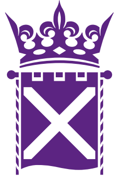

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Health, Social Care and Sport Committee

Inquiry into perinatal mental health

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Contents

Summary of recommendations 1
Introduction 8
Background 9
Access to perinatal mental health services 11
Mother and baby units 12
Specialist community services 14
Dr Gray's Hospital in Elgin 16
Joined-up care 18
Third sector support 20
Transitions 22
Workforce 23
Recruitment and retention 23
Training 25
Breastfeeding support 29
Birth trauma 31
Miscarriage and the death of an infant 33
Equalities 36
Stigma 38
The impact of the pandemic 40
Annexe A - Summary of recommendations from the written call for evidence 43
Annexe B - Private informal engagement event summary 46
Annexe C - Minutes of meeting 51
Annexe D - Evidence 52
Written evidence 52
Official reports of meetings 52

Health, Social Care and Sport Committee

To consider and report on matters falling within the responsibility of the Cabinet Secretary for Health and Social Care and matters relating to drugs policy.

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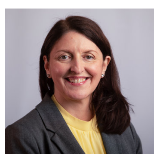

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Summary of recommendations

Access to perinatal mental health services

1. The Committee highlights extensive evidence it has received of the importance and associated benefits of a preventative approach to perinatal mental health. It calls on the Scottish Government to outline what steps it is taking to develop and implement the specific preventative measures recommended in written evidence, as outlined above.

2. The Committee welcomes the five national pathways identified by the Perinatal Mental Health Clinical Network. However, it recommends that the Scottish Government and NHS boards take further action to improve access to perinatal mental health services via these pathways. This should include plans to ensure increased awareness of services, early identification of perinatal mental health issues, and ensuring these pathways are robust and able to deliver joined-up care including an optimal combination of third sector and statutory services.

Mother and baby units (MBUs)

3. The Committee is clear in its view that, for new mothers with complex needs, wider access to Mother and Baby Units has a significant positive impact on perinatal mental health.

4. At the same time, the Committee is concerned by evidence of significant inconsistencies in accessibility of MBUs across different NHS board areas and the lack of provision in the north of Scotland, which means mothers are having to travel long distances to access an MBU. It is equally concerned by an apparent lack of awareness from referrers in certain areas of the country of services available from MBUs.

5. The Committee calls on the Scottish Government to set out the rationale around decisions not to establish MBUs in some parts of the country, particularly in highly populated NHS boards such as NHS Grampian.

6. The Committee looks forward to seeing the outcome of the options appraisal of MBU capacity in Scotland. Based on the evidence received, it believes there is a strong and compelling case for the establishment of a new MBU serving the north of Scotland.

7. At the same time, the Committee highlights the importance of ensuring that all MBUs in Scotland are adequately staffed and resourced. It therefore calls on the Scottish Government, following publication of the results of the options appraisal, to set out a comprehensive plan aimed at ensuring all of Scotland’s MBUs are served by an appropriately sized workforce pool of trained specialists in this field.

8. It further calls on the Scottish Government to set out what specific action it will take to raise awareness among referrers throughout the country of the availability of Mother and Baby Units, the services they can provide and the associated benefits to perinatal mental health.

Specialist community services

9. The Committee has been concerned to hear evidence of inconsistent access to specialist community perinatal mental health services across the country.

10. The Committee welcomes the establishment of the Perinatal and Infant Mental Health Programme Board. However, it has concerns that the subsequent allocation of spending on perinatal mental health services across all NHS boards has not so far translated into additional community perinatal mental health service provision across the country.

11. The Committee calls on the Scottish Government to set out how it will ensure that current and future funding and service provision delivers equity of access to specialist community mental health services throughout Scotland.

12. While welcoming the commitment to a maximum 6 week waiting time from initial referral for women to access perinatal mental health services, the Committee has heard extensive evidence this commitment has so far not been met. Furthermore, it is concerned that many women and families are currently having to wait significantly longer than 6 weeks to access support.

13. The Committee calls on the Scottish Government to confirm in which NHS Board areas the waiting time commitment is currently being met and those areas where it is not. It further calls on the Scottish Government to set out a timetable and associated plan for delivering the commitment across all NHS Board areas.

Dr Gray's Hospital in Elgin

14. The committee received many submissions from women who felt their perinatal mental health was impacted by the downgrading of maternity services at Doctor Gray’s Hospital in Elgin.

15. The Committee notes the short term recommendation of the independent review of maternity provision at Dr Gray’s Hospital by Ralph Roberts that a ‘Moray Networked Model’ should be provided with a community maternity unit linked to Raigmore Hospital. The Committee requests an urgent update from the Scottish Government on the planned timetable for implementing this recommendation.

16. The Committee calls on the Scottish Government to set out what actions it intends to take to support maintenance and development of consultant-led services in rural areas across Scotland.

Joined-up care

17. The Committee has heard evidence from a number of witnesses of the significant benefits of creating a service specification for perinatal mental health services as a mechanism for delivering better, more joined up care. It therefore welcomes the Scottish Government’s commitment to introduce such a service specification.

18. The Committee calls on the Perinatal and Infant Mental Health Programme Board to provide more information on the proposed service specification, including:

- the timetable for stakeholder consultation,
- the timetable for development and introduction, and
- detail on how the service specification will ensure consistent, joined up delivery of perinatal mental health services in Scotland.

19. The Committee calls on the Scottish Government to provide clarification on how development of the service specification and future provision of perinatal mental health services will be aligned with the proposed National Care Service.

Third sector support

20. The Committee has received substantial evidence of the vital role played by third sector organisations in providing quick and tailored access to perinatal mental health support for many women and families.

21. The Committee has heard evidence that perinatal mental health services provided by third sector organisations tend to be more flexible, better tailored to individual needs and subject to shorter waiting times than corresponding statutory services.

22. The Committee calls on the Scottish Government to develop a comprehensive strategy to improve communication, collaboration, co-operation and exchanges of best practice between third and statutory perinatal mental health support to make sure that women and families are appropriately and adequately supported.

23. The Committee calls on the Scottish Government and NHS Boards to ensure all primary care practitioners can offer effective signposting towards available third sector provision of perinatal mental health support services.

24. The Committee calls on the Scottish Government to undertake a comprehensive audit of funding available for perinatal mental health support across both the NHS and the third sector to ensure optimal use of limited funds and redeployment where necessary.

25. We further urge the Scottish Government to ensure third sector organisations providing perinatal mental health services are afforded greater financial security by moving towards longer term funding cycles.

Transitions

26. The Committee recommends the Scottish Government undertake work to ensure NHS boards improve the integration and continuity of perinatal mental health services in the longer term for those families that need it. The Committee believe this should not be restricted to the one year period following the birth of a child.

27. The Committee recommends that NHS boards take action to ensure transitions from perinatal mental health services into adult mental health services are as smooth as possible for families. It seeks reassurance that ongoing provision of perinatal mental health support through adult mental health services is prioritised

and resourced.

Workforce

Recruitment and retention

28. The Committee is of the view that having an appropriately trained and supported workforce is crucial to ensure individuals get the support they need. It calls on the Scottish Government to provide an update on progress towards implementing the key recommendations from the PMHN Scotland report around staff recruitment and retention In particular, this should address what actions are being taken to provide better wellbeing support for midwives and health visitors.

29. Beyond the PMHN Scotland report recommendations, the Committee further requests an update on any additional work currently underway to deliver the increased staffing complement necessary to ensure perinatal mental health support and knowledge is embedded as part of practice and held in the same parity as direct clinical care.

Training

30. The Committee notes the work underway to offer perinatal mental health training to midwives and health visitors. The Committee calls on the Scottish Government to ensure further education institutions deliver perinatal mental health training as core training for all midwifery and nursing students as a priority. This should have due regard to the relevant Nursing and Midwifery Council standards of proficiency related to perinatal mental health.

31. The Committee calls on the Scottish Government to provide a detailed update on progress towards implementing the key recommendations from the PMHN Scotland report related to workforce training, along with timescales and sources of funding for completion of any actions that remain outstanding.

32. The Committee has heard evidence that improved training provision will only have a positive impact if the workforce has the flexibility to be able to complete training either in normal working hours or away from work according to their own preferences. Evidence has also highlighted the knock-on impact of staff shortages on available time for staff to undergo continuing professional development.

33. The Committee therefore calls on the Scottish Government to commission further research to identify what proportion of perinatal mental health staff are encountering barriers to completing training and the nature of these barriers. The Scottish Government should use the findings of this research to inform a targeted strategy aimed at increasing rates of uptake of training opportunities by perinatal mental health staff.

Breastfeeding support

34. While the Committee acknowledges and is encouraged by evidence that breastfeeding rates have increased during the pandemic, it is also concerned to

learn that in certain circumstances breastfeeding support has been negatively impacted by Covid restrictions.

35. The Committee calls on the Scottish Government to provide an update on the impact of the pandemic on breastfeeding support and to outline what plans are in place to resume services as part of Covid recovery.

36. While accepting that breastfeeding should be a matter of personal choice to suit individual circumstances, the Committee has also heard evidence of the need for further action to support new mothers who wish to breastfeed across all maternity services.

37. The Committee calls on the Scottish Government and further education institutions to ensure every student midwife receives practical breastfeeding support training and that this is also available to all midwives, health visitors and newly qualified midwives.

38. The Committee also calls on the Scottish Government to provide an update on the eight recommendations in the Becoming Breastfeeding Friendly Scotland report, with particular focus on the implementation of recommendation to develop and implement a breastfeeding advocacy and promotion strategy.

39. The Committee is concerned around the issue of stigma and freedom of new mothers to choose the method of feeding that suits them and their child. With this in mind, the Committee would welcome further information from the Scottish Government about its strategy for supporting mothers with feeding their baby irrespective of their individual choices and circumstances.

Birth trauma

40. The Committee is concerned about the sharp rise in birth trauma incidences reported during the pandemic and the lack of services that directly address birth trauma as highlighted by NHS Lothian. The Committee urges the Scottish Government to develop and support birth trauma prevention work as a matter of urgency and to work across all NHS Health Boards to implement resulting measures including:

- supporting the well-being of midwives and health visitors, so they can better support birthing women,
- ensuring staff have adequate time to spend with women to help prepare them for birth and reflect on the birth afterwards,
- ensuring resources are available to support staff to diagnose birth trauma,
- developing care pathways to prevent and treat birth trauma,
- providing dedicated treatment for birth trauma across all NHS board areas, and
- ensuring women always have access to emotional support or a birth partner.

Miscarriage and the death of an infant

41. The Committee is concerned about the evidence it has heard around the lack of support for parents and families affected by miscarriage, stillbirth and the death of an infant.

