Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Cofnod y Trafodion
The Record of Proceedings

Y Pwyllgor Plant, Pobl Ifanc ac Addysg

The Children, Young People and Education Committee

06/07/2017

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Mark Reckless	Aelod Grŵp y Ceidwadwyr Cymreig
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Eraill yn bresennol
Others in attendance

Barbara Cunningham	Ymddiriedolwr, Perinatal Mental Health Cymru Trustee, Perinatal Mental Health Cymru
Charlotte Harding	Sylfaenydd a Chadeirydd, Perinatal Mental Health Cymru Founder and Chair, Perinatal Mental Health Cymru
Dr Jess Heron	Cyfarwyddwr, Action on Postpartum Psychosis Director, Action on Postpartum Psychosis
Helen James	Pennaeth Nyrsio Iechyd y Cyhoedd i Blant a Gwasanaethau Pediatrig, Bwrdd Iechyd Lleol Addysgu Powys Head of Children's Public Health Nursing and Paediatric Service, Powys Teaching Local Health Board
Sharn Jones	Pennaeth Gwasanaethau Cleifion Allanol i Fenywod, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr Head of Women's Outpatient Services, Betsi Cadwaladr University Local Health Board
Jon Morris	Rheolwr y Gwasanaeth Amenedigol a'r Gwasanaeth Cyswllt Seiciatreg, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr

	Service Manager for Perinatal and Liaison Psychiatry, Betsi Cadwaladr University Local Health Board
Dr Dwynwen Myers	Seicolegydd Arweiniol, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr Psychologist Lead, Betsi Cadwaladr University Local Health Board
Dr Annemarie Schmidt	Seiciatrydd Ymgynghorol, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr Consultant Psychiatrist, Betsi Cadwaladr University Local Health Board
Carol Shillabeer	Prif Weithredwr, Bwrdd Iechyd Lleol Addysgu Powys Chief Executive, Powys Teaching Local Health Board
Sally Wilson	Gwirfoddolwr, Action on Postpartum Psychosis Volunteer, Action on Postpartum Psychosis

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

Sarah Bartlett	Dirprwy Glerc Deputy Clerk
Rebekah James	Y Gwasanaeth Ymchwil Research Service
Llinos Madeley	Clerc Clerk

Dechreuodd y cyfarfod am 09:35.
The meeting began at 09:35.

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 this morning's meeting of the Children, Young People and Education Committee? We've received apologies for absence from Llyr Gruffydd. I'm very pleased to welcome Mark Reckless, who is joining our committee, replacing Mohammad Asghar, and I think we would all want to place on record our thanks to Mohammad Asghar for his hard work and his contribution to the committee up until now. So, thank you very much. Are there any declarations of interest? No. Okay.

Ymchwiliad i Iechyd Meddwl Amenedigol: Sesiwn Dystiolaeth 8
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[2] **Lynne Neagle**: Right, we'll move on, then, to item 2, which is our evidence session on perinatal mental health. I'm delighted to welcome the representatives of Betsi Cadwaladr university health board and Powys teaching health board, in particular, Dr Annemarie Schmidt, Sharn Jones and Jon Morris from Betsi Cadwaladr, and Carol Shillabeer and Helen James from Powys teaching health board. So, thank you for attending and thank you for the evidence that you've provided in advance to the committee. If you're happy, we'll go straight into questions. Thank you. Michelle.

[3] **Michelle Brown**: Thank you. Nice to meet you all. I wonder if you could tell us where along in the process you are in planning and implementing perinatal health services, please.

[4] **Mr Morris**: Do you want me to go first? Okay. Hi.

[5] **Michelle Brown**: Hi.

[6] **Mr Morris**: Nice to meet you. Within BCU, we gratefully received a large proportion of the money from Welsh Government, being the largest health board in Wales. Since receiving that money, we've developed a north Wales perinatal service. Where we're up to at the moment is we have recruited the majority of our staff and are looking at a hub-and-spoke model across the north Wales area. As you're aware, it's a large geographical area to cover, so we are looking at having a central base within the central counties. We have practitioners then to be based within the east and the west of the division of the health board. So, currently we have a team manager in post. We have three practitioners and we have one specialist midwife. We have a part-time psychiatrist, a part-time psychologist, and we're just waiting to secure admin support, and there's myself, as service manager, who sits with the perinatal service, and I also service manage psychiatric liaison services. So, that's where we are up to at this moment in time.

[7] We are seeing cases, and complex cases, within the central area because that's where we had a practitioner in post the earliest. So, we have been offering advice there—Dr Schmidt as well—within the central area for some complex cases. The other two practitioners, who have only just recently been in post over the last couple of weeks, have already started out in the east and the west, networking and offering education, but also attending

courses themselves to skill themselves up to be able to offer that expert advice.

[8] **Michelle Brown:** You said you were using a hub-and-spoke model. Where's the hub likely to be, and where are the spoke points?

[9] **Mr Morris:** I think we call it that as in—. As I say, because we are such a large area, we are looking at having a central base, where we will all come together to have clinical meetings and sessions. And the spokes will be the rest of the area. It's such a rural area, and such a distance to travel, that the practitioners will be based—. There are two counties per area, so, we are covering the six counties, so we'll have one practitioner per two counties, and they'll be based within those areas. And then, obviously, Dr Schmidt and our psychologist, Dwynwen, will cover regionally. That's a logistical—. We need to work that out, really, with, obviously, a timetable on how we're going to manage that the best with the resources that we've got.

[10] **Ms Shillabeer:** From a Powys perspective, just to say that we've had a perinatal mental health steering group established since 2014. Mental health is a priority for the board in Powys and has been for some years. So, we had a group already established before we had the money and that group was really around trying to assess where we were as a starting point, which, I think, put us in a pretty good position when moneys became available from Welsh Government, because the team were pretty clear about what the needs in a rural setting such as Powys were, without lots of in-patient facilities on offer—a very primary and community-led model. If I ask Helen to give a little bit more of the detail about who's in post in the model.

[11] **Ms James:** Our model really focuses on prevention and early intervention and, within Powys, we're providing women identified with mild to moderate mental health issues with enhanced community support delivered by nursery nurses, which means they have some practical assistance with transition to parenthood, child development and brain development and those sorts of things. So, that's been really helpful. So, we've got 1.2 whole-time equivalent nursery nurses in post, and they are supported by a 0.2 of a band 7 health visitor, who's a clinical supervisor and who has got a special interest in perinatal mental health, as well as some admin support. So, that's what our model is providing.

[12] **Michelle Brown:** How will your services be provided? Are you going to use a hub-and-spoke model, the same as in north Wales, or—?

[13] **Ms James:** The hub element of our model really relates to the perinatal mental health steering group, as Carol spoke about, which really has been instrumental in delivering services since 2014, and the spoke element, really, I suppose, is that we are now spreading out to five distinct areas within Powys, which align with the community health teams as well. We've got nursery nurses in all of those key areas, so, if a woman is identified as requiring extra support, then the midwife or the health visitor can make a direct referral to the nursery nurse for that additional support.

[14] **Ms Shillabeer:** I think one of the challenges we've got in Powys is that the population's really quite small. It's only 4 per cent of the whole of Wales's population. So, when funding is calculated on a population basis, we get quite a small amount. It's very hard to then provide a specialist service that you may see in other health boards, because that person would be almost forever in their car. So, what we've learnt through experience is we need to invest in the generalist and community service and help to upskill and support them in order that, actually, these services are far more accessible locally. So, that's where we've spent the reasonably small amount of money and tried to build upon midwives, practice, health visitors and colleagues from mental health, as well as the community psychiatric nurses and the psychiatrists in the service.

[15] **Ms James:** And I think our model is very much underpinned by those robust pathways to those services. That's very clear within our processes as well.

[16] **Lynne Neagle:** Hefin.

[17] **Hefin David:** If I direct the first two questions to Betsi Cadwaladr university health board, can you outline the referral process for women with mild to moderate mental health issues?

[18] **Dr Schmidt:** Any woman with mild to moderate mental health issues who's identified, whether it's by midwives, health visitors, a GP or anybody else who may have contact with the woman, can do a referral to our service, and that will go via SPOA, which is our single point of access for all referrals to mental health services. The perinatal team will be notified of that referral and the decision will be made about where that patient would best be helped. So, it may well be in primary care, particularly if it's mild to moderate, it may be in secondary care, or it may be that the perinatal service

is exclusively involved for either people who are well, who may need preconception counselling, or may be well but have a serious mental illness and be at a high risk of relapse, and we would look after those patients exclusively. But I think, in terms of mild to moderate, it would be referral into perinatal services directed to primary care.

[19] **Hefin David:** So, if you're referred to primary care, how would that care then be provided? What would be the nature of that?

[20] **Dr Schmidt:** I think what we all hope is that every patient will get a comprehensive psychiatric assessment like any other patient with a mental health problem, but obviously, in perinatal mental health, we need to think about the baby as well, and all the different agencies that may be involved.

09:45

[21] Following that, a decision will be made about what that particular patient needs. It may be that they, in primary care, can access antenatal, postnatal groups, which is what we're hoping to establish. They may have some individual counselling from a primary care practitioner. We're also spending a lot of time linking up with third sector organisations that can support mothers with mild to moderate mental health problems. So, in north Wales we certainly have Flying Start, we have Home-Start, we have the parent information service, family services. So, there's a lot of the third sector that we would be tapping into.

[22] **Hefin David:** Would you say the individual patient receiving that care for mild to moderate issues would see a consistency of service from the time they're referred onwards?

[23] **Dr Schmidt:** I think that's what we're aiming for, and definitely—. Continuity, seeing the same person regularly, not having to repeat your history—we're very aware that those are issues for mothers.

[24] **Hefin David:** Is that still happening?

[25] **Dr Schmidt:** It definitely would be, at the moment. I think, in terms of the service in Betsi Cadwaladr, it's a very new service. There was no existing service before. We're in the process of developing. Although we're seeing some patients in the central area, we're not seeing patients yet across the whole of north Wales. All of the people who were recruited into our team,

apart from our psychologist, had no previous experience or expertise in perinatal mental health. So, as a first step, we're having to skill up our team so they can provide an expert service and then train other people. I think we're on track, but we're in the early stages of our development.

[26] **Hefin David**: And what about more severe cases that are referred to the—?

[27] **Dr Schmidt**: I think the more severe cases are definitely where we're going to place ourselves to start, and if somebody needs to be seen urgently, if it's an emergency, they'll be seen by our usual emergency services, whether it's liaison or the duty person on call for psychiatry that day, but we will be informed the next day and get involved. If somebody needs an admission, we will try to get that patient into a mother and baby unit as early as possible.

[28] **Hefin David**: Two questions just to finish. How will you ensure that this is done in a timely way and that you're up to full speed as soon as possible? How long do you think it's going to take?

[29] **Dr Schmidt**: Across north Wales, as I say, our central practitioner is already seeing patients, and I'm also seeing patients in the central area. We haven't officially launched, and that's because we're still waiting for our base and an admin and setting up systems, but, certainly in the central area, we will be fully launched in September. Our other two practitioners: one started on 7 June, the other one on the twelfth, and our midwife on 19 June. It's very early days for them, so, at the moment, they're attending courses, forming links in their areas, and we are anticipating that, by November, they will be in operation across north Wales.

[30] **Hefin David**: Okay, and would you see a consistent service across north Wales, then, by November?

[31] **Dr Schmidt**: Definitely, definitely. We'll have a central hub where our base will be, and we will have the psychiatrist, psychologist, team leader, admin based there. We will also offer a telephone duty service Monday to Friday, 2 p.m. to 4 p.m., and that will be for advice referrals, maybe GPs phoning in for advice regarding medication. Anybody can phone in to that service for advice and guidance.

[32] **Hefin David**: What about the less severe cases? Would that take a bit

longer, beyond November, to be fully operational?

[33] **Dr Schmidt:** I think that would, because that will involve training up everybody to detect maternal mental health problems early and do the necessary referrals.

[34] **Hefin David:** It will be a bit longer.

[35] **Dr Schmidt:** It will be a bit longer, but we're in the process of doing that. Although we're not up and running, what we have been doing regularly since January is visiting health visitors, midwives, maternity units, CMHTs, some contact with GPs, saying, 'Listen, we're here. We're not fully operational but this is what we hope to be doing. What do you need from us?' So, that's started.

[36] **Hefin David:** Okay. I fully appreciate the amount of work you must be doing. And, Powys teaching health board, what's the referral process for cases with you?

[37] **Ms Shillabeer:** I'll ask Helen to give the detail, but just to mention to you that, over the last 18 months or so, there have been some significant changes in mental health for Powys in the management of mental health services. So, mental health services for Montgomeryshire used to be managed by Betsi Cadwaladr, and they are now managed by Powys. And, in the south of the county, they used to be managed by Aneurin Bevan health board and Abertawe Bro Morgannwg—both of those have repatriated. So, Powys health board, we, as a health board, now manage all mental health services. That puts us in a really good place for improving multidisciplinary working and, actually, multi-agency working, because we've got to think this is not just about the health service, but also about social care and other services that exist as well.

[38] **Hefin David:** Just before you move on, do you have a specialist perinatal mental health team?

[39] **Ms Shillabeer:** No, we don't.

[40] **Hefin David:** So, Welsh Government funding was given for that, but you didn't use it for that purpose.

[41] **Ms Shillabeer:** We used it for early intervention, prevention, enhancing

the current pathway. Just in terms of Powys, and I made reference to it slightly earlier, what we found over the years on a whole range of issues is, because of our population—our low numbers of population—when there's an allocation of funding, it's often really very small. In order to use that, we often can't follow the model that has been used elsewhere by employing a specialist, because it might be that we have one specialist person. Trying to cover a quarter of the land mass of Wales with that one specialist person just doesn't work for people. So, we've often had relationships with other health boards that are in reach, or we've—I don't like to use the word, but—upskilled and supported generalists to operate at a higher level with supervision and support. That's the way in which we've taken it here.

[42] **Hefin David:** Okay.

[43] **Ms Shillabeer:** What I would say on that is, because we are now managing mental health services and we've got the whole of the service back just from 1 June of this year, there is much more potential for us to be developing new roles in mental health that bridge across mental health and maternal health services. So, I'm saying this may be something for the future.

