women is to give the women the treatment they need to get them as well as possible as quickly as possible.

[333] **Lynne Neagle:** Okay, thank you. Darren.

[334] **Darren Millar:** I noted from your 'Maternal Mental Health: Women's Voices' report that there were some data in there that seemed to suggest that there might be longer waiting times for people who might need access to psychological therapies here in Wales for mums in those very difficult situations.

[335] **Professor Jones:** Was that the Royal College of Obstetricians and Gynaecologists' report?

[336] **Darren Millar:** I think it was, yes, sorry. In that report—it was only a small sample size—

[337] **Professor Jones:** It was a self-selected—

[338] **Darren Millar:** —it was, that's right, but it did seem to be more of a problem here. What evidence is there to suggest that we don't have sufficient capacity in the system, and what does that tell us about the workforce in Wales?

[339] **Professor Jones:** I think the area of perinatal mental health brings a lot of issues for mental health in general into very good focus, actually, and access to psychological therapies is one of them. Access to psychological therapies is not just an issue for perinatal mental health—it's an issue for health in general. How maternal mental health brings that into focus, I think, is that because of pregnancy I think we need to be even more careful about using medication. Undoubtedly, medication has its place in pregnancy and when breastfeeding, and undoubtedly some women hugely benefit and I wouldn't want to increase the stigma around that, meaning that women haven't got access.

[340] But there is evidence, and recent evidence that I have seen, suggesting that, for example, the proportion of pregnant women in Wales who are taking selective serotonin reuptake inhibitor anti-depressant medication is considerably higher than the UK average. So, I do think in the perinatal mental health period it's a really good time to really look to see if this medication is indicated, if it's beneficial and if it's doing good, and if there are other options that are available that could equally be as effective in treating this condition. If there's no access to those psychological therapies—the cognitive behavioural therapies and the other really evidence-based therapies—then that is a problem.

[341] The National Institute for Health and Care Excellence guidelines for perinatal mental health say that there should be priority for women who are pregnant, perhaps because of the issues of medication being a bigger issue, and that women should have access within four weeks—the NICE guidelines say—and that's certainly something that's—

[342] **Darren Millar**: Is that being monitored, then?

[343] **Professor Jones**: Not to my knowledge.

[344] **Darren Millar**: There's nothing reported, sort of—

[345] **Professor Jones**: I know that there were data from Wales from that report, but that was a self-selected—women were invited to log on and give their experience. I'm sure that there must be data within Wales about that. The problem with it is that if there's nothing to refer to, then waiting times—if people are not considering that as an option, because they know that it's not going to happen for 18 months, then in some respects the problem is bigger than the waiting times would indicate.

[346] **Darren Millar**: So, in terms of holding people to account for delivery against the NICE guidelines, though, you'd like to see those sorts of things measured in the future, would you?

[347] **Professor Jones**: Yes, I think that I would. You know, I'm a clinician and I'm a psychiatrist—I'm not in any way wanting to say that medication does not have a role, and I think part of the problem in this area is probably there are people who are receiving medication who don't need it and there are better options. But also there are probably women who are not getting medication that may help. But certainly, there's a case to be made that, because of the particular importance of getting women as well as possible in that period before their baby is born, because of the particular implications that it has on being unwell at this time, having implications on developing a bond with the baby and the long-term consequences—we worry about that—there could be a case to be made for saying, actually, this is something that services prioritise. Because of the issues with medication and because of the particular context, this is something that should be prioritised.

[348] **Darren Millar**: And then in terms of the evidence that we've received, it seems to suggest that our midwives and our health visitors need to be better

equipped, really, to deal with these low and moderate mental health needs. Do you think our workforce has got the capacity in Wales to be able to deliver an improved service in that area? Clearly we've got some excellent midwives who are doing that job already, but others may need more development and training, and we may need more of them in order to give them the time to be able to spend with mums.

[349] **Professor Jones**: My observation is, having worked closely with midwives for many years, there's no shortage of an interest in this area. In fact, I'm sure you heard it from the midwives today: midwives recognise these issues of the importance of parity of mental health and physical health care. The problem that they have is that they're increasingly asked to take responsibility for so many areas of women's care. But the interest is there and we need to think of creative ways in which we can ensure that the workforce is trained right, whether that's in statutory training, whether that's in coming up with—. We developed, with some Welsh Government money, actually, a number of years ago, a very successful online training package for midwives about recognising women at high risk of severe mental illness around childbirth. Those kinds of ways forward are important. But, no, I don't think there's any issue of them not recognising this as being an important area. I'm sure one of my midwife colleagues probably raised this—one of the things that's being developed around the UK is the concept of the specialist mental health midwife.

[350] **Darren Millar**: Yes, I was going to come on to that.

[351] **Professor Jones**: Sorry, yes—

[352] **Darren Millar**: I was just going to ask you: what's your view on that? Do you think that that's a model that we need to adopt in Wales?