42. The Committee believes it is unacceptable for those parents and families affected to have to wait until 2024 for specialist baby loss units to be established. It therefore calls on the Scottish Government to liaise with NHS boards to explore all avenues to enable the timetable for establishment of these units to be accelerated and to provide the Committee with further updates on progress.

43. The Committee has also been concerned to hear stories of women affected by baby loss being treated in maternity wards alongside women giving birth to healthy babies. Until such times as specialist baby loss units have been established, it calls on the Scottish Government, as an urgent priority, to establish national protocols informed by existing good practice that ensure families affected by baby loss are consistently treated with respect and compassion and in a trauma-informed way in a separate area from maternity wards, ideally with a means of entry and exit separate to those wards.

44. The Committee further calls on the Scottish Government, as a matter of urgency, to develop and implement the policies and associated funding necessary to ensure that every bereaved mother and parent accessing maternity services is met by a specialist bereavement midwife as a matter of course and that perinatal mental health services are fully accessible to bereaved parents.

45. The Committee recognises and commends the work of Sands to provide support to those affected by the death of a baby and improve the care bereaved parents receive.

Equalities

46. The Committee has been concerned to hear evidence about the barriers encountered by women and families in accessing perinatal mental health services, particularly those from minority ethnic backgrounds, those for whom English is not their first language and those from particularly vulnerable or at risk groups, such as care experienced new parents who may have experienced childhood trauma.

47. The Committee would welcome an update from the equalities group on work they have undertaken to date to identify inequalities in access to perinatal mental health services, what work it is undertaking to develop a comprehensive strategy to tackle these and, as recommended by the Mental Health Foundation, to equality-proof the future development of these services.

Stigma

48. The Committee is concerned of the stigma associated with perinatal mental health issues and the resulting reluctance for individuals to fully engage with healthcare professionals.

49. The Committee note the delay in publication of the Programme Board's *Raising Awareness Strategy* and call on the Scottish Government to urgently prioritise its publication. The Committee would also welcome further detail on plans for promotion and dissemination of the strategy.

50. Until the strategy is published, the Committee seeks reassurance that the Scottish Government, supported by all other stakeholders involved in delivery of perinatal mental health services, is taking action to address the issue of stigma and to give new mothers engaging with perinatal mental health services confidence that they will not be judged or stigmatised by doing so.

The impact of the pandemic

51. While acknowledging that, as essential services, maternity services and infant feeding teams were protected, the Committee has heard concerning evidence that many other types of professional and community support were unavailable during the pandemic.

52. The Committee has been concerned to hear evidence that, in many instances, Covid-related restrictions severely impacted the support women were able to receive from partners and families during the perinatal period, and the associated rise in incidences of birth trauma.

53. The Committee wishes to highlight that these negative experiences during the pandemic will have knock-on effects on the mental health of those women affected throughout and beyond the perinatal period.

54. The Committee therefore calls on the Scottish Government to undertake a review of perinatal mental health service provision during the pandemic to ensure appropriate lessons are learned for the future.

55. The Committee has also been concerned about evidence heard that individuals have been unable to access GP appointments to suit their circumstances, which has impacted their ability to access perinatal mental health services. It calls on the Scottish Government to outline what action it is taking to ensure alternative routes are available for referrals into perinatal mental health services to ensure no-one is missed due to pressures caused by the pandemic.

Introduction

56. In October 2021, the Committee agreed to undertake a short inquiry into perinatal mental health.

57. For this inquiry, the Committee was keen to explore the key issues around mental health facing new mothers during pregnancy and following the birth of a child that can impact on mental health. This was intended to include:

- new mother care;
- breastfeeding support;
- training for midwives and health visitors; and
- Support following bereavement from miscarriage or the death of an infant.

58. While not the primary focus of this inquiry, the Committee notes that men and other caregivers can also experience mental health problems while their partner is pregnant or after they give birth. There are a range of different family structures and this might affect the type of support parents and caregivers need or how comfortable they feel accessing services.

59. The Committee wanted to understand some of the barriers to new mothers accessing support, to understand the impact of COVID19, and explore opportunities to improve and increase access to perinatal mental health services in Scotland.

60. We issued a general call for evidence in November 2021, asking three questions:

1. How can the Scottish Government improve perinatal mental health services in Scotland, both in the short term and over the next five years?
2. How has the COVID-19 pandemic impacted on the mental health of new mothers and the support available to them during the perinatal period?
3. How has the COVID-19 pandemic impacted on the mental health of those who have experienced the death of a baby, and the support available to them?

61. The Committee received 104 responses in total [1] . A table summarising the key recommendations for the Scottish Government, based on the answer provided in written responses to the question “How can the Scottish Government improve perinatal mental health services in Scotland, both in the short term and over the next five years?” is included in Annexe A.

62. Committee Members held an informal meeting on 6 December 2021 to hear directly from individuals who have experienced mental health issues during pregnancy or after their baby was born. Supported by Aberlour, Fife Gingerbread, Home Start Scotland and Mind Mosaic, this session provided an opportunity to hear first-hand accounts of individual experiences. A summary of points raised during the meeting is included at Annexe B.

63. As part of its short inquiry, the Committee also held three formal sessions, taking

evidence from:

- professional organisations and academics
- voluntary sector support organisations, and
- the Minister for Mental Wellbeing and Social Care and Minister for Public Health, Women's Health and Sport[i] and the Chair of the Perinatal and Infant Mental Health Programme Board.

64. Links to the responses and the Official Report of Committee meetings can be found in Annexe C and Annexe D.

Background

65. Perinatal mental health problems are problems which occur during pregnancy and up to one year after a child's birth. They affect up to 20% of women in Scotland [2] and cover a wide range of conditions, including mood disorders, depression, anxiety and psychosis. These can be new or recurring difficulties.

66. If left untreated, perinatal mental health problems can have long lasting effects on women, their relationships with their baby and other family members, and on the child's cognitive and emotional development [3] . Additionally, the report Confidential Enquiry into Maternal Deaths and Morbidity, published in December 2019, noted maternal suicide remains the leading direct cause of maternal death between six weeks and a year after the end of pregnancy [4] .

67. The Scottish Intercollegiate Guidelines Network (SIGN) produced guidelines on Management of perinatal mood disorders in 2012: SIGN Guideline 127 [5] . These guidelines are now out of date and are due to be withdrawn in 2022. The guidelines made a number of recommendations including the establishment of a national managed clinical network for perinatal mental health in Scotland, and further recommendations that the network should develop standards, pathways, training and ensure women have access to care appropriate to their level of need. Some of these recommendations have since been implemented.

68. The Scottish Government's Mental Health Strategy 2017-2027 [6] committed to fund the introduction of a managed clinical network to improve the recognition and treatment of perinatal mental health problems. The Perinatal Mental Health Network Scotland (PMHN Scotland) was established in April 2017.

69. Following review of service provision across Scotland in 2019, PMHN Scotland published its report *Delivering Effective Services: Needs Assessment and Service Recommendations for Specialist and Universal Perinatal Mental Health Services* [7] . The report made 28 recommendations for the Scottish Government, NHS Boards and Mental Health Services.

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i For this inquiry, Scottish Government policy on perinatal metal health and wider policy for the perinatal period falls within the remit of both the Minister for Mental Wellbeing and Social Care and the Minister for Public Health, Women's Health and Sport.

70. At the same time, the Scottish Government announced funding [8] for perinatal mental health and the establishment of the Perinatal and Infant Mental Health Programme Board to:

- oversee the £50 million investment;
- provide strategic leadership; and
- have overall management of the delivery of improved perinatal and infant mental health services.

71. The Programme Board recently published its third delivery plan, which covers the 2021-22 period [9] . It states that the pandemic has posed additional challenges for women's perinatal mental health especially those from minority ethnic and socially disadvantaged groups, as well as placing additional strain on services and the staff . This delivery plan has two strategic actions:

- to develop and sustain services in challenging times.
- to ensure a systems approach to service development and delivery across perinatal and infant mental health.

72. In the Forward, the Minister for Mental Wellbeing and Social Care noted the Programme Board would be placing particular focus on establishing clear regional structures for the delivery of perinatal and infant mental health services [10] .

Access to perinatal mental health services

73. The Committee repeatedly heard evidence that access to appropriate services was a major barrier for individuals who needed support, including to primary care services, community services, third sector services, specialist mental health services and specialist perinatal mental health services.

74. The Committee also heard that women who have experienced miscarriage or baby loss are extremely vulnerable. Professor Knight emphasised that deaths often occurred as a result of gaps in service [11] . Dr Arun Chopra, Executive Director of the Mental Welfare Commission highlighted the need for clear pathways for accessing services. Professor Marian Knight, Professor of Maternal and Child Population Health, MBRRACE, outlined the particular barriers for individuals with co-morbidities such as mental health problems and substance misuse. Dr Mary Ross Davie, Director for Professional Midwifery, Royal College of Midwives highlighted additional barriers for black and minority ethnic groups [12] .

75. The Committee heard that waiting lists can be long and universal services can lack the requisite skills and knowledge to support individuals.

76. Written evidence to the Committee suggested various measures to improve both identification of need and access to support. These were overwhelmingly preventative in nature, including:

- automatic referrals for at-risk individuals, particularly in the case of women with existing mental health issues pre-pregnancy, who were not identified for additional support or help to manage their condition during pregnancy;
- referrals for all pregnant mothers to see a mental health midwife for assessment regardless of their circumstances;
- provision of mental health information during prenatal appointments;
- mental health professionals on maternity wards providing support immediately after birth;
- provision of mental health support hubs, groups and helplines; and
- more at-home visits from health visitors in the post-natal period.

77. Professor Marian Knight, Professor of Maternal and Child Population Health, MBRRACE, commented on the value of pre-pregnancy planning between GPs and mental health services as a preventative measure, especially for at-risk and vulnerable women [13] . At the same session, Cat Berry, Group Facilitator and Volunteer Coordinator at Juno Perinatal Mental Health Support, described post-birth PTSD as preventable in many cases, where appropriate support is provided [14] .

78. NHS Lothian also raised the importance of antenatal classes and parent support groups in written evidence [15] :

> "A need to improve access to groups, antenatal classes and mother and baby classes in the postnatal period was identified, to help reduce impact on mental health and support recovery. The need for pathways of care to be robust with closer connections with community support services for example Dads supports."

79. At its session on the 14 December [16] , the Committee heard from the Minister for Public Health, Women's Health and Sport and the Minister for Mental Wellbeing and Social Care. The former highlighted the best start approach, which focuses on the safe delivery of high quality maternity and neonatal services in Scotland, and emphasised the important role of the primary midwife in supporting individuals. The Minister also acknowledged "work is under way to produce nationally consistent guidance and pathways and to cope with different levels of complexity" and early intervention and a co-ordinated multi-agency approach to care are key to improving outcomes.