[44] **Hefin David:** Okay. To turn that around, to think, well, you know, I've got a fairly clear picture from the Betsi Cadwaladr health board that if I was a patient, I would know the route, both with primary care and referral to the perinatal mental health team. What would I experience? A woman with perinatal mental health: what would her experience be from her point of view?

[45] **Ms Shillabeer:** I'll ask Helen to give the detail, but it starts at universal services.

[46] **Hefin David:** Okay.

[47] **Ms James:** Obviously, we've worked really hard at making our universal services more robust and have upskilled a lot of staff and they've had lots of training. So, our midwives and health visitors are getting more skilled at identifying women with a mild to moderate perinatal mental health issue, and, if that's identified, then they can access the new community service that we've set up, which is delivered by our nursery nurses. At the same time, they're going to be offering the listening visits that we know are effective, but they can also access their local primary mental health service via the GP. So, that's also an option for them if they've got mild to moderate perinatal

mental health issues.

[48] **Hefin David**: Can I just come in there? One of the problems that we've already mentioned is the inconsistency, because you don't see the same midwife or the same health visitor time and again. Is that happening?

[49] **Ms James**: I think, within Powys, we're very fortunate that we're able to provide that bespoke care, yes. I'm quite confident that we can provide that in Powys.

[50] **Hefin David**: So, you don't have to keep telling the same story over and over again.

[51] **Ms James**: No, absolutely not. Absolutely not. So, for those with obviously more severe, more enduring mental health issues, then we would make a referral to the secondary or the community mental health team as we normally would. That's been very responsive, and, again, we've got really close working relationships within Powys, and we can pick up a phone and have a discussion before we make a referral to make sure that it's appropriate and to, kind of, take some advice as well. So, those networks are really quite strong in Powys for us.

[52] **Hefin David**: So, it would be fair for me to say, just to round off, the geographical nature area of the area that you cover means that you can't provide the same style of service, but you aim to have the same outcomes. Is that fair to say?

[53] **Ms James**: Absolutely, yes.

[54] **Ms Shillabeer**: Indeed.

[55] **Hefin David**: Okay, all right. Thank you.

[56] **Lynne Neagle**: Thank you. Can I just ask about young people, and what the referral pathway is for somebody who's under 18 who is expecting and there are, possibly, going to be problems? What is the interface, then, with the child and adolescent mental health service in both the health board areas?

[57] **Ms James**: Again, within Powys, our CAMHS service sits within our structure. So, again, we have excellent working relationships with our CAMHS

colleagues, and the process would be the same, you know. If we're identifying a young person with mild to moderate, we would provide our normal, universal community service plus be able to refer across to CAMHS. So, we do have those really robust services.

[58] **Lynne Neagle**: Okay, thank you. And Betsi?

[59] **Dr Schmidt**: Very similar in Betsi. If there's a young person who is pregnant or postnatal and has a mental health problem, they would be referred to CAMHS and we would work jointly with CAMHS. So, that's how we're envisaging it would work.

[60] **Lynne Neagle**: Okay, thank you. The committee has heard calls for a national care pathway to be in place for the whole of Wales. What is your view on that? I'm conscious that, given the differences that exist in Powys, it might create some issues. Can we just get a feel for what you would think about that being in place? Carol.

[61] **Ms Shillabeer**: I think the summary that you made, if I may just refer to that, is about trying to get to the same outcomes, but the models of care being very different for urban, rural, and the needs of the population. So, whilst I think it is really helpful to have national approaches and consistency, it's got to be consistency of outcome, and a level of flexibility around how that gets applied. So, that would be my view.

[62] **Ms James**: Yes, not too prescriptive, probably, either.

[63] **Lynne Neagle**: Okay. And Betsi.

[64] **Dr Schmidt**: We've been participating in the all-Wales steering group and going to the sub-groups that are looking at a national care pathway. I think that's really useful in making sure that there are equitable services across north Wales, but, as Powys has said, there will have to be variation in the model, because of the huge differences in geographical areas and number of births. In north Wales, we have a very large rural area, but we also have quite concentrated areas like Wrexham.

[65] **Lynne Neagle**: Okay, thank you. The next questions are from John Griffiths.

[66] **John Griffiths**: Yes. I have some questions on data collection and

monitoring—questions for both health boards. Firstly, in terms of waiting times and the current picture, are you able to tell us or at least give us an estimate of the current waiting times for services, both for non-severe perinatal mental health services, such as therapeutic services, but also for the more severe problems as well?

[67] **Ms James**: For our community-based nurse service, there's currently no waiting list for that particular service. With regard to the mental health services, I think, obviously, the usual timescales apply for those. Perhaps Carol can say some more.

[68] **Ms Shillabeer**: So, one of things we want to do, and it's really just started—in the very early stages—is to have a level of prioritisation for women with a perinatal mental health issue within the broader mental health service. So, in Montgomeryshire, we're testing, from the mental health service, a specific clinic service slot for women with perinatal mental health issues, so that that rapid access, that ability to assess quickly and get a plan in place, is afforded to those people. Clearly, there are other waiting times requirements, so we do need to be mindful of that.

[69] But what we are trying to do is to speed up for those who have got that more significant—clearly, if it's a severe crisis issue, then other services kick straight in, so it is more of an emergency response there. So, if you're talking about the more severe but not in a crisis, we are trying to prioritise those. We are going to test out, in Montgomeryshire, how that works, what the demands are coming through, and see whether that is helpful or actually whether there needs to be more of a duty system and we can pick up the cases in a timely way through that. So, we're just testing that out. But, just to reinforce, on the universal services, we're very pleased we've been able to make sure that we've got good levels of staffing in universal services, so that we can be really responsive.

[70] **John Griffiths**: In terms of therapeutic services, for example, what would be the picture there in terms of waiting times?

[71] **Ms Shillabeer**: I was going to mention it earlier, so now's a great time to pick that up. We've got issues in Powys on access to psychological therapies and timescales on that. What we have done, as part of trying to tackle that issue, is we secured some EU funding a couple of years ago to introduce something called computerised CBT, cognitive behavioural therapy, under a project called the MasterMind project. That means that people can

access a package of CBT in their own home, using their own computer, whenever they want to. So, they haven't got the challenge, in rural Powys, of getting an appointment, getting a bus—there aren't many buses—et cetera, et cetera. So, we are trying to use different ways of service delivery to help people to access more of the psychological therapies. We have got a long way to go. We've got a psychological therapies committee that has got a real focus on broadening the spectrum of therapies and the numbers of staff who are able to offer that. So, that's our biggest issue, but we are trying to look at different modes of delivering and supporting.

10:00

[72] **Lynne Neagle**: Carol, can I just ask there, the paper that we've had from the British Psychological Society basically says that you don't have any access—there's zero consultant specialists, zero consultants and zero assistant psychologists. So, what happens if a woman in Powys needs psychological support at the moment?

[73] **Ms Shillabeer**: I saw that, and just to be really clear, we have got psychologists in Powys. We've got quite a few of them, particularly since we've just repatriated mental health services back to us, so I'm not quite sure—

[74] **Lynne Neagle**: I think the figures relate—. They're saying they're sessions dedicated to perinatal mental health, so, yes.

[75] **Ms Shillabeer**: Oh, sessions dedicated—no. Thank you for the clarification. And that would be true. A bit like the way in which we described the approach to specialists, we haven't got somebody with a badge that says, 'I am the specialist psychologist for perinatal mental health', so it's the general service. What we've got to do with the general service is ensure there's enough capacity and capability to respond to the demands coming through. The demands are often small and in different parts of the county, so we have to have that more flexible approach to this. So, they'd be absolutely right on that. I don't want to give the impression we haven't got any psychologists, though. They might get a bit worried if they—.

[76] **John Griffiths**: In terms of the computer access to CBT, then, has much evaluation been done on the effectiveness of that provision? Is it effective?

[77] **Ms Shillabeer**: Yes. I think it's really got huge potential for us in Wales

and this isn't just about women with their perinatal mental health issue; this is a general—. So, the client group we've been targeting is those with mild to moderate depression, which is about 8 per cent of the population. And we were one of 16 regions across the EU to use this. NHS Scotland have gone for it on a large scale. About 40 per cent of people who interact with it get on very, very well, and it really helps them and you can see the before and after. It's a supportive system where, if somebody is tipping into a crisis or what looks like a crisis, there is an alert system and you can intervene. For about 40 per cent, that will mean that for those people who would otherwise have had face-to-face and a longer wait, they can receive a perfectly adequate—if not very good, actually; we've good evaluation—service there. We therefore need to do face-to-face with some of the other people.

[78] We're using another prompting tool called 'Florence', which is a text messaging service that helps to encourage people to remember to use the internet CBT service and keep people motivated, because motivation is one of the biggest issues of drop-out. So, other health boards in Wales are interested in this, and we are partnering with Scotland around it. So, I think it's got real potential.

[79] **John Griffiths:** Okay, and in terms of targets that you have to meet—the waiting times for perinatal mental health services—are they general ones that apply generally, as you said earlier, or are there particular ones for perinatal mental health services?

[80] **Ms Shillabeer:** I believe they're general.

[81] **John Griffiths:** They're general. And are you meeting those at the moment?

[82] **Ms Shillabeer:** We are. We are trying to move beyond what's written on the target in terms of particularly you were asking earlier about people who are more severe. We just recognise how difficult this is when you're trying to bring up a family and really not well, so the sense of trying to move beyond what's required just on the target.

[83] **John Griffiths:** Yes, okay, and the same questions, really, for Betsi Cadwaladr.

[84] **Dr Schmidt:** I think, to date, anybody with a perinatal mental health problem in north Wales has had to access conventional services, and we

don't have data available about how many people that is, because, up until now, whether somebody's pregnant or in a postpartum period has not been recorded in data collection. So, exactly how many people have been accessing services to date, we don't know. But what we hope to do as a service is to see routine referrals within four weeks, emergencies the next day and urgent referrals within a week. That's what we're hoping to do, and that's what's in our operational criteria. Whether we will be able to achieve that with our staffing—we will have more information about that over the next few months.

[85] In terms of psychological therapies, we have 0.5 of a psychologist. Her remit will be to supervise our practitioners, do some individual families, individual psychotherapy, and to train our practitioners in brief psychological interventions, and also maybe set up groups in the community mental health teams and primary care. It's a very big remit for her, and I suspect that we're very quickly going to struggle with the individual therapy. If we're going to use conventional services to provide individual psychological therapy for our perinatal patients, we're not going to manage it. The average waiting list in north Wales for individual psychological therapy at the moment is 19 months—the shortest seven months, in Wrexham, 33 months in the west. So, it's not something that's going to help us in perinatal services. I think that's a standard in terms of the perinatal quality network that we will struggle to reach.

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

[87] **Lynne Neagle:** We are short of time because we started a bit late, so can I appeal for brief questions and answers that are as brief as possible, please?

[88] **John Griffiths:** Okay. So, in terms of data, then—I mean data on referrals, which services you've referred women with perinatal mental health issues to; in general, the data that you have—would you say that they're virtually non-existent at the moment?

[89] **Dr Schmidt:** They're non-existent for all practical purposes.

[90] **John Griffiths:** Yes. Okay. Just going back to Powys, in terms of referrals on to other services, would you have that information?

[91] **Ms Shillabeer:** Yes. We do, and at the more or most severe end—I

know you've taken evidence from the Welsh Health Specialised Services Committee—WHSSC holds data about our population and our requests going through and our length of stay for women who would be accessing mother and baby units. So, we hold some and WHSSC holds some.

[92] **John Griffiths:** Okay. And a final question for Powys, then: in terms of women being diagnosed with severe mental health in this perinatal mental health illness that requires hospital treatment, do you know the current level of demand? Are you tracking those women who go for treatment in terms of how many go over the border to England, for example?

[93] **Ms Shillabeer:** Yes. So, we've got that. There's a slight wrinkle in all of this, which is we know the requests we have from clinicians for an admission to a mother and baby unit, and we know how many that go. What we haven't got are the data collection systems—I think this is a Wales issue—of women who may go to a general mental health facility who may have a connection of being actually a perinatal mental health patient. So, there are some limitations to the data that we've got.

[94] **John Griffiths:** But you can provide the committee with those statistics.

[95] **Ms Shillabeer:** Yes.

[96] **John Griffiths:** I take it that—

[97] **Dr Schmidt:** It would be a similar situation in north Wales, yes.

[98] **John Griffiths:** Yes.

[99] **Lynne Neagle:** Okay. We're going to move on now to talk a bit about mother and baby units. Thank you. Julie.

[100] **Julie Morgan:** Yes. Thank you very much. So, if we start with Betsi first, do you think there should be a mother and baby unit in Wales, and what experience have you had of a mother and baby unit?

[101] **Dr Schmidt:** As we all know, there's no mother and baby unit in Wales. I think there are 15 in England. Just speaking from a north Wales point of view, I'm sure that south Wales needs a mother and baby unit, and they certainly have enough births to warrant that. In north Wales, we have approximately 7,500 births a year. That was the number in 2015. That

doesn't qualify us, according to what the Royal College is saying—that you need 15,000 to 20,000 births to fill an eight-bedded unit to capacity. However, we do have patients who need to go to mother and baby units, and at the moment we use the Wythenshawe Hospital in south Manchester. That's our closest, and that's the unit that we've tried to establish a link with. And, certainly since I've been in post, in March, we've had two patients who've been admitted there. They don't always have beds in an emergency, so that means our patients are admitted to acute facilities without their babies, with all the long-term consequences of that. Distance is a big factor. For many mothers, their families don't want to travel. It's not so difficult for patients in the Wrexham area, but certainly from the west it's several hours' drive, and we've got a patient at the moment who's in an in-patient unit without her baby, who's refusing to go because of the distance. So, that is a problem.

[102] It would be great if we did have a mother and baby unit in north Wales in a central area, because that would obviously solve a lot of those difficulties. If that can't be achieved, then I think we need to build networks with the north-west, because anything that happens in south Wales is unlikely to benefit our patients in north Wales. And maybe—this is where I'm coming from—wherever you are in north Wales, some people are going to have to travel to get the best service with the best outcome, but obviously we want to minimise the distance.

[103] **Julie Morgan:** So, at the moment, there are women who need a mother and baby unit, but they're not able to access a mother and baby unit in north Wales for numerous reasons.

[104] **Dr Schmidt:** For numerous reasons, yes.

[105] **Julie Morgan:** Thank you. And what about Powys?

