Cynulliad Cenedlaethol Cymru / National Assembly for Wales
Y Pwyllgor Plant, Pobl Ifanc ac Addysg | Children, Young People and Education Committee
Iechyd Meddwl Amenedigol | Perinatal Mental Health
PMH 01
Ymateb gan: Pedwar Ymarferydd Iechyd Unigol
Response from: Four Individual Health Practitioners

Inquiry into Perinatal Mental Health

This submission is presented on behalf of the four individual health practitioners who work in Monmouthshire through Aneurin Bevan University Health Board. The submission however is as individuals and not on behalf of the organisation. We work collaboratively with colleagues in early years , social care, police and third sector services as part of Flying Start and Families First to support perinatal and infant mental health. Julie Wallace and Paddy Martin are Parent Child Psychotherapists with expertise in infant mental health. Angela Lewis is a Health Visitor by profession and the manager of the health services delivered through Flying Start in Monmouthshire. Dr Aideen Naughton is a consultant community paediatrician delivering services to children and families in North Monmouthshire and has provided leadership to the early development of infant mental health awareness. Together we have successfully bid for Families First Grant to deliver a weekly infant led evidence based therapeutic intervention for parents and their babies where the relationship is at risk.

Thank you for this opportunity to contribute to the Inquiry. We have provided views in relation to each of the Inquiry's specific areas of interest.

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

While we were very encouraged by the Welsh Government's decision to invest £1.8 million in this area of health care, our experience has shown that there was insufficient consultation as to which professionals should be involved in providing this specialist approach. There are a number of training packages currently available to increase professionals' skills in recognising and

assessing potential perinatal mental health problems. However some of these do not have any evidence base, and can sometimes be marketed as an intervention rather than assessment. We are therefore suggesting that a working group of appropriately qualified and experienced professionals is convened to evaluate what is currently in use and to standardise their suitability for use throughout Wales. This expert group could inform the work of the PHW led 1st 1000 days programme.

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

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

The perinatal mental Health Service provided by the teams is community based; this is satisfactory for most mothers however from our experience some severe cases need admission. Therefore Wales needs to have Mother and Baby inpatient beds. Clients who have thoughts of harming themselves or their baby need constant supervision, it is not satisfactory for them to be visited weekly or fortnightly solely in the community.

The funding of perinatal mental health services covering prevention, detection and management of perinatal mental health problems has improved, however the decisions made in some areas have not been right. Welsh Government need to provide more guidance to ensure the best evidence based perinatal service is delivered throughout Wales. The funding needs to be sustainable and needs an appropriate management group in each Health Board that can make the right decisions for the family.

Perinatal Mental Health inevitably involves both mother and infant, and consequently a service must include those professionals with a high level of skill to work with both. Without this dual approach, there will inevitably be recurring difficulties, which will absorb further services, and potentially put vulnerable people at risk.

It is important to recognise the intergenerational aspects of mother and infant mental health so that attention and support given to mothers' mental health is mindful of the impact of parental mental health upon the crucial stage of earliest emotional and psychological development in the infant (ACE, 1001 days).

· The current clinical care pathway and whether current primary care services respond in a timely manner to meet the emotional well-being and mental health needs? Of mothers, fathers and the wider family during pregnancy and the first year of a baby's life.

Within this Health Board in Monmouthshire, there has been a lot of training provided to Flying Start and Generic Health Visiting Services, and more training is planned for later this year. This has focussed on the early recognition of maternal mental health difficulties. However the response to highlighting these difficulties is patchy and inconsistent, and largely dependent on where the family lives. Families within Flying Start areas receive a more timely and integrated approach than those who live elsewhere. There is currently planning to develop a more comprehensive and widely available Infant Mental Health Service throughout the Health Board's area of responsibility. This will inevitably include perinatal mental health.

The value and importance of early recognition cannot be over-estimated and must be considered in the light of long-term (life long) costs. The majority of potentially vulnerable mothers can be identified in the earliest stages of pregnancy and even prior to pregnancy in many cases. Equally, the impact of high levels of anxiety, stress, depression upon the unborn foetus is well researched in terms of exposure in utero to high levels of stress hormones etc

Our current perinatal service has improved but could be improved further by widening the threshold of referral as it has quite strict parameters. Also we know a mother and her child who has suffered with PND will require a lot of support, support that is required after 6 months. There is not a consistent approach to this in Wales. Also support longer term for the Child as they have experienced a significant Adverse Childhood Experience that we know will affect their life chances. We could improve the Childs outcomes if we were able to support them.

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

Attempts are being made to offer an integrated approach, but this is hampered by the scarcity of resources. It is further restricted by a "one-size fits all" response to perinatal mental health, largely based on a medical, adult mental health model.

There is an argument that some investment and training, provided by specialist experienced workers could eventually be rolled out into schools so that there is greater understanding of early impacts on the emotional well being and health of babies.

Antenatal education needs to be evidence based. Antenatal classes should not just concentrate on Labour, Pain Relief and Birth. They should cover the emotional needs of the baby. More antenatal support should be given to mothers and fathers so they are able to discuss their feelings. Skill mix should be introduced into Midwifery. The resources used could be electronic e.g. apps or utube videos this would enable the service to reach the wider family.

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

This is the area of most concern, as there are insufficient, appropriately trained professionals available to provide effective and timely interventions.

Training for frontline staff is essential. However most staff do understand the importance of this subject but they just do not have sufficient time to give clients. The best option would be to increase the number of midwifes, other options would be to employ more appropriately trained skill mix, or develop links with a voluntary organisations who will train volunteers to support mothers with attachment, bonding and breastfeeding or bottle feeding during their hospital stay and when they are discharged. e.g breastfeeding peer supporters.

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

There must be the correct skills mix (and experience) in a peri-natal team, and these must be available universally across Wales, rather than be restricted to areas where the specialism already exists. This needs to be centrally coordinated with an agreed comprehensive and universal strategy for identification, provision and clear active pathways for referral.

Given the above comments and considerations, it will be apparent that whilst an investment of £1.8 million is welcome, the real initial cost of providing a truly preventive service of specialist provision would be much higher but that the overall cost would be vastly outweighted by the long term savings in terms of infant mental health, adult mental health and the intergenerational aspects. The Welsh Assemblies own commitment to the 1001 days cross parliamentary initiative and recognition of the impact of adverse childhood experiences (ACEs) in terms of long term physical and mental emotional health and even longevity is a clear expression of this.

We need to educate children on the importance of emotional wellbeing in school. We need to deliver parenting training in school. We need to work better with our LAC children and children who have experience ACE's by providing them with evidence based interventions, by skilled practitioners. We know LAC children are more likely to be our missing children and will struggle with parenting. All LAC children have 6 monthly health assessments; these should be an intervention to help them deal with becoming looked after and what caused them coming into the care system, not wait for them to require help.