80. The Minister for Mental Wellbeing and Social Care noted that the perinatal mental health clinical network has set out a series of five national pathways, these cover:

- pre-conception advice,
- psychological support for mild to moderate concerns,
- specialist assessment for severe and complex needs,
- emergency assessment for mother and baby unit admission, and
- specialist assessment and intervention.

81. The Committee highlights extensive evidence it has received of the importance and associated benefits of a preventative approach to perinatal mental health. It calls on the Scottish Government to outline what steps it is taking to develop and implement the specific preventative measures recommended in written evidence, as outlined above.

82. The Committee welcomes the five national pathways identified by the Perinatal Mental Health Clinical Network. However, it recommends that the Scottish Government and NHS boards take further action to improve access to perinatal mental health services via these pathways. This should include plans to ensure increased awareness of services, early identification of perinatal mental health issues, and ensuring these pathways are robust and able to deliver joined-up care including an optimal combination of third sector and statutory services.

Mother and baby units

83. In Scotland, there are 2 regional 6-bed mother and baby units (MBUs) providing specialist in-patient care for women with severe mental ill health and their infants. The first was established in Glasgow in 2004 and the second in Livingston in 2017.

84. The Mental Health (Scotland) Act (2015) contains a duty to provide for joint admission of a mother and baby to suitable facilities, where the infant is under 12

months, and it is in the best interests of both mother and child [17] .

85. Evidence suggests that MBUs positively impact on maternal mental health, the mother–infant relationship, and child development [18] . Evidence received during this inquiry suggests such units have a positive impact on maternal and infant mental health and the Mental Welfare Commission's 2016 report highlighted positive experiences [19] . Maternal Mental Health Scotland note individuals' experiences of attending the MBU in Glasgow [20] :

> The Mother & Baby Unit, with whom I was in contact throughout my pregnancy, supported me during a 5-week stay as an inpatient. The nurses and nursery nurses reassured me that I was, and would be, a good mother, and that I would get better. The doctors made sure my medication was right. I chatted with other patients and we spent time with our babies, dragging ourselves out for walks with the prams!

86. Each Mother and Baby Unit in Scotland has different commissioning arrangements and the PMHN Scotland reported that oversight arrangements and access to these units was inconsistent across NHS boards [21] .

87. The PMHN Scotland report made a number of recommendations, including [22] :

- establishment of an additional two to four MBU beds either within an existing unit or in a third MBU located in the north of Scotland;
- equity of access to a regional MBU for those women who require inpatient care regardless of which NHS board they ordinarily reside in; and
- decisions on admission are made exclusively on clinical need.

88. At the session on 7 December [23] , Dr Arun Chopra, Executive Director of the Mental Welfare Commission for Scotland commented on awareness and availability of MBUs in Scotland. He noted a difference in admission rates to the units based on which NHS board a woman is located within, with the rate of referrals higher in those areas that have a mother and baby unit. He further noted various barriers to access resulting in women not being admitted to the units when they should be. This included geographical barriers with some women facing long distances to travel to units, lack of childcare for other children and a lack of awareness from referrers about what a mother and baby unit could provide. Dr Chopra explained that the availability of a mother and baby unit in an NHS board area led to a greater awareness of the services it provided.

89. When asked about the recommendations for more MBU beds and whether another unit was required, Dr Selena Gleadow-Ware, Perinatal Faculty Chair of the Royal College of Psychiatrists highlighted the limited bed availability in units and re-emphasised geographical barriers [24] . However, she also noted that:

> To have sustainable, safe and effective mother and baby units, we will need a much larger workforce pool of trained specialists— if units are to be created in areas where they do not currently exist [25] .

90. At the session on the 14 December the Minister for Mental Wellbeing and Social

Care highlighted that a number of options for increasing MBU capacity was underway and noted his intention for a public consultation in early 2022. He further advised that the Scottish Government has:

> funded an increase in staffing for mother and baby units and have created the mother and baby unit family fund to support families in visiting their loved ones in in-patient [26] .

91. The Committee is clear in its view that, for new mothers with complex needs, wider access to Mother and Baby Units has a significant positive impact on perinatal mental health.

92. At the same time, the Committee is concerned by evidence of significant inconsistencies in accessibility of MBUs across different NHS board areas and the lack of provision in the north of Scotland, which means mothers are having to travel long distances to access an MBU. It is equally concerned by an apparent lack of awareness from referrers in certain areas of the country of services available from MBUs.

93. The Committee calls on the Scottish Government to set out the rationale around decisions not to establish MBUs in some parts of the country, particularly in highly populated NHS boards such as NHS Grampian.

94. The Committee looks forward to seeing the outcome of the options appraisal of MBU capacity in Scotland. Based on the evidence received, it believes there is a strong and compelling case for the establishment of a new MBU serving the north of Scotland.

95. At the same time, the Committee highlights the importance of ensuring that all MBUs in Scotland are adequately staffed and resourced. It therefore calls on the Scottish Government, following publication of the results of the options appraisal, to set out a comprehensive plan aimed at ensuring all of Scotland's MBUs are served by an appropriately sized workforce pool of trained specialists in this field.

96. It further calls on the Scottish Government to set out what specific action it will take to raise awareness among referrers throughout the country of the availability of Mother and Baby Units, the services they can provide and the associated benefits to perinatal mental health.

Specialist community services

97. The PMHN Scotland report [27] recommended that all NHS Boards should have community specialist perinatal mental health provision. The Perinatal and Infant Mental Health Programme Board stated in their 2021-22 Delivery Plan [28] that £4,075,222 was invested in 2021-22 towards Specialist Community Perinatal Mental Health Services.

98. The PMHN Scotland report noted at that time, four NHS boards had multidisciplinary specialist stand-alone teams for perinatal mental health; NHS

Greater Glasgow & Clyde, NHS Lothian, NHS Lanarkshire and NHS Grampian. However, the report also outlined that none were resourced to provide fully comprehensive care and while other NHS boards had some provision for perinatal mental health support, it was not specifically funded. It also noted that infant mental health support was very limited in most NHS board areas [29] .

99. Many submissions to the Committee's call for views highlighted the role of local or community support, with individuals feeling that local support was not always adequate or available. The Maternal Mental Health Alliance also published a map of specialist community perinatal mental health teams in Scotland in 2020 [30] . This showed that women did not have access to specialised perinatal community teams in many areas of Scotland. One submission noted there should be “a full and safe maternity model in all areas” [31] . Others highlighted geographical differences, such as the Highlands, and commented on the lack of services in certain areas, such as Caithness compared to central-belt areas. One very specific area of concern was Dr Gray's Hospital in Elgin, addressed later in this report.

100. During evidence the Committee heard that it can be difficult for women to engage with NHS perinatal mental health services, with support often only available for acute cases and interventions. NHS Lanarkshire noted in their written submission that outwith acute specialist perinatal mental health services, women can face very long waiting times, meaning "services can miss a crucial window of opportunity to intervene [32] "

101. The British Medical Association reported that its Members had said that:

> “in their experience it can be difficult to engage with NHS and get individual 1:1 support for patients as the bar for referral is set high, only taking on patients with acute postpartum psychosis. Waiting times for referrals to community mental health teams (CMHT) are long and this is not appropriate for mother or child. [33] ”

102. Following the session with Ministers on 14 December, the Scottish Government has provided an update on spending allocations for community specialist perinatal mental health provision. It reported that:

> The roll out of funding to Health Boards has been in progress from the start of the Perinatal and Infant Mental Health Programme Board in 2019 with initial development funding to two Health Boards in the North of Scotland. Funding was then rolled out to all mainland Boards in 2020/21 and was then allocated to all Boards within Scotland in 2021/22 [34] .

103. The Scottish Government also reported that £8m per annum has been earmarked as recurring funding to Health Boards to support the sustainability of perinatal and infant mental health services across Scotland following conclusion of the current Programme Board in March 2023. This is to include £5m specifically for specialist Community Perinatal Mental Health services [35] .

104. Hugh Masters, Chair of the Perinatal and Infant Mental Health Programme Board, addressed the issue of waiting times for access to services at the session on 14 December. He stated that access arrangements would be a key focus of the programme board in 2022. In relation to waiting times for perinatal mental health

services, he further gave a commitment that women should be seen no later than six weeks from the time of referral.

105. The Minister for Mental Wellbeing and Social Care emphasised his intent to concentrate on providing community perinatal mental health support:

> We need to get it right in communities across the country, and that means that the investment that we have put in needs to be spent wisely on developing those community assets. Beyond that, we also need to ensure that our investment in the third sector is there to allow those organisations to play a real part, with their expertise, in helping women and their families.

106. The Committee has been concerned to hear evidence of inconsistent access to specialist community perinatal mental health services across the country.

107. The Committee welcomes the establishment of the Perinatal and Infant Mental Health Programme Board. However, it has concerns that the subsequent allocation of spending on perinatal mental health services across all NHS boards has not so far translated into additional community perinatal mental health service provision across the country.

108. The Committee calls on the Scottish Government to set out how it will ensure that current and future funding and service provision delivers equity of access to specialist community mental health services throughout Scotland.

109. While welcoming the commitment to a maximum 6 week waiting time from initial referral for women to access perinatal mental health services, the Committee has heard extensive evidence this commitment has so far not been met. Furthermore, it is concerned that many women and families are currently having to wait significantly longer than 6 weeks to access support.

110. The Committee calls on the Scottish Government to confirm in which NHS Board areas the waiting time commitment is currently being met and those areas where it is not. It further calls on the Scottish Government to set out a timetable and associated plan for delivering the commitment across all NHS Board areas.

Dr Gray's Hospital in Elgin

111. A number of the written submissions highlighted issues around the provision of maternity services at Dr Gray's Hospital in Elgin; an issue debated in Scottish Parliament on 15 June 2021 [36] .

112. The following testimonies were received from affected individuals:

> I suffered major anxiety when I arrived at Dr greys to be told I was booked in for Aberdeen without my knowledge (maternity notes stated Elgin all the way through pregnancy and there was no reason for an Aberdeen birth) and I would have to leave at 11pm, in labour and transport myself to Aberdeen. I was in a huge state of panic leaving Elgin for Aberdeen [37] .

> My mental health was impacted hugely by the heavily medical birth I had because I had to be induced in Aberdeen. If I had the chance to give birth at my local Hospital I believe I might of been able to have less intervention and therefore less complications & even if this was not the case I still would have been able to be close to home & not have the agonising 60 mile journey home. This is causing a huge amount of stress on the women in Moray at an already very unpredictable time...I also feel that there should be a more local mental health unit for babies and mothers for mums suffering with things like post natal psychosis. One is not enough & Grampian along with the highland and islands is very much forgotten [38] .