[353] **Professor Jones**: I think it's fantastic. I think the issue that we have in perinatal mental health is it covers so many different—yes, I think the word 'silo' has been used already this morning. There's primary care, there's antenatal care, there's mental health care, and, actually, for good care what's needed is people talking to each other. And the model of identifying specific midwives to have particular training and particular expertise, develop specific relationships with mental health and to be a resource that midwives in general can use and discuss, I think, is an excellent model. It's working really well in many parts of Wales.

[354] One of the issues, I guess, is when the money came in it went to mental health and, actually, I think, because of, perhaps, this silo way that we think in, the thinking of putting some of that money into funding specialist midwives didn't occur to most health boards, I suspect. So, I think we're behind the curve a little bit there, but I do think it's a really important model. And my experience, having established—in Birmingham, in the UK, when I was there, and in Cardiff—some maternity liaison services in this area, is getting that relationship and that buy-in and having enthused and specific midwives with responsibility in this area is absolutely vital for good services.

[355] **Darren Millar**: You mentioned earlier on, I think, in your opening remarks about the cash that had been invested by the Welsh Government—the £1.5 million in order to improve the service—and you said that an additional slab of cash has been promised, if you like, in England, but is yet to be delivered, or is partially on the way. If that resource does come and Wales receives a consequential as a result, and decides to invest that in perinatal mental health, would you like to see that more targeted to overcome this differential level of service issue that you said had almost been embedded by the previous slab of cash, because, whilst everybody's service improved, if you were still far behind other services, that gap was still there?

[356] **Professor Jones**: That would seem to be a sensible way forward to me. I think there was a really good case for the decision that was made to do it like it did, because I think there would be a real danger if the Welsh Government said, 'Here's your bit of the cash that's coming in: provide mental health', and for health boards to say, 'Well, actually, we've got a service'. So, I think that was very good, but I do think that that lack of parity across health boards now is something that should and needs to be addressed. I think the work that we're going to be doing with NSPCC over the next year will really identify what the situation on the ground is after this new money comes in. My suspicion is—one of my big worries is that now that some money has gone in to perinatal mental health, in the minds of the health boards and the Welsh Government it would be, 'That box has been ticked'. I appreciate hugely that we're in incredibly difficult financial—. There's so much demand for spending, and I appreciate that, but what I would hate to see that, just for that money that's gone in, that the box has been ticked.

[357] **Darren Millar**: One final question from me, and that's on how we measure success, really, in terms of improvements in this area. Obviously, you're doing your own work, but that's still only periodically—it takes one

big snapshot, if you like. What should be reported on a more regular basis that we as Assembly Members and as a parliamentary institution can hold our health boards to account to, and indeed the Government to account to, in order to get it right in the future?

[358] **Professor Jones**: I think that's a really interesting and important question, actually, because the information the Government demands from the health boards and what drives them to do it—. I think we have, as we've talked about already, guidelines in place about what should be delivered and I think measuring activity against—. The advantage of something like the NICE guidelines is that they cover the whole pathway from primary care, maternity services, through to specialist care and mother and baby units. Measuring against criteria—there's some work that I think would need to be done to pull out of that some things to measure. But it struck me that that point is incredibly well made that, unless the Welsh Government sets the priorities for what needs to be met and be reported against—. And, actually, that would help unify things across Wales as well, I think.

[359] **Darren Millar**: In terms of access to service et cetera.

[360] **Professor Jones**: Yes.

[361] **Darren Millar**: Thank you.

[362] **Lynne Neagle**: Just finally, then: you've said that for effective perinatal mental health services to work there should be accountability, community and training. If I can just press you on the training issue—

[363] **Professor Jones**: Okay.

[364] **Lynne Neagle**: I saw that you were in the gallery for the previous session. Were you surprised that only 19 health visitors had received the specialist perinatal mental health training? Because it seems to me that health visitors are a universal service, so they are the least stigmatising way, really, that women can get access to mental health support. To what extent do you think we have got it right, then, in relation to training health visitors, and shouldn't we be looking to ensure that all health visitors have that level of perinatal mental health training?

[365] **Professor Jones**: Yes, I agree entirely. When we were deciding in the Maternal Mental Health Alliance what to call the campaign, the thing we

ended up with was calling it 'Everyone's Business', and the philosophy behind that was that all professionals who come in contact with women through this journey through pregnancy and the postpartum period have a responsibility, not just for their physical health but for their mental health, and I think the access to training that these different professional groups need is a fantastic example of that. Coming back to one of the things that we said earlier, I think that's one thing that we can think about linking up on a UK-wide basis, and take advantage of some of the developments that are happening on a UK-wide basis, so that we're not reinventing the wheel, developing our own training programmes for the sake of it, but that we've made sure that our professionals in Wales have access to some of those training schemes that have been developed across the UK.