[106] **Ms Shillabeer:** We access services in Birmingham and Bristol for our patients. You'll know that it's not unusual in any way for the Powys population to travel outside of its borders for in-patient specialist care, which is one of the reasons why we really wanted to try to strengthen the community offer and just make sure that we are supporting people as early as possible, so that people don't have to travel, but the numbers are very small. Just an observation that, if there was a mother and baby unit in Cardiff, as there used to be, our population would probably be traveling largely the same, maybe marginally shorter distances, but they would still be traveling. I know that you are aware of the complexities of the data, et

cetera, so there is a piece of work for us to do, probably across Wales, or certainly in our own health board, which is about the demand that we may not be seeing because of women going into a general mental health unit, just to be absolutely sure.

[107] **Julie Morgan**: And are you not sure of that at the moment then?

[108] **Ms Shillabeer**: No, because we don't classify it in that way, but we can do a piece of work to try to identify that.

[109] **Julie Morgan**: And so, what about links? Do you have strong links with Birmingham and Bristol?

[110] **Ms Shillabeer**: So, in Powys we buy services from everywhere. So, part of our clinical leadership—and our clinicians are very used to linking with other providers and trying to co-ordinate the care across Wales. It's often a very complex situation, so women will have a care and treatment plan and be supported from the more remote unit back into Powys. The numbers are very small—fewer than five in the last three years.

[111] **Julie Morgan**: So, if there was to be a mother and baby unit in Cardiff, as there was at one stage, would you see an advantage in having something in Wales for your area?

[112] **Ms Shillabeer**: Access is one thing; I would want to be absolutely sure that it was sustainable, it was open 24/7 when we needed it, it was high quality, and that the experience of the mothers and the families was good. It's difficult to say, because I recognise fully how challenging it is for people to travel, but in my experience, talking with people, they're willing to travel for a really high-quality service, one that's open day in, day out. So, I think we've got to weigh up a number of factors here beyond access and travel times.

[113] **Julie Morgan**: Yes. I think we've had debates about how the mother and baby unit functioned before when it was there, and that the model needs to be a sustainable model.

[114] **Ms Shillabeer**: Yes.

[115] **Julie Morgan**: Thank you.

[116] **Lynne Neagle**: Thank you. Darren, on this.

[117] **Darren Millar**: I just wanted to ask both health boards what sort of numbers are being referred to these mother and baby units in both Manchester and over the border in Birmingham. You've mentioned since March—.

[118] **Dr Schmidt**: Since March we've had two and there's a third one we're trying to facilitate. We don't have the data for north Wales for the past. We know that there were, I think, 13 requests across north Wales and six actual admissions last year, but that's as much as we know.

10:15

[119] **Darren Millar**: So, when you say 13 requests but only six admissions, that would imply that there were some refusals of those requests. By whom? By the Welsh Health Specialised Services Committee?

[120] **Dr Schmidt**: No, WHSCC doesn't refuse. I think the patients didn't go because they decided not to go. Maybe that is was too far, or the situation changed.

[121] **Darren Millar**: I see. So, it was the geography that made them reluctant.

[122] **Dr Schmidt**: Geography is a huge problem.

[123] **Darren Millar**: Okay. And in terms of Powys.

[124] **Ms Shillabeer**: Over the last five years, fewer than five.

[125] **Darren Millar**: Right, okay. So we're talking small numbers, but those numbers would be pretty consistent with the numbers that we're told would require admission into a mother and baby unit—around 15, I would expect, on an annual basis in north Wales, roughly. Between 10 and 15.

[126] **Dr Schmidt**: I think at least, if you think we should have 15 postpartum psychoses and 15 relapses of severe mental illness and maybe 125 to 150 severe postnatal depressions, and a proportion of all of those might benefit from a mother and baby unit. I think what we don't know is all the patients who, if we had a unit that was accessible, we would have referred in the past.

[127] **Darren Millar**: And obviously both north Wales and Powys teaching health board are responsible for populations of Welsh-speaking mums. There isn't necessarily going to be a Welsh-speaking service in England, understandably, for obvious reasons. To what extent is that a problem, and are Welsh women being disadvantaged as a result of that?

[128] **Ms Shillabeer**: If I can just say that it's a factor not just in perinatal mental health. So, people in Powys will travel across the border to have their appendix out, or a whole host of things. So, it's bigger than that, and it's a real challenge—how do we ask our English providers to provide a service in Welsh? We're trying to grapple with that, which is why we are consistently trying to support people closer to home.

[129] If I can just clarify to you why I'm saying fewer than five—it is because the numbers are so small they can be identifiable. So, you take from that that it is significantly fewer than five. On the challenge of access, for much of the Powys population the border doesn't really exist between England and Wales, so it really is about, 'Will this deliver the best service that the individual needs?'

[130] **Darren Millar**: I suppose the point I'm making is that having your appendix out in a hospital is very different from a mental health problem, where you might want to talk things through with people in your mother tongue. So, I'm just thinking from an equalities point of view in particular, are Welsh-speaking mums being significantly disadvantaged by the fact that there's less of a service for them, or a less well-developed service, in terms of access to these sorts of mental health services?

[131] **Ms Shillabeer**: I absolutely take your point. We need to be upfront and say we don't know. I don't know the ladies. We probably could be a little bit more creative around how we use our resources to support some of that outreach. But you know, it's a very well-made point.

[132] **Lynne Neagle**: Some women are supported in the community with severe mental illness, and that was one of the arguments that was made when the mother and baby unit was closed. I just wanted to ask to what extent you are confident that you can manage the risk of that in the community, really. Because we're not really clear as a committee how much support goes into those homes when that is happening.

[133] **Ms Shillabeer**: Interestingly, we had a discussion about this just before we came in. The issue of risk assessment is really critical, and having very skilled and confident practitioners to undertake that risk assessment's really important. You're probably better off having more of a clinical view than a manager's view on this.

[134] **Dr Schmidt**: I think that risk assessment in the perinatal period is a little bit more complicated than in other areas of psychiatry, and a lot of our patients would present quite well but be quite unpredictable, and their mental state can fluctuate and deteriorate very rapidly. So, if you've got home treatment going in once a day, the patient may seem fine in the morning but the situation is very different at night. I think you have to be very careful and very experienced. I think that's one of the arguments for having a specialist perinatal community team to help with those risk assessments, but I think, if somebody needs to be in an in-patient unit in that period, they actually need to be in a mother and baby unit and I suspect that, in the past, we probably haven't got that right.

[135] **Lynne Neagle**: Okay, thank you. Mark.

[136] **Mark Reckless**: I wanted to ask you about managed clinical networks. In Betsi, in your written evidence, you did refer to services wanting to give consideration to this. I just wonder whether you can go a bit further and say whether you consider that a managed clinical network for perinatal mental health should be set up in Wales.

[137] **Dr Schmidt**: I think that anything that will help develop improved services and makes sure that services are equitable across north Wales would be beneficial, and I think that that would be one of the purposes of the clinical network. So, yes, I think that that would be an important part of perinatal services.

[138] **Mark Reckless**: Do you see that being done on an all-Wales basis?

[139] **Dr Schmidt**: At the moment, there's the all-Wales steering group community of practice, which meets regularly and has sub-groups, so that's happening. We also have the north Wales steering group, which has relevant stakeholders. That also meets every three months. We're also trying to establish some links with the north-west, just because of proximity and the fact that we use their units and we participate in their educational events.

[140] **Mark Reckless:** Could I ask you about integration of services? I come to this from two different angles. Firstly, on the engagement you have in perinatal mental health, what proportion of those patients have been engaging previously with mental health services, compared to what numbers present really for the first time to you in a perinatal perspective?

[141] **Dr Schmidt:** We can't give you numbers, but people who have a previous mental illness, if they do become pregnant or in the postnatal period are at increased risk of having a relapse of their existing condition. So, anybody with a past mental illness is at high risk of relapse during the perinatal period and a lot of people who we see would be those patients: patients with schizophrenia, patients with bipolar disorder and with severe depressive and anxiety disorders—all of those patients we would want to see in the perinatal period.

[142] **Mark Reckless:** What degree of emphasis—to both boards if I may—do you give to integrating third sector providers in your clinical response?

[143] **Ms James:** I think, within Powys, we've got very strong partnerships with our voluntary organisations and they really do help to provide universal support within our communities. We've got some really nice groups: we've got buggy walking, bump-to-buggy walking, Splash a Sbri for parents and we've got baby massage programmes. All of these things help to enhance the community experience of some of these women. So, they are really instrumental in working in partnership with health board staff to deliver some of these programmes. So, it's very helpful.

[144] **Mr Morris:** In Betsi, we involve Caniad. We also have other third sector agencies: counselling services; Parabl. We're developing focus groups with mothers, such as walking groups and networks. We feel that's a way forward and an important part of the service.

[145] **Ms Jones:** We also have permission to do some mental health training from the midwives and the health visitors.

[146] **Mark Reckless:** Could I also ask—and this comes from the perspective of having three children, who are aged five or under, and having homes both in England and in Wales—once the mother is discharged by the midwives who've been coming to the home, if after that, for example, postnatal depression were to present, how do you ensure that that is dealt with properly through the perinatal context, rather than becoming a general

mental health issue?

[147] **Ms James**: The midwife will hand over to the health visitor at the appropriate time and obviously that would be part of the handover and the sharing of information at that time. Again, with the Healthy Child Wales programme now throughout all of it, there is a real focus on social and emotional well-being, attachment and bonding and perinatal mental health. So, the health visitor will just pick up and carry on with that programme, asking, at the appropriate times, the universal questions that we're asking. So, I think there is continuity of that throughout, with the health visitor, once the midwife finishes her role.

[148] **Ms Jones**: It's probably the same in Betsi, although there have been some challenges, I believe, recruiting health visitors to the Healthy Child Wales programme.

[149] **Mark Reckless**: Particularly not having that mother and baby unit locally, does that tend to push people more towards the general mental health services, rather than having a specialist care path?

[150] **Ms Jones**: I think now that the perinatal mental health team is in being, they'll go that route.

[151] **Mark Reckless**: Thank you.

[152] **Lynne Neagle**: Thank you. Before we go on to training, can I just get a response from Powys on the managed clinical network and whether that is something that you would support for Wales?

[153] **Ms Shillabeer**: Can I just say that it depends what you mean? There are two types, in my view. There's the sort of community of practice, developing standards network, and then there's the clinical management of patients network, where you get much more regional working and cross-cover and support. I think there is an argument, much more with specialist services that may have a lower number of specialist clinicians—what happens when there are staff vacancies and turnover or sickness, how do different parts of Wales support one another? So, I think there is something to be said about building the resilience across Wales of those services. For us, we'll be tapping in to other services across Wales anyway, but it might be more important for, certainly, the services in south Wales and north Wales to be closely connected.

[154] **Lynne Neagle:** Okay. Thank you. Hefin, briefly on training.

[155] **Hefin David:** You've touched on training already, so, can you just give me an indication of the balance between the nature of initial training and ongoing professional development practice for healthcare professionals with regard to this?

[156] **Dr Schmidt:** Because our practitioners, myself included, didn't have previous perinatal experience, I think, to start, we've all been doing intensive perinatal courses to skill us up to what you need to know as a specialist in this area. So, courses—our practitioners have also been going on courses to assist them with assessing and supporting mother and infant bonding. I think after that, we'll be doing CPD and we'll be, as individual practitioners, identifying what their needs are. But also, the Royal College of Psychiatrists quality network has a list of competencies that every practitioner needs to fulfil, and I think that if you go through that, you can see what you are okay in and what you need to do.

[157] **Hefin David:** Okay. Just to follow up, I was satisfied with the evidence on training we received from other health boards and have received today. What I'm really struggling with and am surprised at is what appears to be a limited understanding of continual professional development, or limited application of it. Is that fair, or do you think that I'm underestimating how well it's done?

[158] **Dr Schmidt:** I think, certainly from a psychiatry point of view, individuals have to be part of a whole range of things to make sure that they stay up to date. So, we have appraisal, we have personal development, peer groups. And so, I meet with other consultants in the north-west, and we do case-based discussions, we discuss our development plans, we share knowledge, and then we agree a personal development plan for each individual who is a member of that group. So, we have a lot of structure around that. I can't really talk about the other professionals in our team.

[159] **Hefin David:** Okay. That sounds like best practice. Is it—?

[160] **Mr Morris:** It's the same within—. From a manager and a nursing background myself, and for my team of nurses, it's the same process.

[161] **Hefin David:** How do you keep data?

[162] **Mr Morris:** Sorry?

[163] **Hefin David:** How do you keep data?

[164] **Mr Morris:** How do we keep the data? It's all on file, in the personal files of that member of staff, with their appraisal and a development plan within that.

[165] **Hefin David:** When is it reviewed?

[166] **Mr Morris:** The appraisals are yearly. So, a PADR—a personal appraisal. And we have supervision on a monthly basis, once a month.

[167] **Hefin David:** How effective is that—

[168] **Lynne Neagle:** Hefin, we can't pursue this in great detail at this stage in the meeting now.

[169] **Mr Morris:** It's early days with my team, because we've only just started doing that. So, it's something I'm keen on, to continue and be quite robust with, to provide that continued development.

[170] **Hefin David:** Thank you for your indulgence, Chair.

[171] **Lynne Neagle:** Thank you. Just a final question, then, on attachment. Mark.

[172] **Mark Reckless:** I just wanted to say that the relative emphasis given to breastfeeding and bottle feeding—is it from a perspective of breastfeeding potentially being better for attachment and bonding with the baby, or is it solely from the physical perspective of the different qualities of the breast milk and the formula milk?

10:30

[173] **Ms James:** Breastfeeding will obviously promote attachment and bonding, but I would say just successful feeding for these women is also really important. I think some of these women feel really guilty if they can't breastfeed, so I think the focus has to be on feeding successfully, and feeding with closeness, and the same principles of breastfeeding. So, we

must really try not to focus so much on the breast, just successful feeding, and not make women feel guilty if they can't breastfeed.

[174] **Mark Reckless**: Thank you.

[175] **Lynne Neagle**: Okay. We have come to the end of our time. Can I thank you all for attending and answering all our questions? You will be sent a transcript to check for accuracy in due course, but thank you very much for your time, we very much appreciate it. Thank you.