113. The provision of maternity services at Dr Gray’s Hospital was the subject of an independent review led by the Chief Executive of NHS Borders, Ralph Roberts, following NHS Grampian's temporary downgrading of the maternity unit at Dr Gray’s in 2018 due to issues with staff recruitment and retention.

114. The review reported on 3 December 2021, stating recommendations in the short term to provide a 'Moray Networked Model' with a community maternity unit linked to Raigmore Hospital. Longer term recommendations detail the development of a rural consultant-supported maternity unit at Dr Gray's Hospital. However, this longer term recommendation is dependent on an increase in staff recruitment and continuous development of Dr Gray’s Hospital [39] . The report has been presented to the Cabinet Secretary for Health and Social Care and the Minister for Public Health, Women's Health and Sport for consideration.

115. The committee received many submissions from women who felt their perinatal mental health was impacted by the downgrading of maternity services at Doctor Gray’s Hospital in Elgin.

116. The Committee notes the short term recommendation of the independent review of maternity provision at Dr Gray’s Hospital by Ralph Roberts that a ‘Moray Networked Model’ should be provided with a community maternity unit linked to Raigmore Hospital. The Committee requests an urgent update from the Scottish Government on the planned timetable for implementing this recommendation.

117. The Committee calls on the Scottish Government to set out what actions it intends to take to support maintenance and development of consultant-led services in rural areas across Scotland.

Joined-up care

118. Individuals giving evidence to the Committee have recounted experiences of a lack of joined-up care during the perinatal period. During the informal meeting with individuals on 6 December 2021, individuals told the Committee they had experienced:

- inappropriate referrals to some services with the services unable to help with perinatal issues;
- a lack of follow-up treatment, and support, following being discharged from both hospital and other perinatal mental health services; and
- a disconnect between health visitor, GP and mental health services.

119. At the session on 7 December, the Committee also heard about the importance of preventative care and a joined-up approach. Dr Selena Gleadow-Ware, Perinatal Faculty Chair of the Royal College of Psychiatrists told the Committee there was a need for joined-up care pathways across specialist and universal services. However, she also emphasised that protected funding was needed to ensure its success and sustainability:

> We need sustained protected investment across those areas to ensure that we do not roll back on the gains that we have made and that we try to consolidate and continue the robust progress of change. Failure to do that will, unfortunately, lead to adverse outcomes not only for women but for their infants and family networks [40] .

120. Maternal Mental Health Scotland advised similar concerns, highlighting the role of integration:

> “Integrated Joint Boards are central to this work. A high-quality local offer requires joint working between mental health services, psychiatry, midwifery, primary care, children’s services, obstetrics, paediatrics, adult services and the voluntary sector. [41] ”

121. Healthcare Improvement noted a collaborative approach was needed across mental health, maternity and primary care, and highlighted the importance of joined-up working with the third sector [42] . Maternal Mental Health Scotland also advocated for a “whole family approach to maternity”, with fathers being “critical to family functioning in the perinatal period. [43] ”

122. Cat Berry, Group Facilitator and Volunteer Coordinator at Juno Perinatal Mental Health Support spoke in detail of the work of the third sector and the need for a "more joined-up approach to communicating and working with the NHS, those mums and families who are currently falling through the service net will not fall through it quite so much. [44] "

123. During the session on 14 December, the Minister for Mental Wellbeing and Social Care told the Committee [45] :

> In perinatal care, we are proposing the introduction of a service specification, which will be absolutely vital in ensuring consistency of care and in promoting joined-up care pathways. While we do that, we will also have national and local conversations with the third sector and people with lived experience to ensure that we get the specification right and can adapt it accordingly. We will carry out that vital work to ensure consistency of care across the board.

124. Professor Marian Knight outlined major concerns about a fundamental gap in access to perinatal services, namely that perinatal mental health services do not usually accept women who have had a loss event, which includes miscarriage, baby death, stillbirth or neonatal death, and child removal. However, she went on to explain that women affected by such a loss event have the same need for perinatal mental health care as women with a living baby. She further noted that a service specification[ii] for perinatal mental health services was a vital prerequisite for ensuring clear pathways with clear communication between different services to help eradicate the gap in service provision for women having experienced a loss event [46] .

125. Dr Arun Chopra, Executive Director of the Mental Welfare Commission told the Committee of the benefits of a service specification in terms of providing joined up care:

> If we had those pathways, that would be an improvement, and it would remove any uncertainty around what women and their families might expect...it is important to ensure that we have a clear national service specification that operates across Scotland, so that people know exactly what to expect. That will provide a really good benchmark for organisations such as ours in assessing how things are progressing.

126. The Committee has heard evidence from a number of witnesses of the significant benefits of creating a service specification for perinatal mental health services as a mechanism for delivering better, more joined up care. It therefore welcomes the Scottish Government’s commitment to introduce such a service specification.

127. The Committee calls on the Perinatal and Infant Mental Health Programme Board to provide more information on the proposed service specification, including:

- the timetable for stakeholder consultation,
- the timetable for development and introduction, and
- detail on how the service specification will ensure consistent, joined up delivery of perinatal mental health services in Scotland.

128. The Committee calls on the Scottish Government to provide clarification on how development of the service specification and future provision of perinatal mental health services will be aligned with the proposed National Care Service.

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ii A service specification outlines provisions individuals can expect from the NHS. They are written guidelines that clarify all the requirements and objectives of each specific stage of a service.

Third sector support

129. The Committee heard evidence that third sector support was often a lifeline for individuals during the perinatal period. During the informal meeting with individuals on 6 December 2021, many individuals told the Committee that they would not have coped without the support offered by third sector organisations. During the session, all individuals noted positive experience with third sector services. They told us they felt organisations:

- were quicker and easier to access services than statutory services;
- had more time to talk to individuals;
- tailored support to individual needs, not offering a one size fits all approach;
- provided support for a range of people in a range of different circumstances, something individuals commented that statutory services were not as good at; and
- were able to refer on to and help individuals access other services, where previously they had been unable to.

130. In particular, individuals noted befriending services were very helpful, especially in combination with other services or medication. Individuals also noted they were more willing to open up to a charity, as it was not linked to the NHS or social services.

131. Written evidence highlighted similar themes, with one individual noting the "only support I've been able to find has been an online charity. Been waiting for mental health nurse for over a year. [47] " Another noted "if it wasn't for the charity organisations I leaned on...I don't know where I would be. [48] "

132. Cat Berry, Group Facilitator and Volunteer Coordinator at Juno Perinatal Mental Health Support also highlighted that third-sector organisations are often picking up services that the NHS should be providing. She further noted:

> Even before the pandemic, we noticed that the women we see at Juno were on very long NHS waiting lists not just for cognitive behavioural therapy or eye movement desensitisation and reprocessing treatment through the NHS, but to see other third-sector organisations that provide counselling. The waiting list to get one-to-one support from third sector organisations is about four or five months. For the NHS, it is much longer—it is up to a year at the moment [49] .

133. The Minister for Mental Wellbeing and Social Care noted the crucial support provided by third sector organisations and highlighted:

> The best way to ensure that we get services right for women and families across Scotland is to have complete co-operation and collaboration and a lot of communication between NHS boards, the third sector and the voices of lived experience [50] .

134. However, the Committee heard third sector funding remains a challenging issue. The funding landscape for third sector organisations delivering perinatal mental

health services is complex.

135. However, a key source of funding for third sector perinatal mental health organisations is outlined in the Perinatal and Infant Mental Health Programme Board's 2021/2022 Delivery Plan [51] . Funding under the delivery plan is broken down as follows:

- Funding prior to launch of the main Fund: £395,252
- Perinatal and Infant Mental Health Fund: £664,981 in year 1 and £814,038 in year 2
- Small Grants Fund: £200,000 over years 2 and 3 of the main fund

136. The Perinatal and Infant Mental Health Fund [52] , for third sector organisations who provide non-clinical support to women and families, was launched in May 2020. Between October 2020 and March 2021, the fund provided £665,000 to support 16 third sector organisations. However, at the session on 7 December, Joanne Smith, Chair of Maternal Mental Health Scotland reflected that the fund is insufficient, is only a one-off fund and was significantly oversubscribed during the application process.

137. Hugh Masters, Chair of the Perinatal and Infant Mental Health Programme Board also described third sector funding as short term and fragile in his written submission, highlighting that certain third sector projects could be at risk unless sustainable funding is available. He also stated that, while the Board's two funding streams (the Main Grants Fund and the Small Grants Fund) has been welcomed, "it is clear that the pandemic has further impacted on Third Sector funding which they report as predominantly short term and fragile. [53] "

138. Joanne Smith, Chair of Maternal Mental Health Alliance (Scotland), highlighted that funding for the third sector represents a small percentage of the overall perinatal investment in Scotland. She also described the current short-term funding structure as unsustainable and emphasised the need for longer-term, recurrent funding [54] .

139. At the session on 14 December, the Committee heard a commitment from the Minister for Mental Wellbeing and Social Care's to work with third sector organisations to provide the resources and the services that women and families need across the country. [55] At the same session, Hugh Masters, Chair of the Perinatal and Infant Mental Health Programme Board, added that, in 2022, the programme board will be exploring and focusing on how to continue funding beyond the life of the programme board [56] .

140. The Committee has received substantial evidence of the vital role played by third sector organisations in providing quick and tailored access to perinatal mental health support for many women and families.

141. The Committee has heard evidence that perinatal mental health services provided by third sector organisations tend to be more flexible, better tailored to individual needs and subject to shorter waiting times than corresponding statutory

services.

142. The Committee calls on the Scottish Government to develop a comprehensive strategy to improve communication, collaboration, co-operation and exchanges of best practice between third and statutory perinatal mental health support to make sure that women and families are appropriately and adequately supported.

143. The Committee calls on the Scottish Government and NHS Boards to ensure all primary care practitioners can offer effective signposting towards available third sector provision of perinatal mental health support services.

144. The Committee calls on the Scottish Government to undertake a comprehensive audit of funding available for perinatal mental health support across both the NHS and the third sector to ensure optimal use of limited funds and redeployment where necessary.

145. We further urge the Scottish Government to ensure third sector organisations providing perinatal mental health services are afforded greater financial security by moving towards longer term funding cycles.

Transitions

146. Written evidence submitted to the Committee also raised the importance of ensuring the availability of perinatal mental health services for mothers of children older than 6 month, and securing seamless transition and continuity of care from perinatal mental health services to adult mental health services. Respondents highlighted that mental health issues do not "magically resolve on a child's first birthday [57] " and that adult mental health resources tend to be poorly resourced. In its written response, NHS Grampian noted:

> Women are often willing to accept perinatal mental health care as part of their antenatal and post natal care, where they would not individually attend a psychiatric clinic, and this is a good thing, but we have immense problems when babies reach 12 months old and there has to be a transition to General Adult services [58] .