12:30

[366] In my area, in psychiatry, for example, I'm off next week to London. We're training 60 new perinatal consultants in an intensive three-day course, and the Welsh Government have bought some access for the new consultants that have been appointed to that, and I think that's an excellent model. What they have in England as well, for psychiatry for example—I know I keep talking about this; it's what I know more—is Health Education England have developed a bursary mentoring programme where people have training for a year and go and work in services, come back, and develop their own services. So, things like that that are being developed, that potentially Wales could say, 'Actually, that would be very good for professionals here.' So, there's those. There's work that's being done, and I know that Jane Hanley and others have been really involved with it, developing training programmes for health visitors. We've developed, along with midwife colleagues in Wales—Grace Thomas and others—some packages to train midwives. I think training is absolutely key, but actually we need to take that wider picture, I'd say, and look to see what's available, and not think that we have to reinvent the wheel.

[367] **Lynne Neagle:** And is it your sense, then—? You've mentioned a good example there of where that is happening, but you don't feel that that's happening across the board, then, in terms of dialogue with England.

[368] **Professor Jones:** I think there's an issue we have in Wales, in that—. It hasn't come up, but I think it would be important to mention that one of the ways that the new money is being spent in England is to fund managed clinical networks. In Wales, we have done something—it's probably not fair to

call it ‘a managed clinical network lite’, but our community of practice here has some of the same aims, but hasn’t got the resources that they have in England. I think that has caused some difficulties and some problems, and I think, actually, one of the things that I think would be—. And, actually, I did argue with the Welsh Government when the money was given, that taking some money, top-slicing from all of the health board budgets and funding a network at that time, with proper time funded for it and having a senior clinician to lead—. Scotland have just done this, actually, and Roch Cantwell, who is a very senior clinician, has been given, I think, two and a half days a week and has been funded to lead that network, with admin time, with a training budget—those kinds of things. I think the community of practice as it is is good; I think there are some good things it’s done, but I don’t think it’s resourced properly at the moment to really be a managed clinical network in the way that it could be. And training is an ideal example of what you could give that clinical network responsibility to work out, and a budget: ‘How are we going to train our professionals? What is it that we can buy in and buy into?’ Wales supports five places on this intensive course that I’ve been involved in organising. That’s the kind of example. So, yes, I suppose that’s another point that I’d probably make: I think there would be an advantage to moving towards a better funded managed clinical network, to take on some of these aspects.

[369] **Lynne Neagle**: Okay, thank you very much. Okay, well, we’ve concluded our questions, unless there’s anything you’d like to flag up with us—anything else that we’ve missed.

[370] **Professor Jones:** No, I just think that there’s a huge move to parity between mental health and physical healthcare, and I think there’s no better illustration than in some of the problems in this area. I think if we had a lack of parity in cardiac care as we do in perinatal mental health care, it would be a scandal that would shut down the health service. But yes, actually, we seem to tolerate this more. And I think the Welsh Government’s been really encouraging the moves that have been made, but my worry is that we don’t see that that box has been ticked, and we need to carry on moving forward. That responsibility is on our shoulders, as professionals in the area, but I think there are some issues for the Welsh Government as well. I think one of the ways forward would be properly funded clinical time to ensure that we drive things forward.

[371] **Lynne Neagle:** Okay. Well, can I thank you very much on behalf of the committee for attending this morning? I think we’ve all found it a really

useful and informative session. You will be sent a transcript to check for accuracy in due course, but we thank you for your time this morning.

[372] **Professor Jones**: Thank you very much. Yes, it's been an absolute pleasure. Thank you.

[373] **Lynne Neagle**: Thank you.

12:35

Papurau i'w Nodi
Papers to Note

[374] **Lynne Neagle**: Okay. Item 5, then, is papers to note. Paper to note 6 is a letter from the Cabinet Secretary for Education. Paper to note 7 is a letter from the Minister for Lifelong Learning and Welsh Language. Paper to note 8 is another letter from the Cabinet Secretary for Education following our meeting on 5 April. Paper to note 9 is a letter from the Chair of the External Affairs and Additional Legislation Committee about the great repeal Bill. Hopefully, we can discuss this when we have a wash-up following the meeting. Paper to note 10 is a letter from the children's commissioner on 'The Right Way: A Children's Rights Approach in Wales'. Paper to note 11 is a letter from the Cabinet Secretary for Communities and Children on the Prisons and Courts Bill legislative consent memorandum. Paper to note 12 is a letter from the First Minister to the children's commissioner on the additional learning needs Bill. Paper to note 13 is a letter from the Police and Crime Commissioner for South Wales on adverse childhood experiences, which, again, I'd like to touch on in the wash-up, if that's okay with everybody. Happy to note those? Okay.

[375] Well, can I just remind Members that the next formal meeting will be on Wednesday 14 June, when we'll be having the Cabinet Secretary for Education in for general scrutiny, and also private sessions to consider the draft report into teachers' continuing professional development, and also the forward work programme? Can I thank Members for their attendance and close the meeting? Thank you.

Daeth y cyfarfod i ben am 12:37.
The meeting ended at 12:37.