10:31

Ymchwiliad i Iechyd Meddwl Amenedigol: Sesiwn Dystiolaeth 9
Inquiry into Perinatal Mental Health: Evidence Session 9

[176] **Lynne Neagle**: Good morning. We'll move on now then to our second evidence session. I'm very pleased to welcome Dwynwen Myers, who is psychologist lead with Betsi Cadwaladr university health board, but is here representing the British Psychological Society today. Thank you for your attendance and for the written evidence you've provided in advance. If you're happy, we'll go straight into questions. The first question is from me. Just to say, really, if you could just—. We've had this extra money for perinatal mental health. Can you just give us something of a sense of how that is working in terms of psychological support, what the process is for a woman who needs psychological support to access it, and what your sense is of whether we have anything approaching enough psychological support for women who need it?

[177] **Dr Myers**: Okay. That's quite a lot in there. Bore da. Good morning. I guess it might be helpful for me just to first point out that it was my colleague Cerith Waters from the south here who did write the initial document, and I've got that here. He was, unfortunately, not able to be with you today. So, that's why I'm standing in for him. I hope I'll be able to represent my psychological colleagues with a current update.

[178] I have had some updates from my colleagues who are already in post in Wales. We're talking about nine clinical psychologists who are now employed since the additional money has come through, and my post is one of those. We're all, however, very much session based. What that means is that none of us are full-time, and we are all appointed at specialist level, which means that it's eight As or eight Bs. That's what that means. So, in

terms of what you would expect from a psychologist at that level, you'd be expecting to have a clinical psychologist at doctorate level, like myself. So, we will have had a number of years of experience. We will have also developed particular areas of interest and we will be governed by evidence-based work. So, currently, in terms of what we've been able to provide with the money, psychologists are employed within the teams, apart from Powys. Powys does not have a clinical psychology input.

[179] As part of our training, we would be delivering psychological therapeutic inputs. So, we're trained to deliver individual-based approaches, and to work directly face-to-face with people, and with families. Within a perinatal field, you'd expect that we'd have an understanding of working with children, and also working with adults, because it's an individualised approach working with women. But it isn't just the woman. We must remember that with perinatal mental health services, there wouldn't be a need for them if there wasn't a baby. So, it's really important that we don't forget the babies in all of this as well, and the impact that it would have on their mental health. I guess I'm digressing a little bit, but I think that in terms of what's happened, we really welcome—and I think that was the initial report—the additional money, because that's actually made it possible for people like myself to be able to be appointed where there was no service previously. So, I think that, prior to the money, there was only Cardiff and Vale, which I think you have probably heard subsequently is quite well—. It had some input, and so the additional money has actually meant that they can continue to improve and hone their services. That's why, in terms of psychology input, they have got psychological input crossing all of the targeted areas that were laid down by yourselves—thinking about detection, early intervention, team working, and how we would operate in terms of who is going to be doing what. So, we are not stand-alone as a profession; we are integrated within a multidisciplinary perinatal mental health service. That's what the evidence base said we should be doing. That's the professional training that we will have had to enable us to be able to do that work. I'll stop there. If I'm missing the point, please come back to me.

[180] **Lynne Neagle**: So, to what extent, then—? You've said about Powys, and we've already discussed the lack of specialist provision in Powys, but every other health board has some psychological specialist input, but it varies. To what extent can we be confident that the need for access to psychological support for women in Wales is being met in the perinatal period?

[181] **Dr Myers:** I think there's a lot of goodwill, and that's beginning—because I think you are welcomed into services. So, integration and also co-ordinating across what's already in place is going to be really key. So, there have been people working with this client group. It's just been very, very patchy and there was nobody with specialist input to join that up. So, this is the first opportunity that we have that. In terms of the small numbers that we are, though, it is a start. I wouldn't want to denigrate the fact that it is a beginning. To be honest, it is but a beginning. I have been in post now for four months, so I can't actually speak about the direct impact I can actually have in my health board because we are not yet operational. We are working on the basis of the epidemiology, so I think that's probably—certainly, for myself—one of the major attractive things about working in a perinatal mental health field. You can say from the beginning—. You know. The epidemiology is really clear. We have a really good grasp of who are likely going to be the people we need to work with. It is really clear what kind of work will be effective. We've known that for a very long time. But it's actually getting it to the point where we can deliver those services.

[182] Money has been put into training of all staff and psychologists, in particular, who meet the need for working with mothers and babies. So, being able to utilise our professional capacity—I think it's a shame that it isn't being utilised to the full. I think that, for me, personally, it is really, really hard. I have worked in the past—. I've been working for the last 13 years, if I take me as an example—I was initially working in Derby when I trained, and in a community clinical psychology training in Exeter. I then joined the mother and baby service two-year course post qualifying, in Derby. I worked within a mother and baby unit, and we developed that service. I am going back over 15 years, shall we say; 20 years now. Then, I moved to north Wales 13 years ago, and I have been working in a child and adolescent mental health service. So, there has not been a dedicated service.

[183] But in terms of our clinical training and what we can offer, there is much I would be able to offer if I was able to in this post. But, the reality is going to be that I am going to be really, really limited. Hopefully, I will be able to ensure that I am helping to skill up staff. The key staff who have to be helped are the health visitors and the midwives—really important.

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

[185] **Michelle Brown:** Thank you, Chair. You've stated in your evidence that it's difficult for the new perinatal health services to meet the national

standards because of current levels of funding and staffing. What do you think the health boards need to do to meet those standards?

[186] **Dr Myers**: Well, clearly, there will be some guidelines out there and that's what the table that Cerith prepared alludes to, really. So, there are two key documents. Interestingly, though, it looks like there's a disparity with that, so that's why, I think, you're presented with what might appear like conflicting information, and it might be a bit confusing. I think it's confusing and I'm working in the field and I've had the opportunity to be thinking about this for quite a long period of time. I think the difficulty will be making a decision about at what level you want your perinatal mental health service to be actively working and integrating services. So, if you decide, like the Royal College of Psychiatry, the main document—. I think it's probably been used, certainly in England—that's the document they've used to decide on staffing levels and I think that's what's been used in Wales as well. So, that's a key issue for psychologists, I would say, because nowhere does it say what sort of expertise you might need, so you could be employing a psychologist with two years post-qualifying experience, like a junior doctor, or you could be employing somebody who's actually got quite a great deal to offer in terms of developing a new service, in terms of individual-based approaches, in terms of being able to skill up and provide support to other professions—somebody who's probably got over six years of experience.

[187] Also, if you think through how the structure works, you do need to be able to provide new clinical psychologists with training. So, for us in Wales, with a live birth population of, say, 33,000—I'm just rolling it down because the numbers would get lost in my head—you are talking about quite a lot of women who you need to target, because of the levels of distress. If you go with one document, it's telling you you need to be pitching your staff for the 5 per cent most severe, and if you take another document, which is the one prepared by the British Psychological Society, they are saying you need to target your 10 per cent. Now, other services will say, 'Well, actually it's 20 per cent of women who've delivered who are likely to have perinatal mental health difficulty to some level', and, of course, there's something that you can do to help at all levels, but I don't think it needs to be the perinatal mental health service that leads on some of that work, but they do need to be there to help support, and also in terms of knowing at what level is something becoming more severe or not. I think those are the skills that a clinical psychologist brings. But if they're a bit too thin on the ground—we're talking, say, for north Wales, which is my area, quite a large geographical area, as some of you, I'm sure, are very aware—it can take going from

Wrexham to Pwllheli to Dolgellau. You're talking about at least two hours in the car to travel from one end to the other—

[188] **Michelle Brown:** [*Inaudible.*]

[189] **Dr Myers:** [*Inaudible.*]—like I did from north Wales. [*Laughter.*] But the reality is that, to actually meet the needs, we're going to have to be really, really careful and quite creative about how we're going to do that. So, it may well not be face to face, but it might well be telephone consultations, and I certainly know that that is what one of my colleagues in post in Hywel Dda is doing. She's actually doing a lot of telephone consultation and advice giving via telephone. So, there are various attempts to meet what we know is the agenda that we have, or trying to tackle, really.

[190] **Michelle Brown:** Do you think sufficient numbers of suitably qualified and experienced psychologists and other staff are being put in place to actually provide for the level of demand that we're likely to have? I understand you say that there seem to be different documents all giving different guidance about the size of the service and the numbers of people you should be targeting, but do you have a feeling, from common sense and past experience, what sort of size the service should be, and are there enough staff on the ground to actually cater for the number of women at various levels of mental health problems who are likely to need help?

[191] **Dr Myers:** No, there aren't enough.

[192] **Lynne Neagle:** Okay, thank you. What about the evidence in the paper that there is a lack of consultant clinical psychologists? To what extent is that going to undermine the efforts to have this really good perinatal mental health service in Wales?

10:45

[193] **Dr Myers**: I think talking about psychology, in terms of the impact that will have on other psychologists, it means—. So, for example, for our professional development and our supervision, which is integral to every profession and also part of the accreditation processes—so for a service to be accredited, we need to be able to ensure that our staff are receiving appropriate expert supervision—to access that, according to the recommendations that will be in place and in terms of what we have, we'll be looking to supervision outside Wales. I'll be looking to find a supervisor for

my clinical work outside of Wales, because there's no consultant perinatal psychologist in post in Wales. So, that's the immediate impact that it has on me sitting here.

[194] The impact on the wider network will be the impact it will have on what we're able to deliver in terms of what consultant clinical psychologists bring—it's another level up, in a way. I was working in Derby as a consultant clinical psychologist, so I guess I can talk from experience from that perspective, because that's definitely not the banding I'm on now. At that time, a large part of your role would be supporting staff, ensuring that training was there and that your evidence base is actually being adhered to. So, being able to not just ensure that there's an overview of your staff, but that you'll also be able to deliver the key requirements, and most other professionals working both in perinatal and in the facilitating posts are also looking for that. They often look for you to help them in terms of supervision, formulation and thinking about 'What do we do next?' and 'What would work?' In psychology, we talk about biological, sociological and psychological difficulties, and within that, we will map out a tailor need for any woman and family—not just the child but also the partner. Again, at that level of expertise you would have somebody who would actually be able to think more widely, so it's not just individual-based intervention, but it may well be about us engaging with the system and engaging with families.

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

[196] **John Griffiths:** I have some questions about waiting times for psychological therapies. Given the importance of women in the perinatal period accessing those therapies, if they need them, as quickly as possible, could you tell the committee what the picture is across Wales from one health board to another? What are the waiting times?

[197] **Dr Myers:** I can't give you that information. From the information that I do have, if we're talking about psychology input or psychological input and support—

[198] **John Griffiths:** Psychological therapy.

[199] **Dr Myers:** Psychological therapies—I'm talking about psychology here. Within a perinatal mental health service we wouldn't be looking to having a waiting time, because it defeats the whole purpose of having a timely, appropriate service, so there wouldn't be, specifically, a waiting time.

However, if I qualify that in terms of what I do know about my colleagues who are currently in post, because they've got limited provision—. So, for example, in Abertawe Bro Morgannwg, money has developed the services there, but it hasn't increased the psychologist's time, so her time remains—. I think I've got it here somewhere. She works one day, two days a week, I think. It's quite limited, but going to your point, what she's actually told me—and this is literally in the last week—is although she's meant to cover the three towns, she only is able to cover Bridgend. So, the services for women in Bridgend, there is no waiting time, but she's very careful about what she is able to provide. There are many things that they won't be able to provide because they can't do the one-to-one work. In Hywel Dda, they don't provide—. Psychology does not provide one-to-one therapeutic work within the perinatal service; they can only manage group work. So, it's trying to use that differently.

[200] I don't know quite yet what's going to happen for me, because we're not operational. I know what I can provide, but I think the reality of it will be we're talking very, very small numbers. If I look more widely out at what's in place—. I can only talk about my own trust. I do know what the numbers are for psychological therapy waiting times in psychology in Betsi Cadwaladr health board. The psychology waiting time in Wrexham is varied—it's around 37 months, and in other parts, in the central, it's seven months. So, there's a mean of 19 months waiting. Well, I'm afraid that doesn't fit within the perinatal mental health service. We need to be responding within four hours, and then two weeks, and a minimum of four weeks wait for individual therapeutic work or psychological interventions. So, I think you would find, if you asked for specific treatments and specific approaches, there would be a wait. But in terms of what can help to manage as a team, then we can't wait.

[201] **Lynne Neagle**: Okay. Mark, on this, was it?

[202] **Mark Reckless**: Yes. I just wanted to ask when you expect to be operational and what your role is pending that becoming operational.

[203] **Dr Myers**: Currently?

[204] **Mark Reckless**: Yes.

[205] **Dr Myers**: Well, I think we are meeting some of the expectations of what you would be expecting from a psychologist's role. Clearly, the important things are going to be mapping. You know, what's actually

happening at the moment? So, there will be some things with psychology input into, and developing psychological models and training. So, there will be things happening in my own Betsi Cadwaladr university health board. I know there will be things ongoing, and we're currently finding out what they will be. There's a lot of liaison. There are clear safeguarding issues that are of concern across services. My background in the child and adolescent mental health service in north Wales is quite facilitating because it then means that I'm able to join in with some of the other managerial and clinical networks with the children's committees that we've got going, looking at making sure that services are joined up. So, I'm attending those meetings and we're taking advice and listening to what's currently working and what people are saying they would find helpful.

[206] **Mark Reckless**: But you're not actually seeing patients currently.

[207] **Dr Myers**: No, we're not operational.

[208] **Mark Reckless**: Another witness, I think from Powys, was referring to having cognitive behaviour therapy online provision. Is that a satisfactory alternative to seeing a clinician on a one-to-one basis?

[209] **Dr Myers**: We'll go back, then, to where you're putting your cut-offs. So, in terms of mild, they've been developed as very rigorous and really good—you know, there's an evidence base to them. But the people who have helped develop those are very expert, but they're not the people who are actually delivering it. What you have are very, very good strategies that can help for the mildly anxious—we're into thresholds again. They wouldn't be within the service of a perinatal mental health service because the severity wouldn't—it's not going to be enough.

[210] **Lynne Neagle**: John, did you—?

[211] **John Griffiths**: Yes, just to ask, then, about alignment between perinatal mental health services and parent/infant services and CAMHS. Do you consider it important that there is that alignment, and if so, how do you think it could best be achieved?