147. The Committee recommends the Scottish Government undertake work to ensure NHS boards improve the integration and continuity of perinatal mental health services in the longer term for those families that need it. The Committee believe this should not be restricted to the one year period following the birth of a child.

148. The Committee recommends that NHS boards take action to ensure transitions from perinatal mental health services into adult mental health services are as smooth as possible for families. It seeks reassurance that ongoing provision of perinatal mental health support through adult mental health services is prioritised and resourced.

Workforce

Recruitment and retention

149. During the perinatal period, individuals access support from a number of universal and specialist services. Midwives, health visitors, GPs and obstetricians remain at the forefront of this work, but a broader range of professions and organisations are also involved in providing care and support.

150. The Minister for Public Health, Women's Health and Sport highlighted the crucial role midwives, health visitors and family nurse practitioners have in identifying and preventing perinatal mental health problems [59] .

151. The Committee heard a range of both new and existing mental health issues during the perinatal period can be prevented if women and families have access to the right support at the right time. However, it is clear from the evidence received that this support was not always available pre-pandemic, and the situation has deteriorated during the pandemic.

152. Many written submissions also highlighted issues around workforce planning, staff numbers and the wellbeing of staff.

153. The Royal College of Nursing Scotland commented that vacancies in mental health nursing in Scotland are currently at a record high, with services being affected by low staffing levels and remaining staff are overworked and feel unable to provide the care they would like to. It highlighted in its view:

> the single biggest difference the Scottish Government can make to improve perinatal mental health services in Scotland is to ensure that existing services are adequately staffed [60] .

154. The British Medical Association highlighted that the demand placed on midwives on overstretched postnatal wards resulted in pressing clinical needs taking precedence over emotional and psychological needs. It further highlighted a similar situation for postnatal community care, with high demand on health visitor services meaning the focus is on child protection issues and people struggling can get missed or overlooked [61] .

155. NHS Grampian highlighted resource issues with specialist nurses, noting health visitors and midwives are doing home visits and trying to plug the gaps of a very under resourced area. The time health visitors have to spend with new mothers was also raised as an issue:

> They do not have the time to help parents with their mental health, the service is vastly overstretched and underfunded and this has only become worse since COVID-19 [62] .

156. The PMHN Scotland report made a number of recommendations on staffing recruitment and retention [63] :

- The Scottish Government and NHS boards should ensure that MBUs are staffed at the recommended level to provide a comprehensive clinical service.
- NHS boards should ensure that maternity hospitals with fewer than 3,000 deliveries per year have access to psychological therapies in local primary care psychological therapies services, adult mental health psychological services or perinatal mental health clinical psychology. Services should have sufficient psychological therapist provision to meet this need.
- The Scottish Government and NHS boards should develop additional workforce capacity to deliver timely psychological interventions for mild to moderate perinatal mental health disorders in women and men. This should be developed incrementally, with evaluation of local need conducted in parallel.
- The Scottish Government and NHS boards should develop a workforce plan to ensure that there are sufficient numbers of appropriately trained staff to support service development. Implementation of this work and longer-term roll-out should be included in a national delivery plan as soon as practicable.

157. However, NHS Lothian told the Committee that more work is needed over and above these recommendations due to the increased demand on services and additional pressures on staff due to the COVID-19 pandemic [64] . NHS Grampian also highlighted the impact of COVID-19 on staff:

> Both [the] physical and mental health of caregivers and professionals has been stressed by COVID so reducing the amount of care available once basic COVID duties are done. Staff morale is understandably low in some cases, with resultant effects on the confidence and sense of security of patients [65] .

158. NHS Lothian noted more work is needed to develop a sustainable workforce and ensure that services that are suitably attractive to recruit and retain staff. It specifically highlighted:

> There is a need to consider an increased staffing complement to ensure that education and training, clinical supervision and support are embedded as part of practice and held in the same parity as direct clinical care [66] .

159. At the session on 14 December, the Minister for Mental Wellbeing and Social Care highlighted that workforce and sustainability are at the centre of the programme board delivery plans. He further highlighted the Scottish Government:

> will look at a new workforce strategy for mental health services within the first half of this session of Parliament. We are well on the way in this area and we can see that in the recruits we are managing to get in [67] .

160. The Committee is of the view that having an appropriately trained and supported workforce is crucial to ensure individuals get the support they need. It calls on the Scottish Government to provide an update on progress towards implementing the key recommendations from the PMHN Scotland report around staff recruitment and retention In particular, this should address what actions are being taken to

provide better wellbeing support for midwives and health visitors.

161. Beyond the PMHN Scotland report recommendations, the Committee further requests an update on any additional work currently underway to deliver the increased staffing complement necessary to ensure perinatal mental health support and knowledge is embedded as part of practice and held in the same parity as direct clinical care.

Training

162. During the inquiry, the Committee heard there was a need for better support and training for healthcare professionals working in perinatal services, particularly to enable early identification and prevention.

163. NHS Lanarkshire commented that there is a need for:

> "…further training and education for all health professionals in contact with women and their families in the perinatal period. This would build on the work already started by NES. There is still work to be done around the early detection of mental health difficulties in the perinatal period. The long-term goal would be to ensure that perinatal mental health is being reviewed throughout perinatal care from primary care settings to specialist perinatal services. This would include checking-in during GP reviews as well as midwife/health visitor appointments [68] ".

164. Joanne Smith, Chair of Maternal Mental Health Alliance (Scotland), spoke about the critical need to prioritise training to upskill the primary care workforce to ensure appropriate and timely access to specialist services. She further highlighted that additional training for GPs, midwives and maternity staff can help with early identification of perinatal mental health issues, secure inpatient care when needed and prevent maternal deaths [69] .

165. The Committee has heard evidence that in many circumstances, health professionals lack the appropriate knowledge and training to be able to refer patients to perinatal mental health services appropriate to their needs. During the informal meeting on 6 December 2021, individuals told the Committee some of the services they had been referred to were inappropriate and professionals within those services were unable to help with perinatal issues. They also told the Committee that when they were referred to the right service, such as to local perinatal mental health teams, experiences were positive and the support made a difference. Professor Marian Knight, Professor of Maternal and Child Population Health, MBRRACE highlighted that the "GP is a clear linchpin in continuity of care prepregnancy, during pregnancy and particularly post-pregnancy". She highlighted that there are clear examples where GP and mental health services have discussed risk-mitigation strategies to support individuals pre-pregnancy, but the same level of support and knowledge of where to refer individuals during and post-pregnancy can be lacking [70] .

166. Evidence received also highlighted the need for specialist mental health training

within midwifery training. The Nursing and Midwifery Council (NMC) is the registered body for nurses and midwives in Scotland. Nurses and midwives working in the UK are required to join the register. The NMC Standards of proficiency for midwives [71] include standards around providing ongoing information, support, and care on all aspects of a woman's mental health and well-being, and that of partners, where concerns have been identified. In its submission, NHS Borders commented that all midwifery university courses should have appropriate perinatal mental health modules in place to ensure the future workforce has adequate training and supervision [72] . Many submissions also commented that all health visitors should be trained in perinatal mental health.

167. Maternal Mental Health Scotland also raised concerns over current workforce capacity and knowledge to deliver perinatal and infant mental health services at a local level. It further noted there is insufficient promotion and investment in developing the specialist skills required within psychiatry, psychology, nursing and social care [73] .

168. NHS Borders also suggested further investment in training was needed from the Scottish Government. In its submission it noted that financial support was needed to give widespread training to all health care staff linked to maternity services, to aid all levels of staff the ability to recognise the signs and symptoms of mental health issues early and refer as appropriate [74] .

169. Dr Selena Gleadow-Ware, Perinatal Faculty Chair of the Royal College of Psychiatrists praised the work of the national managed clinical network; Perinatal Mental Health Network Scotland (PMHN Scotland), the aim of which is to help develop and improve access to high quality care for women, their infants and families. However, she also highlighted the importance of ensuring the workforce is afforded appropriate time to undertake training [75] . Dr Mary Ross Davie, Director for Professional Midwifery, Royal College of Midwives further highlighted the endless cycle of staff shortages and the impact this has on available time for training:

> What is difficult about staff shortages is that they reduce the amount of time that midwives are given for continuing professional development. Midwives are expected to undertake CPD in their own time. Ring-fenced time for education throughout a midwife's career is vital [76] .

170. The PMHN Scotland report recommended the following in relation to workforce training [77] :

- NHS Boards, Integrated Joint Boards, Local Authorities and other relevant organisations should ensure that all staff working with women during pregnancy and the postnatal period have the knowledge, skills and attitudes to ensure they deliver appropriate care. Staff should meet the requirements of the Curricular Framework for Perinatal Mental Health and undergo induction and regular updated training where appropriate.

- The Scottish Government should work with NHS Education for Scotland and the Perinatal Mental Health Network to develop a suite of educational tools matched to the Curricular Framework competencies, and an induction programme for all staff new to specialist services. Implementation and roll-out of education and training should be included in a national delivery plan as soon

as practicable.

- The Scottish Government should ensure that education and training is underpinned by a one-stop digital resource providing a hub for online training for professionals, and perinatal and infant mental health information for professionals, women and their families. This resource should be included in a national delivery plan as soon as practicable.

171. The Perinatal and Infant Mental Health Programme Board outlined recent progress in workforce training, particularly that developed and implemented by NHS Education for Scotland, on perinatal and infant mental health in their 2021-22 Delivery Plan (area 6) [78] .

172. At the session on 14 December, Hugh Masters, Chair of the Perinatal and Infant Mental Health Programme Board, noted:

> We are offering health visitors and midwives training on perinatal mental health so that they understand the issues and have the confidence to offer that kind of support and to assess properly. We are getting some very positive feedback on that [79] .

173. The Minister for Mental Wellbeing and Social Care also informed the Committee that in relation to training:

> The aim is to further develop expertise at all levels across specialist and universal services. Importantly, we have committed to investment in perinatal and infant mental health services beyond the life of the programme board, which will allow health boards to recruit the required staff on permanent contracts and will support the recruitment and retention of staff and the development of centres of expertise. That expertise is grand—it is brilliant—but we also want others to be able to access the kind of educational materials that Emma Harper has talked about [E-Learning Modules]. We have made that possible [80] .

174. The Committee received updates from the Scottish Government on 14 December on workforce training, where it acknowledged the issue. During the session, the Minister for Mental Wellbeing and Social Care highlighted:

> NHS Education for Scotland has been expanding training places on commissioned programmes as well as ensuring that additional perinatal and infant mental health training is provided across a range of professions. That investment will result in 51 additional psychological practitioners by the end of 2021-22. There is a huge amount of work going on, not just in relation to training and getting folk in but on training others to recognise exactly what is required in this context [81] .