[212] **Dr Myers**: I entirely think it's important. I think, in terms of where we're at with that in north Wales, as I say, I'm attending meetings, I'm getting to know where interface needs to be. Children's services also are patchy in terms of the provision for early intervention. So, for some parts of

the north Wales region, you do have early years services for nought to five-year-olds, whereas in other parts it's more patchy and it's a bit varied. But joining up those elements and certainly working—co-working and maybe some enhanced work from a perinatal mental health service is absolutely the way to be going. That's what we've been spending some of our time—getting that that into place, really. And that's why we'll be seen as being heavily involved in co-working when that's appropriate, so that we don't leave the needs of the infant out. But we're also talking about families, so we mustn't leave the partners out or the families out either. So, being able to have a way of working with families is really, really important. In Betsi, again, that's something that I do bring as a strength, because I'm qualified also as a systemic psychotherapist, which means I'm able to deliver family therapy. The problem will be there will be a great demand on some of that time, so I'll be needing to think extremely carefully and co-work quite a lot fwith my colleagues as to how we can actually reach the people for whom it's going to be the most effective and useful, but also hold in mind how I might disseminate some of those strategies as well.

[213] **John Griffiths**: So, is that co-working being driven by the health board, or is it something that you as practitioners are arranging for yourselves?

[214] **Dr Myers**: It's driven through the National Institute for Health and Care Excellence —the recommendations, really. So, that's an evidence base. So, to not do that, you're breaching your evidence base, really. So, it's kind of very clear. It's very clear what we need to be doing. Our difficulty will be whether we'll be able to manage to do that. For the service for north Wales, a very, very clear message as to why the service has come into existence was also the driver of the coroner's report because of the maternal deaths, and that has been a driver for quite a lot of services in England. I believe that was probably one of the reasons that we had such a good service in Derby when I started 20 years ago. So, those highlight attention, and it's really, really good that we are actually addressing some of those because we know many of the difficulties for women we have been able to help with. But, in terms of suicidal mental health, we don't seem to have been making a sufficient amount of inroads. So, there's quite a big task there to try and get that a bit better.

[215] **Lynne Neagle**: Okay, thank you. We'll move on now to the role of the third sector. Julie.

[216] **Julie Morgan**: Yes. Obviously, there's a great variety in services

offered. How do you see the role of the third sector in providing for and helping mothers with mild to severe difficulties?

[217] **Dr Myers:** It's a crucial role. I guess, for me, it's an obvious question. As a psychologist, it's about taking a stepwise approach. I don't mean this in any disrespectful way, but there are some things you need a plaster for, but then there are some things that you actually need a plaster cast for, and how do we decide on the in-between and getting the right thing at the right time—you know, it's a plaster that you need, not a plaster cast, because that's going to limit your functioning as well? So, it's actually getting those levels right and in place. So, in terms of thinking about where we all fit into that, I think we're in an amazing puzzle. So, I think it can be very peculiar for people to try and grasp that. But one of the things that I think is really helpful that's going on at the moment is the all-Wales committee and the sub-groups within that, looking at perinatal needs locally, which is bringing in the third sector. It's bringing in service users, and it's actually bringing in now staff who are in post, and I am part of that. I've been travelling down to Cardiff, which is quite a big chunk of a psychologist's time, to be able to invest time in these organisations, but it's actually crucial. You get the structure in place and the things will slip into place. When people are well, that's the time to get things into place, because then, when they're unwell, it's a crisis, it's a rush. And yes, we need to be able to manage that, but there are things that we know make a difference if we're well-planned and we're clear and we know what our focus is going to be. We share that, we communicate. And that is the big message: communication is key, making sure people understand what we're talking about.

[218] So, one of the tasks that we're going to have as our operational policy in Betsi, is a very clear glossary, because, across different services—children services and adult services—we may use the same words, like 'early intervention', 'timely' and 'appropriate', but they mean different things within different services, and we want to be really clear what they mean for us in perinatal—it's 'quick', 'within four hours' and 'now'—and just making it really, really clear because there are a lot of shortcuts, like you were alluding to cognitive behavioural therapy. Well, what does that mean? Most people don't know what that is until they've actually had the experience of that. There are many, many aspects to that. There are then lots of things that can be really useful, but there's also an individual tailored approach—that you need to understand somebody's point of view, really. You need to hear their narrative, and that's the other really, really important component—it's actually lived experience, so that people will actually know what that's like,

and you can't leave them out. So, we're actually doing quite a lot to try and get a focus group going in north Wales now, and we're delighted to have a flyer going. Sorry, am I going—[*Inaudible*.]

[219] **Lynne Neagle**: We've got quite a lot of questions to get through.

[220] **Julie Morgan**: So, in the perinatal field in north Wales at the moment, are there third sector voluntary organisations that are providing support and help?

[221] **Dr Myers**: Yes.

[222] **Julie Morgan**: And how widespread is that? Would a mother be easily able to access one of those groups?

[223] **Dr Myers**: Yes, but as to whether they would feel able to—

11:00

[224] **Julie Morgan**: And so you're planning—this group you're coming down to Cardiff for is to try to plan at which level mothers need help.

[225] **Dr Myers**: Yes, that's right. Yes. And at what level they'll accept help. So, for example, even at the most severe end, there may be somebody everybody thinks needs to be in hospital, but they don't agree and neither do their family, and that causes an enormous problem for services. Then you have somebody else who is really, really anxious, really, really worried and tells her midwife, and she doesn't really quite fit the so-called 'Whooley questions', or your Edinburgh postnatal depression scale, or the thresholds that we are trying to put as a structure in place, but you need to be able to hear her experience, and training is part of that.

[226] **Julie Morgan**: And does the third sector have the expertise to be involved in this support?

[227] **Dr Myers**: I think they do some things very, very, very well.

[228] **Julie Morgan**: So, what do they do well?

[229] **Dr Myers**: Take, for example Sands. Sands is there for bereavement, and Parabl in north Wales—and I think that's across other areas as well—

provides input for the milder end anxieties and difficulties. The difficulty they have in third sector is when they identify women who don't meet their criteria—they actually need more that they can provide. That's where the stuck is. So, that's—

[230] **Julie Morgan:** So, what happens then? What are they able to do then?

[231] **Dr Myers:** It's outside of the remit of their training and their expertise. So, it's not about training them to do those jobs—

[232] **Julie Morgan:** No, no. But, how do they—? Are they able to refer them to more expert—?

[233] **Dr Myers:** Yes. So, a good perinatal service will be addressing all those levels, so it's a clear pathway through, and that's what they're asking for. Everyone we've met with, they're competent and able in the work that they're doing. What they want is to know, 'If we're concerned about someone, can we phone you?' And all of the perinatal services that I'm aware of that are in place now are making sure that there's quick access, because that's the bit that's important. So, if they're concerned—doing what they need to do, but if they've got concerns about somebody—they know that they can access a service and somebody's going to respond.

[234] **Lynne Neagle:** Okay, thank you. Michelle, on the mother and baby unit. Can I appeal for brief questions and brief answers please?

[235] **Michelle Brown:** I will try and keep it as quick as possible. In your paper, you've expressed concerns about continuity of care for women who have been in a mother and baby unit in England and they then come back to Wales. Are there different psychological services available to women in England over and above those that are available in Wales, and can you tell us a little bit about the difficulties you see in the continuity?

[236] **Dr Myers:** There's much I can say, but what I will just take, if that's helpful, would be, if you're admitted into a mother and baby unit, you will have intensive input that tailors your needs—those biological, psychological, sociological features that I mentioned. That means you will have the opportunity to see somebody on a one-to-one basis—not group works; that's not what we're talking about, but individual therapy to help you with what's happening for you now. That could be around OCD, so obsessive compulsive disorders, or attachment difficulties with your baby. So, you will

have CBT—so, specific evidence-based interventions that we know help with the moderate to severe end. When you're discharged, you'll be coming back to your community area, and the further that you are, then you're actually going to have to start again in terms of who's going to be able to follow that work up. So, that's one feature: the continuity of care.

[237] People's experience, and I think this is across all mental health difficulties and in most areas, is that if you've had support from someone and you've developed a relationship and you've developed trust and the doctor has helped you, you want to see that person again. So, when I worked in Derby you would see that person again, because we were the in-patient service but we also were the community team, and that's the model of the hub that is talked about, so that you've got the similar staff that are doing both. But, if your mother and baby unit is over 90 miles away, that's not going to happen. That's one reason. I'll stop there. I could write a paper. I get very enthusiastic, I'm sorry.

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

[239] **Michelle Brown**: You stated that some women with severe mental health difficulties are choosing to remain in Wales to be managed in the community. What do you think the impact of that is on them? Why are they choosing to remain in Wales? Would we be better off with a mother and baby unit in Wales that was accessible to women in Wales? I think that's really what these questions are all driving towards.

[240] **Dr Myers**: I can't give you a straight answer on that. I could say, 'Well, maybe it's a piece of research that needs us to do that', but I could also say to you that I think there are a variety of reasons. Some of them we do know what they are. We've got some examples of those in my own trust. I know what those examples are, and I know what some of the examples are from having spoken to my psychology colleagues in south Wales. So, some of those reasons you will have had put to you as well by my colleagues.

[241] One of the key things, I think, that probably drives why is one of the features that are very clear, which is that when a woman has a postnatal mental health problem, she feels that she's a really bad mother. That kind of goes with the territory. So, anything that means that she's the one not looking after the baby, means that the baby is the one that's okay. She will go along with that. So her own needs she will put second to the needs of her baby, and that will probably decide where she agrees to go. Because if she

goes into a mother and baby unit, she's expected to take her baby with her. You would not be admitted to a mother and baby unit without your baby, and I know why, because it's really important that we improve that relationship. So, she needs to be there with her baby. But, if they're travelling far, then you can't keep that family unit together, and it's quite likely that those are the members of the family who have stepped up to try and support a woman, so it's depriving the whole family. And, actually, it leaves quite a difficult legacy in terms of the therapeutic work as well. From working with women who've been separated from their babies, and from personal experience of working in the child and adolescent mental health service, most of my work actually was with families in these latter years, and many of the reasons why there were difficulties in managing difficult teenagers and self-harming children—we know from the literature; it's not a big surprise, but I've actually been working with the tail end of women who had actually been separated from their children, and it has complicated that relationship. So, those would be some of why—the guilt and the shame and the consequences, and they stay. But there'll be many other reasons, and I can't give you all of those.

[242] **Lynne Neagle:** And are you satisfied that there are adequate arrangements in Wales to manage risk where some of these women are being treated in the community rather than being—? There's not.

[243] **Dr Myers:** No. If I'm absolutely honest, I'm scared stiff when we become operational if we haven't got some things in place, because I've always known that I had the support. When I worked in perinatal in the past, if I was concerned about somebody, and I worked with women who were at the moderate/severe end. What is the risk? The fact that somebody is having thoughts of harming themselves, or is falling into some sort of distress—it happens so quickly, you can't just say, 'Well, they might be all right tomorrow'. Tomorrow might be too late. So, we have to really be attentive to the risk. So, they're being admitted into acute units without their babies, and that's causing an enormous amount of difficulties in terms of what happens next, because there's a delay on beds. Because there aren't beds. I think you already will have had that discussion with other colleagues. But it has a major psychological impact on the health of the woman and the health of the family and the health of the baby, in not having those beds.

[244] **Lynne Neagle:** Thank you. Mark.

[245] **Mark Reckless:** Yes, you mentioned the role of the voluntary sector in bereavement support earlier. I just wondered what you thought of the overall

quality of provision of bereavement support in Wales, to the extent that you have knowledge of that.

[246] **Dr Myers:** I don't have knowledge of that.

[247] **Mark Reckless:** And would you see it as being a third sector-led activity or would you expect to see the health boards and the statutory provision leading on that?

[248] **Dr Myers:** That element came to mind because, in my clinical work, a previous bereavement may well be a potential risk factor for later mental health issues. That's something that we are aware of.

[249] **Lynne Neagle:** Darren, on health inequalities.

[250] **Darren Millar:** Yes, I just wanted to touch on the whole issue of health inequalities. We just had a discussion earlier on about the fact that some mums and their babies are being, obviously, sent to mother and baby units over the border in England. Obviously, access then to Welsh-medium talking therapies et cetera is going to be much more difficult for those mums and babies. To what extent do you think that that might be disadvantaging them from making a decent recovery, and do you think that that's acceptable?

[251] **Dr Myers:** Being a Welsh speaker myself, it's a difficult question from an emotional perspective, but I think I can also offer some experience from research and also from clinical experience. I think what we need is quick access. Certainly, within my team currently—as I say, we're not yet operational—I'm still the only Welsh speaker, so, in my part-time psychology time, I'll be the only Welsh speaker who can deliver Welsh as an intervention.

[252] **Darren Millar:** And that's within Wales.

[253] **Dr Myers:** That's within Betsi.

[254] **Darren Millar:** Yes, exactly.

[255] **Dr Myers:** To my knowledge, I don't know if any of the other nine psychologists speak Welsh. I don't know the answer to that, to be honest with you. But we do also know that what makes the difference is having the empathic, immediate support when you need it. So, I think it's a really important feature, and for some it really, really matters. But we are bilingual.

I think, for me, it would be important that I'm able to talk in Welsh with some things, and we also know that, for some people, being able to talk through your first language is actually something that's quite shaming for you, and being able to talk in a language that isn't about you might well be a protective factor. Also, by going across the border to England, there may well be people who don't know you. So, you're more likely if you're shamed and you feel really bad to go out with your baby in the pram, because you think, 'Nobody knows me here'. So, there's a bit more to it than it's just about language, but not having the option I think is the bit that I would be concerned about.

[256] **Darren Millar**: There are obviously mums from homes that are neither Welsh- nor English-speaking as well in north Wales. To what extent do you think that their needs are being met from services?

[257] **Dr Myers**: I don't think I can talk from experience. I think maybe if my colleague Cerith Waters was here he might be able to give you an answer to that, because I know Cardiff and Vale is one of the areas where they receive a lot of migration and immigrants that come into here, so asylum-seeking is a particular area that they're thinking about here. It's something we'll need to be attending to. I'll certainly hold in mind to address those issues that you're quite rightly raising.

[258] **Darren Millar**: We've also received evidence in previous sessions about the particular challenges that present when a mum might have comorbidity with substance misuse problems—alcohol dependence or drug misuse. Are our services robust enough to be meeting their specific needs in a way that is addressing both the mental health issue and the substance misuse issue, or are we still struggling to meet the particular needs of that group?

[259] **Dr Myers**: A quick answer would be that I think the evidence would suggest that we're not.

[260] **Darren Millar**: Okay. And what do you think we need to do in order to make sure that we can address those specific needs?

[261] **Dr Myers**: I think that's a resourcing issue.

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

[263] **Dr Myers**: I think there are midwives specifically employed for

expertise in substance misuse. I know we've got one in Betsi health board, so we will be strengthening our links with her, but that's community-based. We have a specialist midwife who's just been employed within Betsi as well, but she's new to the perinatal service, so we'll be looking to see, 'Well, how can we best utilise our staff? Is it to target specifically those hard-to-reach areas, because there's significant risk?' We know, again, in terms of suicide and confidential inquiry information, that we're not meeting any of this nationally—in the UK now—so, it's clearly a problem in many services across the country.

[264] **Darren Millar:** Thank you for that. And just one final question: obviously, the Welsh Government has some targeted programmes to deal with poverty issues in Wales—Families First and others like them. To what extent is that an advantage to people within those areas, in terms of supporting people with poor perinatal mental health, and to what extent are other people, outside of those areas, perhaps losing out?

[265] **Dr Myers:** I think you raise a really important point. I think we know the impact of poverty and the adverse childhood experiences, and that's something that we're very, very much taking to task in Wales, which is great. The problem is that mental health issues, particularly in their severity, don't really care if you're poor or not, and don't really care where you live, because the epidemiology is really, really clear. And, yes, we can predict the risk. We can try and—. But we are still in the process of prediction, not certainty, so you have to have a service that can be universal and can tend to everybody's needs, and is fair.

[266] **Darren Millar:** Okay, thank you.

[267] **Lynne Neagle:** Just one final question from me: the committee's had quite a bit of evidence about concern about antidepressant prescribing to women who are breastfeeding, and concerns about unclear advice, et cetera. To what extent do you think having prompt access to psychological therapies is vital to ensure that women aren't pushed into those decisions about taking antidepressants that maybe they don't want to take?

[268] **Dr Myers:** That's a good question. I can't comment on should they take antidepressants or not. I think the evidence suggests, around risk, it's really important if it's needed. In terms of can we make a difference, I think psychological approaches can make a difference. I think the earliest that we have the opportunity to interface, and the soonest we're able to bring

information to the table, the quickest that we can actually have an impact before things become more severe and more ingrained. So, speaking for my psychologist colleagues, that they really, really make sure they don't want to drop from the work, they're making sure they're tackling early intervention. And that's what we mean by early intervention—getting in there quick.

[269] **Lynne Neagle**: Okay. Are there any other questions from Members? No. Okay. Well, can I thank you very much for your attendance, and for answering all our questions? We will send you a transcript of the discussion to check for accuracy in due course. But thank you very much for your time this morning. Thank you.

[270] **Dr Myers**: Croeso. **Dr Myers**: You're welcome.

[271] **Lynne Neagle**: And the committee will now break until 11.30.

Gohiriwyd y cyfarfod rhwng 11:18 a 11:30.
The meeting adjourned between 11:18 and 11:30.

Ymchwiliad i Iechyd Meddwl Amenedigol: Sesiwn Dystiolaeth 10
Inquiry into Perinatal Mental Health: Evidence Session 10

[272] **Lynne Neagle**: Can I welcome everybody back to the committee this morning? Our final panel today is to hear from representatives from Perinatal Mental Health Cymru and Action on Postpartum Psychosis. I'm very pleased to welcome Charlotte Harding and Barbara Cunningham from Perinatal Mental Health Cymru and Jess Heron and Sally Wilson from Action on Postpartum Psychosis. So, thank you all for attending. It's good to see you this morning and thank you for the written evidence you've provided.

[273] Are you happy for us to go straight into questions? If I can just start, then, and ask Action on Postpartum Psychosis: you've said you expect there to be around 50 cases of postpartum psychosis in Wales each year. Can you just tell us a little bit about how you reach that figure, how reliable it is, and whether you think all of those women are going to need in-patient treatment?

[274] **Dr Heron**: The prevalence of postpartum psychosis is one to two in 1,000 women. When we've looked at the studies, the best prevalence take seems to be about one in 750. So, with the birth rate in Wales, around about 50 women—50 to 60 women—is what we'd expect from that birth rate.

Professor Ian Jones has looked at the—. That's not just—. Obviously, there are a lot more beds needed than that. I think they estimated that they thought there were about 100 women who would need a mother and baby unit in Wales each year. But, just looking at postpartum psychosis cases, it's probably about 50.

[275] Most women with postpartum psychosis will need hospital admission. I've come across some women who are treated at home by home treatment teams. It's very hard on the family, because postpartum psychosis develops so rapidly, it's so severe, and it's so frightening for anyone who's around it, and for the woman herself, that, normally, getting admission to a mother and baby unit really rapidly within hours is required, rather than a wait-and-see—a wait-and-see-how-you-manage strategy at home is risky for the mum and baby.

[276] **Lynne Neagle:** Thank you, and, in terms of your organisation, can you just tell us a little bit about the demand on your services at the moment?

[277] **Ms Harding:** The demand is very high, not only for postpartum psychosis. I don't feel that we're equipped enough to deal with postpartum psychosis, because that is something that needs hospital treatment and care, as Jess was just saying. Our demand is self-referrals. We also get referrals from social services; we get a lot from alcohol and drug services. How many people do we treat? Well, we run a new mum course, basically, to try and help support these mums, and, per course, we're looking at 10 people attending. We run them for five weeks back-to-back. Some of these mums are not as severe, but having just anxiety is enough in itself to warrant some support. At the moment, with the way we are in Wales, these mums with low mood and anxiety are being swept under the carpet and we're there to support these mums. So, our referrals are quite high.

[278] **Lynne Neagle:** And that tends to be more the lower level need, is it?

[279] **Mr Harding:** Lower level need, yes, but we do get women coming to us who've been failed by perinatal mental health teams, who have said to me, 'Why were we not told of your services? We would have rather talked to somebody who would understand us. Why are we not being talked about?'

[280] **Lynne Neagle:** Okay, thank you.

[281] **Ms Cunningham:** We offer a one-to-one peer support system. The

women know that they can come to somebody who has gone through what they are going through, and that is a huge support, and I know it would have been a huge support to me and to Charlotte when we were going through our situations, and that just wasn't available then.

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

[283] **Darren Millar:** I just want to ask you: you're obviously doing some great work in the area where you operate, but are there any similar organisations to yours in other parts of Wales?

[284] **Ms Harding:** There are similar organisations, and I've seen a lot of peer-to-peer support out there. The problem is that peer-to-peer support can also be quite dangerous if people are not trained correctly, if they don't have links with—you know, for safeguarding reasons—if they don't have links with social services and other people within the care, it can be very dangerous. It would be lovely to say that we could go and have a cup of tea with somebody in a coffee shop and we'd be fine, but that is not the case. We have women come to us who break down, completely break down in front of us, and if we didn't have the correct training, we wouldn't know what to do. I think our biggest problem, again, is that we don't have the links with the teams that we need. That's what we're looking for: we're looking for links with the teams.

[285] **Darren Millar:** So, they don't see you as a sort of formal partner to be able to engage with. Okay, so, I understand the point you make about peer-to-peer support and the value of that—you know, 'Been there, done that, got the T-shirt sort of thing, and I'm with you and I'm standing with you in your difficulties.' You've obviously developed quite a package, really, of support as a result of the experiences that you had and your families had as well, going through problems with perinatal mental health yourselves, but how can we—? If you know that there are other peer support people out there trying to step into the breach, and that that's not being effectively, perhaps, monitored, or that the authorities aren't necessarily aware of it, how can we establish some sort of network so that this stuff can be mapped and that there can be the proper support so that you know when to be able to encourage people to seek the professional medical advice that perhaps they might not be prepared to look for initially?

[286] **Ms Harding:** I think it all comes down to funding, personally. The plan that I have written myself, the recovery plan, I had a three-year goal that we

could get something set up in each area of Wales within three years. I have the cost of how much that would cost. These ladies would need to have a lived experience, but they would also need to be well into their own recovery, because it's quite easy to fall back—we can relapse, we can get ill again. So, these ladies need to be those who are strong enough within their recovery, their children may be a bit older, they've been through it, they understand it, but they need to have intensive training. We put all of our volunteers on intensive training, and I wish we had the funds to be able to say, 'Right, for 10 weeks, we're doing this training. We are going to be covering safeguarding, we're going to be covering the protection of vulnerable adults, mental health awareness, perinatal mental health—.' I could go on for ever. I wish that we could do that in each area where it's needed. Then you have your group. You have your group of support and trainers in each area of Wales. It can be done; it's just a matter of the funds. That's the issue.

[287] **Lynne Neagle**: Julie.

[288] **Julie Morgan**: Yes, thank you very much. It's very good to see you here, and I've been very pleased to visit the Llandaff North hub—quite recently, I think—to see what you are doing. Really, my questions were similar to Darren's. I wanted to know what funding you get and where you get it from. You've said that you need to be strong as individuals to be able to work in this area. What support is available for you who are running this scheme?

[289] **Ms Harding**: Well, support for ourselves, we rely on each other, to be honest, a lot of the time. I have had lengthy conversations with the Cardiff perinatal mental health team about, you know, worst-case scenarios: we need something in place. It's taken me meeting upon meeting to try and get to something, and we're still not at that point. Do you have anything to add on that?

[290] **Ms Cunningham**: To add to that, we do rely on each other a great deal, but we also have trainers coming in. We have a trainer for mindfulness coming in, and we've also recently had links with Mind. So, we do have people that we can fall back on; it's not just us in isolation. But we do want to grow, and without the funding, we can't bring people in, because we are all volunteers at the moment. I work, and it's very difficult to juggle everything, without those funds.

[291] **Julie Morgan**: So, do you have any formal funding now?

[292] **Ms Cunningham**: We've only just recently become registered as a charity, so it's taken an awful long time for the paperwork to go through. There's been an awful lot of toing and froing with that, and Charlotte's worked really, really hard, and last week we were granted our charity number. That means we can apply for funding. At the moment, that funding is going to be through things like local supermarkets—your Tesco, your Asda, your Sainsbury's—but we would hope that we could get funding from other areas. We have also spoken to Cardiff University to look at joint funding bids. So, they would look for funding and then there would be joint activities together.

[293] **Ms Harding**: Yes. Emotion regulation therapy with substance misuse and perinatal mental health, we're looking into something to do with that. But at the moment, it's bake sales, it's bag packing at Asda and Tesco, and green tokens. That's how we get our funds. We also run an exercise class for mother and baby and we have to charge a minimal £4, and £2 of that goes directly to the charity and the other £2 goes to the trainer, because she comes in and does the training. So, we've been looking at little ways that we can get some funds in. But, you don't have to pay. If you come to our group, you don't have to. It's not compulsory.

[294] **Ms Cunningham**: I think what needs to be realised as well is a lot of the women suffering from mental health issues come from backgrounds where they might not be able to afford to pay for courses.

[295] **Ms Harding**: I wouldn't be able to.

[296] **Ms Cunningham**: There are courses out there, mindfulness courses, and they would cost people and awful lot more than we have to pay. We're charging a minimal amount to people to try to get them to come on a regular basis, but also to make them available. And we won't turn people away. If people come to us and they say, 'I'm really sorry, but it's cost prohibitive and I can't come', we would waive that cost for them.

[297] **Ms Harding**: We've even done things like go and collect ladies from their houses. Some of our volunteers will say, 'This week, I'll go and collect Sophie', or whatever their name may be, because some of the ladies found it hard with even bus fares to get to our groups. My plan is to have at least one of our groups in each hub area of Cardiff so we can reach all these other people. It is hard without funding. We barely cover our insurance, but I think

a lot of it is—. It's the hard work from the volunteers—it's worth its weight in gold.

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

[299] **Michelle Brown:** Thank you. Do you think that mothers in Wales would benefit from a mother and baby unit in Wales?

[300] **Ms Cunningham:** Absolutely.

[301] **Michelle Brown:** Why? What do you think the particular benefits would be to those women?

[302] **Ms Cunningham:** Okay, so I'll talk from my experience, if you don't mind. I've had postpartum psychosis twice. My children are now nearly 10 and 13. I was one of the lucky ones; I accessed the mother and baby unit at the Heath twice. The first time, I was fairly unlucky, in that there was no bed available initially, and I was taken into Whitchurch. My son was 11 days old and I was parted from him for four days. I was put on an adult ICU ward. It was the worst experience of my life, but we won't go into that. Then, I was taken to the mother and baby unit at the Heath, and I was cared for there for three months. After that, I came home and my recovery was made at home with a community psychiatric nurse. These units are invaluable. Charlotte and I are both on the tier 4 steering committee regarding the proposed unit and we will fight to the end to get a unit back in Wales. It is just absolutely paramount that you have that unit back.

11:45

[303] **Ms Harding:** Giving my perspective, Barbara was treated in the unit and I wasn't. The mother and baby unit in the Heath had closed when I became ill. As Barbara said, it took three months. It's usually around 12 weeks in a unit that a mother would get well enough to go home. That's not saying that she doesn't need support at home; that's just getting well enough to be able to be at home. Personally, my postpartum psychosis got to the point where I tried to commit suicide, and it took about a year and half for me to actually see straight because my mind was completely filled with horrible thoughts, psychosis. Even with the medication I was taking—. Some days, I wouldn't take it. My partner couldn't control me. He had to leave his job so, financially, we were ruined. I just remember being sat on my sofa all the time and thinking, 'I need help. I need treatment.'

[304] The crisis team said it would have been counter-productive for me to go in to an acute psychiatric ward because, at the time, you know, you are postpartum as well; it is not a place for a postpartum woman. Your body is different; you are lactating. It's not a place where a mum who has just given birth should be. So, a mother and baby unit, you've got the specialist support there; you've got the people who can help straight away, and early intervention can help. I still get flashbacks from my psychosis because it went on for so long. Without my husband giving up his job, I wouldn't be here. I know I wouldn't be here. So, it's definitely needed.