175. Following the inquiry, the Minister for Mental Wellbeing and Social Care and the Minister for Public Health, Women's Health and Sport wrote to the Committee to provide an update on the uptake of perinatal mental health training by midwives and health visitors, and training time [82] . This highlighted progress in delivering the following:

- Perinatal and Infant Mental Health Essentials E-Learning Modules.
- The Institute of Health Visiting's Multi-Agency Perinatal and Infant Mental Health Champions training programme.

176. The update reported that the Perinatal and Infant Mental Health Essentials E-Learning Modules are designed and aimed towards Mother and Baby Unit, and specialist community perinatal mental health teams. These modules are accessible to all mental health staff, (including adult, CAMHS, addictions etc.) as well as maternity, primary care, health visiting and third sector staff who work in an enhanced role, and staff working within specialist perinatal and infant mental services. It reported 7,852 modules have been completed since they went live from May to September 2020. 415 of these were completed by Health Visitors and Family Nurses and 558 were completed by Midwives (7 of these by Maternity Support Workers) [83] .

177. The update also provided further detail on the Institute of Health Visiting's Multi-Agency Perinatal and Infant Mental Health Champions training programme which is targeted specifically towards Health Visitors and Midwives. This is the core of NHS Education Scotland's perinatal and infant mental health offer to universal services. The programme is delivered to trained champions, who cascade the training forward. 58 Champions have been trained to date, and they have delivered training locally to more than 86 colleagues. Two more cohorts of 20 have been commissioned before end of March 2022 and in 2022/23 there are plans for training a further 120 Champions [84] .

178. The update from the Ministers also noted that staff in maternity and neonatal settings have a percentage of time built in for continuous professional development [85] .

179. **The Committee notes the work underway to offer perinatal mental health training to midwives and health visitors. The Committee calls on the Scottish Government to ensure further education institutions deliver perinatal mental health training as core training for all midwifery and nursing students as a priority. This should have due regard to the relevant Nursing and Midwifery Council standards of proficiency related to perinatal mental health.**

180. **The Committee calls on the Scottish Government to provide a detailed update on progress towards implementing the key recommendations from the PMHN Scotland report related to workforce training, along with timescales and sources of funding for completion of any actions that remain outstanding.**

181. **The Committee has heard evidence that improved training provision will only have a positive impact if the workforce has the flexibility to be able to complete training either in normal working hours or away from work according to their own preferences. Evidence has also highlighted the knock-on impact of staff shortages on available time for staff to undergo continuing professional development.**

182. **The Committee therefore calls on the Scottish Government to commission further**

research to identify what proportion of perinatal mental health staff are encountering barriers to completing training and the nature of these barriers. The Scottish Government should use the findings of this research to inform a targeted strategy aimed at increasing rates of uptake of training opportunities by perinatal mental health staff.

Breastfeeding support

183. Many submissions to the Committee's call for views highlighted the impact experiences of breastfeeding can have on maternal mental health. During the informal meeting with individuals on 6 December 2021, one individuals told the Committee that being unable to breastfeed contributed towards their postpartum depression and a guilt over feeling like a bad mother. Others noted that nurses were very busy after the birth and didn't have a lot of time to provide breast-feeding support. One individual told us in written evidence:

> I breastfed for 3 months which I found demanding, tiring and difficult. I wanted to breastfeed until my little one was at least 6 months. However, with no support and not knowing who to turn to, I ended up giving up. I strongly feel that had I had support, or known where to source the support, then I would have breastfed for longer than I did [86] .

184. The Committee also heard from individuals on 6 December that breastfeeding support through the pandemic was not particularly effective, either because it was provided via online/phone consultations or because nurses were unable to touch mother or baby when providing face-to-face support. Another written submission pointed out that "trying to provide breastfeeding support via video link or over the phone is almost impossible and increases the likelihood of things being missed or misdiagnosed. [87] "

185. The Minister for Public Health, Women's Health and Sport emphasised the importance of breastfeeding support at the session on 14 December, setting out a range of improvements and the long-term commitment to supporting breastfeeding in Scotland spanning decades. This resulted in Scotland becoming the first UK nation to achieve 100% accreditation from the UNICEF UK baby friendly initiative, the Minister told the Committee. At the same time, she noted that breastfeeding rates went up during the pandemic:

> The most recent infant feeding statistics show that almost two thirds of babies who were born in the 2020-21 financial year were breastfed for at least some time after their birth...The proportion of babies aged six to eight weeks who are being breastfed is at its highest since records began. Many people would say that it is still too low, but the figure is up to 45 per cent, and 32 per cent of babies are being exclusively breastfed, which is an increase of 1 per cent on the previous year [88] .

186. During the session, the Committee also heard evidence of the Scottish Government's commitment to provide early opportunities to breastfeed and to

reduce breastfeeding drop-off rates at various stages:

> ...the number of women who initiate breastfeeding and who are supported to breastfeed for longer is increasing. That is due to increased financial investment and a better understanding of what support infrastructure should be around women, so that they are provided with the resources that they need to continue to breastfeed for as long as they wish to do so [89] .

187. The Minister acknowledged that work was still needed to increase these rates further, as well as increase focus on the early stages. The Scottish Government further noted that there had been increased contact with the breastfeeding helpline and that infant feeding teams were largely protected during the pandemic [90] .

188. The Committee notes the 2019 Scottish Government report, *Becoming Breastfeeding Friendly Scotland*, which contains a set of eight recommendations to scale up the protection, promotion and support of breastfeeding in Scotland. The report notes:

> There is recognition that this work must be underpinned by multiple level strategic action to strengthen commitment to breastfeeding and create an enabling environment in terms of awareness, knowledge and evidence, leadership and resourcing [91] .

189. The Committee heard evidence that breastfeeding is a very emotive subject for women in the perinatal period. The prevalent narrative is that 'breast is best' but the Committee heard that many individuals did not not feel the right breastfeeding support was available to them and that the push to promote breastfeeding was stigmatising and could lead to increased guilt and negative mental health. Cat Berry, Group Facilitator and Volunteer Coordinator at Juno Perinatal Mental Health Support highlighted that there needs to be a shift in narrative to ensure that 'fed is best' [92] . Dr Fiona Challacombe, Patron at Maternal OCD noted that additional support was needed to support women however they choose to feed their baby:

> If we had non-stigmatising education and support from professionals and other services that are in contact with women, that would help women to make the best decision for the situation that they are in, be it breastfeeding, bottle feeding or a combination of the two. We need to support women in what can be a difficult and a physically and emotionally exhausting issue [93] .

190. While the Committee acknowledges and is encouraged by evidence that breastfeeding rates have increased during the pandemic, it is also concerned to learn that in certain circumstances breastfeeding support has been negatively impacted by Covid restrictions.

191. The Committee calls on the Scottish Government to provide an update on the impact of the pandemic on breastfeeding support and to outline what plans are in place to resume services as part of Covid recovery.

192. While accepting that breastfeeding should be a matter of personal choice to suit individual circumstances, the Committee has also heard evidence of the need for further action to support new mothers who wish to breastfeed across all maternity

services.

193. The Committee calls on the Scottish Government and further education institutions to ensure every student midwife receives practical breastfeeding support training and that this is also available to all midwives, health visitors and newly qualified midwives.

194. The Committee also calls on the Scottish Government to provide an update on the eight recommendations in the Becoming Breastfeeding Friendly Scotland report, with particular focus on the implementation of recommendation to develop and implement a breastfeeding advocacy and promotion strategy.

195. The Committee is concerned around the issue of stigma and freedom of new mothers to choose the method of feeding that suits them and their child. With this in mind, the Committee would welcome further information from the Scottish Government about its strategy for supporting mothers with feeding their baby irrespective of their individual choices and circumstances.

Birth trauma

196. A number of submissions raised the issue of birth trauma for new mothers and its subsequent impact on partners. Birth trauma is a phrase that can be used to describe post-traumatic stress disorder (PTSD) after childbirth. Cat Berry, Group Facilitator and Volunteer Coordinator at Juno Perinatal Mental Health Support highlighted that an individual can have a traumatic birth that doesn't lead to PTSD if they are adequately supported during and after the birth. However, conversely an individual can have a good birth, but still experience PTSD if they do not have the necessary support [94] .

197. One individual told the Committee of her experience of birth trauma:

> I had postnatal depression at around 7 months post baby. I was offered mainstream mental health services and not perinatal mh services because the baby was older than 6m. All that was available to me was antidepressants (I declined), an online support group (I didn't join) and online zoom CBT sessions (I attended these but didn't find them helpful because I have a background in psychology and CBT and already apply these techniques for myself). What I needed was to be listened to, and to be asked what would help me. What I needed was to talk through my birth trauma and to have someone to check in with for a period of time so that I felt listened to within a safe space, and cared for [95] .

198. The Committee heard that there are no services that directly address birth trauma. In its submission NHS Lothian noted the lack of birth trauma services that are available for new parents [96] .

199. Cat Berry, Group Facilitator and Volunteer Coordinator at Juno Perinatal Mental Health Support noted that there was a rise in birth trauma before the pandemic, but

that has been exacerbated during the pandemic [97] . In its submission Aberlour also noted that the incidence of birth trauma rose sharply in its perinatal services during the pandemic and remains one of the key contributing factors in referring women for support. [98]

200. Evidence received suggests a number of reasons for the increase in experiences of birth trauma including staff shortages, lack of time for staff to help prepare women adequately for birth, or to reflect on the birth afterwards, and that birth trauma related PTSD is not always being identified. Cat Berry, Group Facilitator and Volunteer Coordinator at Juno Perinatal Mental Health Support highlighted in the session on 7 December that the biggest cause of PTSD in birthing women was a lack of care from midwives, due to midwives being so over-stretched [99] .

201. In its submission, Aberlour recommended that the Scottish Government develop and support birth trauma prevention work, to include increased support and resources for staff to facilitate trauma informed practice supporting new and expectant parents [100] .

202. The Committee is concerned about the sharp rise in birth trauma incidences reported during the pandemic and the lack of services that directly address birth trauma as highlighted by NHS Lothian. The Committee urges the Scottish Government to develop and support birth trauma prevention work as a matter of urgency and to work across all NHS Health Boards to implement resulting measures including:

- supporting the well-being of midwives and health visitors, so they can better support birthing women,
- ensuring staff have adequate time to spend with women to help prepare them for birth and reflect on the birth afterwards,
- ensuring resources are available to support staff to diagnose birth trauma,
- developing care pathways to prevent and treat birth trauma,
- providing dedicated treatment for birth trauma across all NHS board areas, and
- ensuring women always have access to emotional support or a birth partner.