[305] **Dr Heron**: Can I talk about the perspective of APP's research into mother and baby units? So, what we know from—. We did a survey of 218 women who've had postpartum psychosis. The background to this is that the evidence base was very minimal, except that we know from the Confidential Enquiry into Maternal and Child Health and the maternal deaths report that suicide rarely occurs to women have been admitted at some point to a mother and baby unit. From our own survey, we found that women who were admitted to a mother and baby unit were more satisfied; they felt safer during their care; they felt better informed about their illness; they felt more confident in the staff; they felt more supported with their recovery; they felt more recovered on discharge; they felt more confident with their baby and as a mother; and they had a shorter time to full recovery. And when we looked at full recovery, if we compared women who went to a mother and baby unit and those who went to a general unit, 27 per cent of women who went to a mother and baby unit said that they didn't feel recovered at 12 months, compared to 55 per cent of those who went to a general unit, which was statistically significant. So, just from that research perspective, it does make a big difference.

[306] From the point of view of the charity, and coming across and peer supporting women who have suffered from postpartum psychosis, I know everybody here knows that suicide is a leading cause of maternal death, and a great many of these—the largest proportion—happen to women who suffer from postpartum psychosis. The good and difficult thing is that women recover really well from postpartum psychosis; if we can get them through that really hard first year, they go on to be good mums and recover fully. Although some remain at risk of future episodes of bipolar, compared to any other psychiatric illness, there's really good recovery. What's really devastating for our volunteers when they are supporting women is that, when women do die, they look at their children and they know how easily

that could have been their story. Best practice care for women who have postpartum psychosis is really important because, again, it's a really risky illness. Women with a severe psychiatric illness are responsible for a newborn baby at the most vulnerable time in their lives. So, tragedies can happen. They are very rare, but they can happen. It's a really important time in the development of a family. Partners are new dads as well, and it's a really important time for child development, as I'm sure you've heard from many other groups as well. So, we know that women suffer huge trauma from being separated from their baby at that time, even when they're severely psychiatrically ill. When you listen to women recollecting that time in their life, even many years later there's so much anger, trauma and guilt from that separation. We know that separation of mother and baby at this time is just wrong. We know that it's wrong for the mother and wrong for the baby's development and we know that mother and baby units have all these special ways set up to care for young families at this time, including the right facilities, the right support with bonding and the right support with teaching mums how to parent as they recover from the severe illness. So, even things like learning to bath their baby is something that gradually, as women get better, they're supported with on the unit, and it doesn't happen in a general unit. As Charlotte mentioned, they can provide the right care for all the physical problems that you have after having a baby, of which there are many, and women who are psychiatrically ill often can't explain what's going wrong. They don't understand lactating. Some of them initially might even forget they've had a baby. Dealing with the tears and all the other things that you have as a new mum—. So, mother and baby units have that expertise on site to do it properly. As well as that, they have a family focus, so dads are able to come in. They're safe environments for babies to be in. It's much less stressful for dads to come in and see their partner being safely cared for in the right environment and feeling welcome, rather than having to come in to the chaotic situations that general adult wards are—.

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

[308] **Michelle Brown**: Can I just ask one more question, please? We have women who are now being referred to mother and baby units in England. I appreciate that from some parts of Wales it's probably closer for them than to go to one in Wales, but what's the impact on the mother and the family in the short term and long term for women who are in mother and baby units far away from their home?

[309] **Dr Heron**: There's a greater chance that the family won't accept the

care and we know that it is by far the best care. I'll pass on to Sally in a minute who can explain a bit about her situation of not receiving care in a mother and baby unit. But it's less likely that a family will accept best-practice care and then will go on and experience the longer recovery and the traumas of not receiving the appropriate care, because families aren't really educated about the importance of—.

[310] **Ms Harding**: It's unrealistic for someone to travel 200 miles to visit a family member in a mother and baby unit in London. My husband doesn't drive. He's my rock. He looks after me. He cares for me. He was not able to do that and there are families—there are single parents, as well.

[311] **Ms Cunningham**: You've also got to remember that it might not just be that child that you're talking about. You may be talking about other children. I've had this twice. My little boy was three the second time around. I was lucky. I can see the Heath hospital from my house so I could still have day-to-day contact with him. His life wasn't disrupted, but for other mothers it must be an awful wrench to try and decide what you're going to do.

[312] **Dr Heron**: It increases the stigma as well. Because you can't have anyone to visit you on the unit, it's much harder, and partners may have to give up their jobs. They might have to pay hotel bills and you can be in the unit for a very long time. We had a volunteer that couldn't get a bed in Manchester so she had to be sent to Birmingham after a couple of weeks on a general unit, even though it was her second baby and everyone was well prepared for her to have a second episode. She was admitted to the Birmingham mother and baby unit over Christmas. Her partner and her older child had the choice between staying in a hotel, not being able to work, or spending Christmas in a hotel, going to visit her in the mother and baby unit with the five-year-old who was expecting a lovely Christmas. If they had all been in the same place within 50 miles of that unit, they could have had their family Christmas and been to see their mum on the unit. It's the difficulties that it causes for partners when they're trying to juggle going to work, dropping in to see their new baby after work, checking everything's happening with their care, checking that their wife is okay. The distance is just prohibitive and it increases stigma and it increases the difficulty caused to people's lives.

[313] **Ms Wilson**: We chose as a family—. The closest mother and baby unit for myself was Manchester. I live in north Wales, so we had a long discussion about it. At the time I was probably too ill to realise that I needed to be in a

mother and baby unit, but we didn't want to break up the family and travel. So, that kind of not wanting to travel and the stigma associated with travelling a few hundred miles away from the family home was a big thing for us, really. Really, with hindsight, I should have been in a mother and baby unit, but the option wasn't really there for us as a family.

[314] **Darren Millar**: Can I just ask you a question, then, in terms of the advice to you? You were advised to go into a mother and baby unit, but you didn't feel up to being able to make that choice because of your circumstances. What was the response of the health professionals to your suggestion that you wanted to stick it out and muddle through as best you could in other ways?

[315] **Ms Wilson**: When the option was given to us, it was sort of said, 'If you'd like to go to a mother and baby unit in Manchester, then the option's there; we'll look into it.' We said 'no', so then I was discharged from the adult general psychiatric unit into community home treatment, really. So, they helped us to treat me at home, but on the other side of things you're guided by the health professionals, and maybe there should have been a push, really, for me to go into a mother and baby unit.

[316] **Darren Millar**: You would have appreciated more of a push on that.

[317] **Ms Cunningham**: It's not always going to happen like that. Sometimes you don't get a choice. I didn't get a choice.

[318] **Darren Millar**: You didn't get a choice at all.

[319] **Ms Cunningham**: No. I was so acutely ill with my son, I was sectioned under the Mental Health Act and I was put into Whitchurch Hospital. But I was extremely ill. At the time it was just horrendous—for me and for my family.

[320] **Darren Millar**: I'm just trying to get the—. It's difficult for clinicians, isn't it? They want to give you the best advice, but at the end of the day, unless you're being sectioned, you've got a choice, haven't you, to make with the information that is presented to you. If you would have known the sort of research information that Jess has just outlined in terms of the outcomes for women who've been admitted into mother and baby units as opposed to receiving either care in the community and support in the community or being admitted into an acute ward, you may have made a different choice. But you weren't given that sort of information or data, were you?

[321] **Ms Wilson**: No. We didn't have that kind of specialist care and knowledge, really, so I think—. I mean, we found out about APP ourselves, later down the line, but if we'd been given that information it would have been a more informed decision, really. So, yes, the clinicians were helping us, but we would have made a more informed decision about—. And obviously, with hindsight, we would have pushed. I was too ill at the time to know that I should have been in a mother and baby unit.

[322] **Darren Millar**: Of course. And how long ago was that, Sally?

[323] **Ms Wilson**: Two years ago.

[324] **Darren Millar**: It was two years ago.

[325] **Dr Heron**: And Sally didn't actually recover until APP signposted her to Professor Jones at Cardiff, who recommended different treatments and then she—.

[326] **Darren Millar**: So, they weren't able, actually, to give you the support you needed within the health board area either. It took another organisation getting the signposting right so that you could get the expertise that you needed to make a recovery.

[327] **Ms Wilson**: Yes. We found out about the secondary psychiatrist referral team down in Cardiff. He worked with my team up in north Wales and we pushed for different types of treatment, but we only found that out through APP.

[328] **Darren Millar**: So, can I get the bottom of this? Tell me, Jess, and Sally, in terms of that secondary psychiatrist referral, that wasn't perceived to be an option by the health professionals in north Wales at all.

12:00

[329] **Dr Heron**: I don't think enough people know about it.

[330] **Darren Millar**: They weren't familiar with the opportunity for it.

[331] **Dr Heron**: I think health professional training, through all the different layers of people who come into contact with pregnant and postnatal women,

need a lot more training on what postpartum psychosis is, how to manage it, and what care is out there in their own local area and throughout the country.

[332] **Darren Millar**: But I'm just thinking, it sounds to me as though, you know, if there's a care pathway that has developed—and it might be one for Wales or one within each health board or each part of a health board, depending on its size—

[333] **Ms Cunningham**: What you find is that boards don't seem to talk to each other.

[334] **Darren Millar**: But I'm just thinking, you know, presumably, right, if all else fails—second clinical psychologist referral. That's pretty straightforward, isn't it? Everyone ought to be able to cope with that at the end of their list.

[335] **Ms Cunningham**: But also what you have is no continuity of care. After I was discharged from hospital, I didn't see a single person twice, and no person saw me after I had my baby that had seen me before I had my baby. So no one had any benchmark, and my husband was desperately trying to get some help because he knew that there was something wrong, and he just kept getting fobbed off all the time, 'Oh, she'll be fine, she's just happy, she'll be fine.' No, she wasn't fine.

[336] **Darren Millar**: I'm just trying to get to this last chance saloon business, you know, in terms of that ultimate, final, 'this is where we now need to go'. I'm just concerned that that wasn't an option that was put forward by the health professionals themselves and there had to be a third party making that suggestion.

[337] **Dr Heron**: We found that as an issue throughout England and Wales in that GPs and psychiatrists are reluctant to refer on, even to a free service.

[338] **Darren Millar**: So, this service had to be, presumably, signed off by WHSSC, the Welsh Health Specialised Services Committee.

[339] **Dr Heron**: Yes. So, in order to accept anybody to the Cardiff University psychiatry service they need a referral from the person who's responsible for the woman's care.

[340] **Darren Millar**: Okay, thank you.

[341] **Ms Harding:** Can I just make one point about being pushed into going to get treatment and help? One thing that I think is disgusting is that if you have a history of drug and alcohol abuse and things like that, it's even harder to get support. I remember when the crisis team were called up to my house, I'd had one can of lager and they said, 'No one will take you. No hospital will take you.' And my husband was pleading with them. He said, 'She's hurting herself. She's cut her arms, her legs and everything. She needs help.'—'Oh no, but she's had an alcoholic beverage. We're not going to be taking her anywhere.' So, that night was the night I took a lot of tablets and ended up in accident and emergency in hospital anyway. But I think people—again, they're reluctant to refer people with substance misuse issues. I think it's something that needs to be spoken out about more. There are a lot of families with substance misuse issues within the household, and I think it needs to be spoken about.

[342] **Darren Millar:** So, did you have a history of substance misuse?

[343] **Ms Harding:** I did, yes. In fact, when I had my booking appointment, they were more concerned that I was a recovering alcoholic than the fact that I had bipolar and a personality disorder. I'm comfortable admitting it because, you know, I'm sober and everything. But I had a specialist nurse who worked with social services. So, they had planned already that I was not going to be able to take care of this child, and that when I had the child it would be removed. It was only when I said, 'Well, I'm actually five years sober and work within substance misuse' that they backed off. So there's a great stigma there and it's—. I could cry on a daily basis about the mothers that get in contact with me who've had their children removed where they're suffering with perinatal mental health illnesses, but having their children removed.

[344] **Darren Millar:** And is it something you find as well with your work, Jess?

[345] **Dr Heron:** Yes. I think where postpartum psychosis is co-morbid with other illnesses, it is really hard to manage, because we're specialists—. You know, our clinical support is specialist postpartum psychosis, our academic support—we're specialists in postpartum psychosis. So, actually, it's even hard for us, but it is hard to manage where there's additional issues.

[346] **Ms Cunningham:** Additional diagnosis.

[347] **Dr Heron**: Yes.

[348] **Darren Millar**: Okay, thanks.

[349] **Lynne Neagle**: Charlotte and Sally, you've both told us you had your treatment in the community. What do you think the risks and shortcomings are of treating someone with postpartum psychosis in the community?

[350] **Ms Wilson**: I think one of the main things is the length of recovery. So, Jess has already talked about if someone's treated in an MBU, or with specialist teams, then it is a shorter recovery. I think it's harder to keep mother and baby safe in the community, but one of the main things I've found, talking to people and in my experiences, is the more sort of long-lasting effects of not so much the symptoms but later down the line when you're looking at things like confidence with your baby, bonding issues. So, all the kind of extra stuff that you would get that you don't necessarily get in the community is something that's quite hard to deal with later down the line.

[351] **Ms Harding**: Yes, I would agree. The recovery time is longer. And attachment issues, definitely: I remember looking at my son on his first birthday, thinking, 'Wow, you're my child. I love you.' That's wrong; that should have been happening way before then. I shouldn't have had to wait until I saw him on his little toddling bike, you know. My attachment with my son now is good. We bonded over similar things like reading, but I think that the attachment is a big problem.

[352] Also, relationships with partners: I know a lot of families who have broken down in their relationships. I'm quite fortunate; my husband knew me when we were young and I had bipolar. So, he's seen a few episodes, bless him. But, for those who have never experienced a psychiatric condition, it can tear families apart. It really can. Parents don't want to know. I remember my mum, she was scared of it. As soon as I said I was seeing things, they took the baby straight from me and were like, 'Oh, God, she might hurt her child'. Actually, no, my delusional behaviour was that someone was going to take my child from me. So, I overly loved my child, but I don't remember the first year of his life because I was in and out of this sort of conscious mind. I don't think it should be treated in the community, and, if I had the option of taking my child with me somewhere where I could get proper treatment, I would have taken it like that.

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

[354] **Dr Heron**: Can I jump in as well? These are some of the most severe psychiatric illnesses that psychiatrists ever see. They come on so quickly. They get some of the most severe illnesses. They get severe within hours and days rather than the gradual onset that happens at other times. Most women just could not be cared for safely at home by home treatment teams. Women, when they develop postpartum psychosis, their delusions can be so extreme, so frightening, that they're just not really safe in the community. If we tried to do that, many more women and children would die.

[355] **Ms Harding**: I ran away for three days from my house—three days. I just left in what I was wearing, and I turned up at my mother's house, thinking, 'This is where I lived. This was my home. This is the house I grew up in', and my mother had to take me back to my husband and say, 'She's not right. We really need to stop this now'. I was babysat, I was locked in my own home, because every opportunity I had to get out I would get out, because, in my mind, I was somebody else. It's a horrible illness.

[356] I will make one point, though. We're talking about postpartum psychosis, but a mother and baby unit is needed for other psychiatric illnesses—you know, postpartum depression, postnatal anxiety. I suffered postnatal anxiety after my second child and I thought it was worse than the postpartum psychosis. I would be violently sick every time I stepped a foot out of my front door. There was no care there, and there was no help or support, and that needed hospital treatment because I was very, very ill. I lost about two stone in weight within two weeks because I was so anxious. Again, these are illnesses that need to be treated in hospital with their children, with the correct staff who are specialised in this.

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

[358] **John Griffiths**: Yes, I have a question about community perinatal mental health services, obviously where they are appropriate. About £1.5 million was provided on a recurrent basis about two years ago to improve services, but the committee's heard evidence that statutory provision isn't sufficient, that referrals do not always take place when they should and there's not a clear pathway for referrals. Would that be your view, that that is the current state of provision?

[359] **Ms Harding:** We're actually on the steering committee, the all-Wales perinatal mental health steering committee, and a lot of what we've seen with the funds there—. Cardiff is quite fortunate, we've got a few more extra psychiatrists and things like that on board; the team has got larger. Cardiff perinatal mental health used to be able to take referrals three months postpartum and now that's gone up to about six months postpartum, which is brilliant, but Powys had nothing. They had no services whatsoever. And, the further up you go, you find that these other rural areas have nothing. So, the £1.5 million that came into Wales has had to be shared amongst the whole of Wales where there has been no support in other areas. So, it's quite hard to say, really. We don't think it's enough. The money, it's not enough, is it, to do what it needs to do.

[360] **Dr Heron:** I think training in general perinatal illness, but also specific training in postpartum psychosis management is absolutely key here to make people aware that the care pathway for postpartum psychosis has to be urgent, rapid care within hours and days, not days and weeks. And it's really important that GPs and general psychiatrists know about PP, know where to refer, know about its clinical features and the different treatments needed, because it's not the same as treatment at any other time.

[361] **Ms Harding:** I think it should be compulsory for all midwives, health visitors, GPs. I think it should be compulsory that they're educated in perinatal mental health—not just PP, perinatal mental health as a whole. You've got ladies who are pregnant with severe depression. It's all of it, really. I remember I was actually in labour having a hallucination and my midwife found it funny. She said, 'Gas and air works wonders for you, doesn't it?' No, I was hallucinating there was a man coming in the room in a white coat, and they could not even recognise it. At that point—if I had had treatment at that point—if they'd said, 'She's just given birth', it would have—.

[362] **Ms Cunningham:** We both attended the midwifery conference held in City Hall, I think it was back in April, and we spoke and presented a video that we'd made for them talking about lived experience, and we had midwives coming up to us afterwards hugging us and telling us how moved they were by what they'd seen, but also how educating it was to hear people that had gone through what we had done. We also attended, a couple of weeks ago, a health visitors training day—again, thanked again—and provided information to these people that hadn't covered these topics before. That was my problem when I became ill with my son; it just wasn't

recognised. Your family know you more than anyone else, and they should be listened to, but there's just not the training out there, absolutely not.

[363] **Ms Wilson**: Just to add to that, really, just to echo that—so, I'm involved with training some of the student midwives at Bangor University, just to make them aware of mental health issues and postpartum psychosis, and I think that the main theme is that they want to ask patients if they're okay and want to help with their mental health, but they don't have the training and the confidence behind it to follow through, so they sort of avoid it a little bit. So, I think the lack of training is a big thing.

[364] **John Griffiths**: Okay. And I wonder if I could ask about specific pathways for women with postpartum psychosis. You make the case, Action, that there should be a specific pathway and the more general pathways aren't really adequate. So, could you tell the committee exactly what improvements you'd like to see made?

12:15

[365] **Dr Heron**: I think the improvements would happen automatically once training has improved. So, the knowledge about how quick the onset is, so, understanding how to identify early symptoms of postpartum psychosis and what to do when people are experiencing full-blown psychosis, making sure that care is received within hours, not—. Normally, a visit to a GP, writing a letter, sending it through the post, the team discussing it a few weeks later and deciding whether they can take the referral—it's not good enough for postpartum psychosis. The care has to be rapid and same day.

[366] I think probably the breadth of training we can give health professionals will make a difference. So, quite often with postpartum psychosis, say, the ambulance service or the police are involved in that pathway to care. So, training that's as broad as covering how—you know, that the police know what it is and can understand.

[367] **Ms Harding**: I wish they would know, yes. I've been in the back of a police van because of it.

[368] **Ms Cunningham**: I think training is absolutely key, because, a woman suffering from postpartum psychosis, her worst fear is having that child taken away from her. So, she will do her utmost to cover up what's happening because she is desperately, desperately worried that that child is

going to be taken away, and she'll do anything to prevent that happening, because she just doesn't understand what's wrong with her. That's why I became sectioned—because I refused to take medication. The only reason I refused to take medication was that I was feeding that child, and nobody could tell me what the medication would do to the baby. So, I kept refusing the medication because no-one would tell me what would happen to the baby.

[369] **Ms Harding:** I also think that something else that needs to be addressed, really, is that, if a woman has a history of a psychiatric condition like bipolar disorder, I think that they should have a hospital stay a little bit longer after the birth of the baby. I was discharged within 24 hours of giving birth, so I didn't even have time to think, blink, or do anything. I found that I was detached from my child because of this. I was just left there.

[370] When I had my second child I had to stay in hospital for four days postpartum, and the bond with my second child is amazing, and I believe that, in the hospital, where I knew I had the care, where I knew if anything was to go wrong I could say to somebody, 'I'm not feeling great'—. I think that 24 hours is not enough time to be in hospital when you've just given birth if you have a recognised mental illness.

[371] **Lynne Neagle:** We're going to look at training in a bit more detail now. Hefin.

[372] **Hefin David:** Well, I really feel on the whole that most of the questions about training have been answered, but I did have a supplementary to some of the things that, Dr Heron, you've said. How do you sustain that training through the course of a professional's career? Because you're talking about training points, aren't you? How do you make that sustained?

[373] **Dr Heron:** Two things, really. In areas where you've got a mother and baby unit, certainly in Birmingham, it seems to act as a really good hub for knowledge that spreads out because of all the community teams that link in with the mother and baby unit. That best practice knowledge spreads out really well through midwives and health professionals.

[374] I think that generally upskilling—. So, at one point, we need to hugely increase the knowledge that health professionals have got at the moment, but, once that interest and passion is started in health professionals, I think that it then becomes part of university courses, and I think we need to do an

all-out push and then it will happen more naturally.

[375] **Hefin David**: So, you need the university courses to be picking it up to start with. What kind of dialogue goes on between, for example, midwives and health visitors? Do they have co-training events and sharing of practice?

[376] **Ms Cunningham**: They have continuing professional development events, don't they? We went to one recently.

[377] **Ms Harding**: The event that we attended.

[378] **Hefin David**: Together.

[379] **Ms Harding**: Yes, but usually they have to pay as well. I found a lot of the time that health visitors have to pay to take part in a conference.

[380] **Ms Cunningham**: Or get funding from their health board.

[381] **Ms Harding**: Yes, which shouldn't be the case. I think it should be compulsory. I think it should be part of midwifery training.

[382] **Dr Heron**: In terms of expert training in postpartum psychosis, APP has the world-leading experts who can train people and develop a passion and interest in some of those specialist midwives. But, first of all, everybody coming into contact with women in the postnatal period has to be upskilled. But I think a really important part of that perinatal training is hearing from women with lived experience, because I think that promotes an understanding. If you can see women when they've recovered—. When people are ill, it's incredibly frightening—it's frightening for nurses—and it's a very difficult illness to treat, but if you can see women when they've recovered, connect with them and realise that they're just the same as everybody else and they've come through this dreadful experience, then I think it helps health professionals understand that they've got to go the extra mile, that they've got to treat people respectfully, that they've got to treat them as any other person in—

[383] **Hefin David**: And then how do they—? You said they go to a training event, and Sally, Charlotte and Barbara are there to talk to them. How do they then embed that with reflective practice? How does that happen?

[384] **Dr Heron**: So, I guess I can only speak for the feedback that we've got

from health professionals that hear from the women with lived experience. They say that that was probably the most powerful part of the training, that they will take it back, that they feel much more confident in knowing how to work with women and families, and knowing what's needed.

[385] **Hefin David:** I just get the feeling that we've talked a lot about training points and training interventions, but we haven't really understood how that then is embedded in practice over a long period of time. I still feel like I haven't had a firm answer to that question.

[386] **Dr Heron:** The Institute of Health Visiting have a really interesting scheme, which we helped with. They train health visitor perinatal champions in single areas who then go and spread that specialist expertise to other health visitors. It's a general perinatal course, but, within that, they work with APP to have lived experience speakers, and I think that's absolutely changed health visiting with regard to perinatal mental health.

[387] **Ms Cunningham:** What PMH have been trying to do is engage with health visitors and provide them with information of our services because, obviously, we're locally based. So, we've been approaching health visitors at conferences—

[388] **Ms Harding:** Flying Start want us to go and speak to them. Flying Start have a lot of toxic trios going on with substance misuse and perinatal mental health. So, they'd like to talk to somebody who has a lived experience of that, but, again, nobody knows what to do once they have it. I understand what you're saying. Like I keep saying, I think this needs to be embedded into training from university. I don't think—. It is brilliant when lived experience go out there and deliver the training—that's amazing—but—

[389] **Hefin David:** But what happens next?

[390] **Ms Harding:** Yes. It needs to be compulsory. It needs to be in their training.

[391] **Hefin David:** I wondered if a midwife has experience, as you said, and with the gas and air situation, there should be then some opportunity to then have a reflective moment that is separate to a training event, but a reflective moment. And I'm just wondering whether that happens enough in health services.

[392] **Ms Harding:** It doesn't.

[393] **Lynne Neagle:** Okay. Julie, did you have any other points on the third sector?

[394] **Julie Morgan:** I think we covered quite a lot of them. The only point that I wanted to make, really—I think Charlotte said how much her partner supported her—was the issue of support for partners. Is that recognised enough and does anything happen there?

[395] **Ms Harding:** We're just developing Dads Cymru. Dads Cymru is going to be perinatal support for fathers, partners or anyone close to the mum going through it. It's also for men who are suffering with depression themselves, because it is a lot to take on. We're developing that with Mark Williams, who's quite well known in fathers' mental health. It looks like that's going to be launching in September. Presently, we do support fathers in the hub, more on a one-to-one basis. Men don't like to talk in groups.

[396] **Ms Cunningham:** We're looking at a different approach.

[397] **Ms Harding:** We're looking at a different approach. We tried a coffee shop approach and that didn't work. So, a lot of the men like to e-mail. We've been doing a lot of e-mail and things like that.

[398] **Ms Cunningham:** A more online sort of forum-type thing for men. But there is huge recognition at the moment that dads need support and dads do suffer too.

[399] **Ms Harding:** The dads, we find, become aggressive. There's a lot of aggression. We see a lot of drinking. We see anger, really, with the men. It's so hard to try and integrate this in with what we do, because a lot of the ladies are in a vulnerable situation right now, and they don't need the men to come in and say, 'I don't know why I feel this way.' But that's what we've recognised. We've recognised that, with men, their symptoms are different to mum. But it does happen and men can get depressed postnatally.

[400] **Ms Cunningham:** You're in that negative environment and it does rub off. So, the woman, after the manic effects of postpartum psychosis initially will then become very, very depressed. And the depression, as in my case, will go on for months and months and months. And you've got dad trying to struggle to work, to help the mother, to help the baby, to keep everything

running together, where, in the past, quite possibly, mum did all those things. So, dad's now in this terrible situation, and there does need to be more out of there for dads, certainly.

[401] **Dr Heron:** From the qualitative research that we've done with dads, it is a terribly traumatic time. The qualitative accounts are really moving about just how difficult it is for partners. What to do about it is less clear, because partners do find it harder to talk and do seem to want different things. So, APP has a really good guide—a written guide that's online and in print—for partners, and we also have an online peer support community forum, and one-to-one e-mails, run by other partners who've been through it, which works really well. Face-to-face is much more difficult. I think that mother and baby units now have to consider partner support and say what they do with partners, which is really good, and that's newly happened in the last few years. But, in terms of community teams, I don't know if there are any requirements for partner support.

[402] **Lynne Neagle:** Are you aware, when women are coming through this, that women and families are routinely advised of the existence of Action on Postpartum Psychosis, and other organisations that could help?

[403] **Dr Heron:** It's something we know we have to do more work on because lots of women come to us later and say, 'If only I'd found out about you before.' Lots of women come in their second pregnancies, saying, 'I wish I knew about you in my first.' So, reaching health professionals and telling them about the support services that are available is something that we really need to get better at doing.

[404] **Lynne Neagle:** Okay. Thank you very much. Well, we've come to the end of our time, so can I thank you for coming, for answering all our questions, but above all, really, for sharing such personal and powerful experiences with the committee? We really do appreciate it, and it's really tremendously helpful for the work that we are doing. So, thank you very much. You will be sent a transcript to check for accuracy in due course. Thank you very much for your time.

12:29

Papurau i'w Nodi
Papers to Note

[405] **Lynne Neagle:** Okay. Item 5 then is papers to note. Paper to note 6 is a letter from the Cabinet Secretary for Education following our meeting on 14 June. Paper to note 7 is a letter from me to the Cabinet Secretary for Education on community-focused schools.

Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o Weddill y Cyfarfod
Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Remainder of the Meeting

Cynnig:	*Motion:*
bod y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y cyfarfod, yn unol â Rheol Sefydlog 17.42(ix).	*that the committee resolves to exclude the public from the remainder of the meeting, in accordance with Standing Order 17.42(ix).*

Cynigiwyd y cynnig.
Motion moved.

[406] **Lynne Neagle:** Item 6 is a motion under Standing Order 17.42 to resolve to exclude the public for the remainder of the meeting. Are Members content? Thank you.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 12:29.
The public part of the meeting ended at 12:29.