Miscarriage and the death of an infant

203. Access to and provision of bereavement support following miscarriage and the death of an infant was a key focus of the Committee's inquiry.

204. Many of the submissions received in the call for views suggested that current services do not offer appropriate support for the impact that bereavement can have on perinatal mental health. Multiple submissions reflected that medical professionals did not always take the impact of bereavement seriously, especially in cases of miscarriage. The Committee also heard that waiting lists for specialist bereavement support are long, when individuals are referred.

205. In its written submission, Sands noted that perinatal mental health services have traditionally been focused on women who are pregnant or have a living baby. This has resulted in mothers whose baby has died not meeting the inclusion criteria to access support. Sands also highlighted that “many bereaved parents will go on to experience psychiatric illnesses that require specialist support, triggered by intense grief and the trauma of their experience [101] ”

206. Many of the responses to the call for views reflected either inadequate or no support available for the impact of bereavement on mental health. One individual commented:

> I recently lost a baby at 7 weeks and not one medical person offered any service for my loss. They just left me to deal with it myself which I find completely shocking this was my second loss and I’m still struggling with my loss having no one else to talk to since it happened [102] .

207. Evidence from Sands also highlighted that bereaved parents were sometimes “being invited to attend clinics surrounded by families with living babies. [103] ” In another submission an individual mentioned that, after having a miscarriage, they were placed in a labour ward of women “happy with their new bundle of joy as I was sat there crying my eyes out wishing I was them” [104] .

208. During the session on 7 December, Cat Berry, Group Facilitator and Volunteer Coordinator at Juno Perinatal Mental Health Support highlighted the Scottish Government's commitment to introduce specialist baby loss units for parents who are going through miscarriage and stillbirth [105] . However, she also noted that the units will not be operational until 2024 and current practice is exacerbating individuals' trauma:

> I want to make this really clear: at the moment, parents who go to hospital in the knowledge that they will have a stillbirth or who have to get to hospital because they are going through miscarriage are told beforehand that, when they press the buzzer at the door, they will be greeted by a specialist bereavement midwife. That is not happening. They are actually pressing the buzzer to the maternity ward, and they are then greeted at the door by happy fathers with balloons saying, "Congratulations" or "Welcome to the world". They have to run a gauntlet of balloons, teddies and all these things saying "Congratulations". It is not fair; in fact, it is really inhumane for parents who are already going through the trauma of losing a baby to have to go through that added trauma. It is like putting salt on the wound [106] .

209. Clea Harmer, Chief Executive of Sands, noted that the National Bereavement Care Pathway Scotland (NBCP) Project [107] has led to separate baby loss services in some areas. Three areas were piloted before the beginning of the COVID-19 pandemic. However, she reported progress towards separate baby loss services across Scotland had been delayed by the COVID-19 pandemic [108] .

210. The Committee heard particularly strong evidence of the positive impact of work undertaken by Sands as well as good practice examples of initiatives to support the needs of individuals who have experienced miscarriage or baby loss. Clea Harmer, Chief Executive of Sands, explained that:

> ...a Sands teardrop...goes on the notes, which indicates that there has been a previous baby death or pregnancy loss. That means that the parent does not need to tell their story again and again. The butterflies are important for twin loss. In cases in which one twin lives and one dies, the butterfly is used on the cot to show anyone who comes up and sees the beautiful baby that there was another baby who died. The butterfly is incredibly important, because there are so many difficulties with the joy and grief of one baby living and one baby dying.

211. Following the session with Ministers on 14 December, the Scottish Government were unable to provide an update on the percentage of bereaved parents who have had access to care from a specialist bereavement midwife over the past five years. The Minister for Mental Wellbeing and Social Care and the Minister for Public Health, Women's Health and Sport wrote to the Committee to update on work around bereavement support following miscarriage or baby loss, noting:

> Whilst we know that some Health Boards have specialist bereavement midwives and bereavement teams, bereavement care is the responsibility of all health professionals working in Maternity Services [109] .

212. Ministers further highlighted the afore mentioned National Bereavement Care Pathways (NBCP) project, which is funded by the Scottish Government and has been developed by Sands UK, other baby loss charities, royal colleges and bereaved parents. They noted the pathways provide health professionals with evidence based care pathways and describe best practice for bereavement care following a miscarriage, termination of pregnancy for fetal anomaly, stillbirth, neonatal death, or the sudden unexpected death of an infant. They further explained that this work on the project was paused due to the COVID-19 pandemic,

but is expected to recommence in early 2022 [110] .

213. In its written submission, Sands recommend the Scottish Government undertake a review of current provision, quality standards, and guidance to local services to "effectively assess the psychological support needs of bereaved parents" and develop appropriate referral pathways to meet those needs [111] .

214. Multiple submissions also recommended the use of the Sands Maternity Bereavement Experience Measure [112] , which aims to enable parents whose baby has died the opportunity to feed back about the care they received. These submissions expressed a views that this measure should be applied by NHS Boards as a means of auditing their services.

215. Recommendation 41 of The best start: five-year plan for maternity and neonatal care [113] makes suggestions on the bereavement support which should be offered to families before they leave the unit, including access to staff members trained in bereavement care and information on bereavement services.

Action 4 of the Programme Board's 2021/2022 Delivery Plan [114] included a commitment to creating a pathway "to provide continuity of care for women and their partners/co-parents who experience loss or trauma in relation to pregnancy and childbirth whilst engaged with Perinatal and Infant Mental Health services."

216. The Committee is concerned about the evidence it has heard around the lack of support for parents and families affected by miscarriage, stillbirth and the death of an infant.

217. The Committee believes it is unacceptable for those parents and families affected to have to wait until 2024 for specialist baby loss units to be established. It therefore calls on the Scottish Government to liaise with NHS boards to explore all avenues to enable the timetable for establishment of these units to be accelerated and to provide the Committee with further updates on progress.

218. The Committee has also been concerned to hear stories of women affected by baby loss being treated in maternity wards alongside women giving birth to healthy babies. Until such times as specialist baby loss units have been established, it calls on the Scottish Government, as an urgent priority, to establish national protocols informed by existing good practice that ensure families affected by baby loss are consistently treated with respect and compassion and in a trauma-informed way in a separate area from maternity wards, ideally with a means of entry and exit separate to those wards.

219. The Committee further calls on the Scottish Government, as a matter of urgency, to develop and implement the policies and associated funding necessary to ensure that every bereaved mother and parent accessing maternity services is met by a specialist bereavement midwife as a matter of course and that perinatal mental health services are fully accessible to bereaved parents.

220. The Committee recognises and commends the work of Sands to provide support to those affected by the death of a baby and improve the care bereaved parents receive.

Equalities

221. The Committee heard evidence from a number of sources about inequalities of access to perinatal mental health services.

222. Dr Arun Chopra, Executive Director of the Mental Welfare Commission highlighted the inequality of access to mental health care services experienced by people from different racial backgrounds. He also praised the NES curriculum for perinatal mental health, which contains a section on culture and meeting the needs of people who come from different cultures and ethnicities [115] . Maternal Mental Health Scotland noted that COVID-19 had posed additional challenges for women's perinatal mental health, especially for women from minority ethnic and socially disadvantaged groups [116] .

223. Clea Harmer, Chief Executive of Sands described how some immigrant mothers and families experience difficulties with language. She described scenarios where, in the absence of professional translators who understand bereavement and have received specialist training to deal with such scenarios, the surviving children of non-English speaking mothers having experienced child loss were being relied upon to translate communication from health practitioners [117] . Written evidence also suggested that it was difficult for partners and significant others to access support in such circumstances.

224. Marian Knight highlighted the importance of focusing on vulnerable groups, explaining that the majority of women who die have experienced complex adversities:

> They have had adverse childhood experiences or they are victims of domestic abuse. They might have issues with substance abuse, or social services might be involved. To ensure the best outcomes for such women, a trusted therapeutic relationship—having somebody whom they trust to help them to navigate the system and be their advocate—is crucial [118] .

225. One group specifically identified in the evidence as having additional needs were women with substance misuse. Roch Cantwell, lead psychiatry assessor for the UK and Ireland Confidential Enquiries into Maternal Deaths, highlighted that for women with substance misuse, there are repeated recommendations concerning the need for continuity of care, and the involvement of specialist addictions services in their care [119] . NHS Lothian highlighted that investment in associated services would be welcomed:

> There may be a need for investment in other services where there is a need for joint working with consideration to maternal deaths this is most pertinent in substance misuse services, given the high rates of morbidity, mortality and child vulnerability in this group [120] .

226. In its written submission, the Mental Health Foundation recommended that “the development of perinatal mental health services be equality-proofed” in order to reduce the social inequalities that may prevent pregnant and postnatal women from experiencing good mental health [121] .

227. The Committee also heard that it can often be difficult for partners and significant others to access support. During the informal meeting with individuals on 6 December 2021, an individual told the Committee of how difficult it has been interacting with services since the death of his partner. He spoke of how there was a lack of support for single dads, with services only seeming willing to speak with a woman.

228. The Scottish Government published a perinatal and infant mental health: equalities impact assessment [122] in March 2021 which aims to encourage equity of access to mental health services. This highlights that an equalities group which reports to the Perinatal and Infant Mental Health Programme Board has been convened and meets every two months to discuss embedding equalities into policy and service development. It also states that:

> The group will help to further identify and fill gaps in the evidence around inequalities in perinatal and infant mental health and inform any further mitigation required. Monitoring and evaluation will be embedded in to the work of this group, directed by the recommendations from Public Health Scotland and the Monitoring and Evaluation Group of the Programme Board.

229. The Minister for Mental Wellbeing and Social Care noted that the equality impact assessments undertaken highlighted stigma around perinatal mental health issues among BAME groups, but he went on to state that stigma exists across all communities. He noted that there is still a lot of work to do to tackle stigma associated with perinatal mental health [123] .

230. The Committee has been concerned to hear evidence about the barriers encountered by women and families in accessing perinatal mental health services, particularly those from minority ethnic backgrounds, those for whom English is not their first language and those from particularly vulnerable or at risk groups, such as care experienced new parents who may have experienced childhood trauma.

231. The Committee would welcome an update from the equalities group on work they have undertaken to date to identify inequalities in access to perinatal mental health services, what work it is undertaking to develop a comprehensive strategy to tackle these and, as recommended by the Mental Health Foundation, to equality-proof the future development of these services.

Stigma

232. During the informal meeting with individuals on 6 December 2021, multiple individuals reported experiencing a lack of trust in healthcare professionals. A number of individuals noted a reluctance to share details with clinicians for fear that their babies would be taken away from them. This was also reflected in multiple submissions. One written submission noted:

> I was too frightened to actively seek help as I was afraid I would be labelled an unfit mother and my daughter would be removed from my care. Now that I am receiving treatment I realise that feeling was a consequence of my illness and I would never have been referred to social services [124] .

233. Another submission reflected:

> More mums would seek support for their mental health after childbirth if they knew they could do so without being judged or without the fear of having their child taken off them [125] .

234. The Mental Health Foundation focused on mental health stigma and mental health literacy in its submission, with a recommendation for the “development of mental health literacy and anti-stigma programmes for expectant and new parents. [126] ” Other submissions made a number of suggestions as to how stigma can be normalised and public awareness of perinatal mental health issues could be strengthened. These included publishing online resources, creating online and local support groups, providing antenatal support and advice and running social media campaigns.

235. The Perinatal & Infant Mental Health Programme Board’s 2020-2021 Delivery Plan outlined a specific objective to meet the pledge “I am able to talk about my mental health without fear of being judged” [127] . The Programme Board committed to:

    “Develop a raising awareness, promoting understanding and reducing stigma strategy, in conjunction with people with lived experience by end of 2020.”

236. Action 6 of the Programme Board’s 2021-2022 Delivery Plan committed to publishing a *Raising Awareness Strategy* in Autumn 2021 to "drive Programme Board activities to improve awareness, increase understanding and reduce stigma associated with perinatal and infant mental health [128] ." Publication of this strategy has been delayed until Spring 2022.

237. The Committee is concerned of the stigma associated with perinatal mental health issues and the resulting reluctance for individuals to fully engage with healthcare professionals.

238. The Committee note the delay in publication of the Programme Board’s *Raising Awareness Strategy* and call on the Scottish Government to urgently prioritise its publication. The Committee would also welcome further detail on plans for promotion and dissemination of the strategy.

239. Until the strategy is published, the Committee seeks reassurance that the Scottish Government, supported by all other stakeholders involved in delivery of perinatal mental health services, is taking action to address the issue of stigma and to give new mothers engaging with perinatal mental health services confidence that they will not be judged or stigmatised by doing so.

The impact of the pandemic

240. The Covid-19 pandemic has increased the mental health risks new and expectant mothers face. The impact of COVID-19 on perinatal mental health was evident in both the informal meeting on 6 December and the written submissions to the Committee's call for views.

241. Aberlour stated that their services saw an "increase in the number of women in their perinatal period experiencing suicidal thoughts and ideation during the pandemic [129] ". The Royal College of Psychiatrists in Scotland said that the Covid-19 pandemic has had a considerable impact on the mental health of women and families as well as mental health services. They reported it has also exacerbated pre-existing need and gaps in care provision [130] .

242. During an informal meeting of the Committee on 6 December 2021, individuals gave accounts of services being stopped or paused during the pandemic:

- Antenatal classes were paused during the pandemic. Some online resources were available but this did not help individuals to feel prepared or help with support networks.
- Prenatally, appointments were paused during the pandemic and scans cancelled. This left individuals feeling anxious, particularly when they could only go for scans on their own.
- Partners were not allowed in hospital during birth, or sometimes were only allowed in for short amounts of time. This resulted in increased feelings of isolation and loneliness, but also led to an increased demand for advocacy support.
- 6-week check-ups following the birth of a baby were not conducted as standard and some that did happen were undertaken over the phone.
- Individuals didn't feel they could approach their GP during the pandemic.

243. In its written submission NHS Forth Valley reflected:

> The pandemic has had a massive impact as most services were stopped overnight and this has not really improved due to the back log which has developed in the meantime. Also as other support structures such as families and the voluntary sector were also unavailable and for some new mothers this was very traumatic and perhaps if those services had been available at the time maybe the current impact would not be as big. Still it is taking time for services and things like baby groups to get back up and running. As health visitor we are still not able to offer an antenatal visit due to lack of staff which also has an impact [131] .

244. A practicing health visitor highlighted the importance of in person antenatal classes and parent and baby groups:

> During lockdown these valuable classes ceased and new mums often found themselves increasingly isolated indoors at home often with no meaningful support other than from partners or family. Thus, when lockdown restrictions eventually eased, those affected often developed decreased self-confidence with many feeling anxious about coping when socialising with others, having fear of Covid infection or else worrying about how their babies would react to the outside world [132] .

245. A number of submissions also highlighted the impact of not having friends and family able to support them at appointments:

> I was alone when I found out my baby didn't have a heartbeat. My partner was sitting in the car outside. A mother should never have to go through this alone, and a father should never have to comfort his partner over the phone when he could be there in person. Due to restrictions in place at the time my friends and family were unable to support and comfort me, it definitely affected my recovery period [133] .

246. NHS Lothian stated in their submission that some staff were concerned about the impact of some COVID-19 policies on the mental health of women and their infants, particularly those admitted as inpatients. Specifically, these concerns related to the lack of visitors, the need for self-isolation and the policies relating to isolation following exposure to a contact who has tested positive for COVID-19. The submission indicated there was anecdotal evidence to suggest mothers were declining hospital admission because of restrictions on visitors [134] .

247. Individuals told the Committee during the informal meeting on 6 December that they found services to be disjointed, a lack of communication between services and a lack of continuity, with one individual reporting they were unable to see the same midwife twice. This lack of continuity has meant midwives are unable to notice that support is needed pre and post-birth.

248. At that same meeting, individuals also told the Committee they had experienced increased anxiety around the vaccine, hospital restrictions, shielding and isolation, and what to do when discharged from hospital. They highlighted that there was inconsistent or no guidance to support new parents in these areas.

249. Multiple submissions also mentioned that pregnant women were concerned about the potential impact of COVID-19 on their pregnancy. Sands commented that, in the feedback they had gathered from pregnant women, bereaved parents and their families, many women said they were unsure whether it was safe to attend hospital and to contact professionals if they had concerns about their pregnancy [135] . Aberlour also noted that there was anxiety around contracting the virus, and that this was further exacerbated by perceived conflicting advice around vaccination during pregnancy [136] .

250. At the informal meeting on 6 December, individuals also noted how difficult it was to access GP services for their children. Individuals reported the traumatising experience for both parents and children of administering PCR tests to a baby but at the same time being prevented from seeing a GP or healthcare professional unless they could show a negative result. Help and support was often delayed until

a negative result had been reported.

251. As an associated issue, the Committee also heard at the informal meeting on 6 December 2021 that GP appointments were very hard to access during the pandemic, especially for working parents. If an individual couldn’t access the GP they couldn't get referred. If discharged from a service, individuals have to start at the beginning again and try to access the GP.

252. At the same time, the Committee also heard some accounts of positive experiences during the pandemic. Participants highlighted positive experiences of using befriending services during the pandemic, at a time when other support networks and groups were unavailable. Others reported positive outcomes from using phone and online resources. Some individuals found digital resources preferable to meeting face-to-face and felt more comfortable using a digital platform . Closed groups and peer support networks also provided safe spaces to seek support during the pandemic. Some acknowledged that the support they were able to access during the pandemic was better than they had expected it would be. Maternal Mental Health Scotland acknowledged in their submission that digital services can be a preferable option and fulfil an important role for some individuals [137] .

253. While acknowledging that, as essential services, maternity services and infant feeding teams were protected, the Committee has heard concerning evidence that many other types of professional and community support were unavailable during the pandemic.

254. The Committee has been concerned to hear evidence that, in many instances, Covid-related restrictions severely impacted the support women were able to receive from partners and families during the perinatal period, and the associated rise in incidences of birth trauma.

255. The Committee wishes to highlight that these negative experiences during the pandemic will have knock-on effects on the mental health of those women affected throughout and beyond the perinatal period.

256. The Committee therefore calls on the Scottish Government to undertake a review of perinatal mental health service provision during the pandemic to ensure appropriate lessons are learned for the future.

257. The Committee has also been concerned about evidence heard that individuals have been unable to access GP appointments to suit their circumstances, which has impacted their ability to access perinatal mental health services. It calls on the Scottish Government to outline what action it is taking to ensure alternative routes are available for referrals into perinatal mental health services to ensure no-one is missed due to pressures caused by the pandemic.

Annexe A - Summary of recommendations from the written call for evidence

258. Respondents to the call for views were asked: *How can the Scottish Government improve perinatal mental health services in Scotland, both in the short term and over the next five years?* 94 out of the 99 responses provided an answer for this question. Below is a summary of these responses.

Role of the third sector
Increase financial investment in third sector support, especially longer-term funding.
Build partnerships between the NHS and the third sector to increase collaboration and parallel working.
Work with the third sector to increase the number of trained volunteers available from organisations.
Increase the recognition of the value and importance of third-sector support.
Expand the use of third-sector tools, such as the Sands Maternity Bereavement Experience Measure, into NHS Boards.
Closer working between statutory services and the third sector to ensure integration of care, where services overlap.

Workforce
Undertake a review of current ways of working in the NHS across primary and secondary care.
Commit to reviewing workforce planning in the short, medium, and long-term and to ensuring adequate support for career development, teaching, training, and supervision.
Increase the number of staff available – particularly midwives, psychologists, therapists, health visitors, and community mental health nurses.
Improve and increase the training available for healthcare professionals, particularly midwives and health visitors, on key topics – such as: • Support for breastfeeding • Having conversations around perinatal mental health and active listening • Birth trauma • Understanding specific mental health conditions and their impact on perinatal mental health • Bereavement • Early detection of perinatal mental ill-health
Target perinatal mental health education at Undergraduate level. This could include ensuring that all Midwifery courses have modules on perinatal mental health, providing funding for students who wish to specialise in perinatal mental health, and investing in counselling qualifications.
Increase the number of home-visits by midwives and health visitors.
Increase the use of lived experience in the training and education of health professionals.
Increase the number of mental health workers who are based-in and located around GP practices.
Facilitate additional training for professionals in other mental health services who may have significant contact with women experiencing perinatal mental illness.
Continued investment in the National Trauma Training Programme.

Scottish Government Policy & Implementation

Listen to and utilise lived experience when developing perinatal policy.
Each NHS Board should have a Specialist Perinatal Mental Health Service, covering both the antenatal and postnatal period. These services should be community-based.
Local Community Mother and Baby Units should have a dedicated midwife or health visitor attached to them.
Reduce local variations in perinatal services.
Increase the focus on prenatal care, particularly as a preventative measure.
Ensure that women and their birth partners do not need to travel long-distances to give birth, including reinstating the full maternity service at Dr Gray's Hospital in Elgin and having a consultant on-site at Caithness General Hospital.
Provide travel expenses to anyone who is required to travel over a certain number of miles to access care.
Increase the number of beds at Scotland's two MBUs and better accommodate the long-distance which many mothers and partners may need to travel to access them.
Establish dedicated support for all parents who experience a bereavement, with those who need specialist psychological support able to access it.
Ensure that every mother receives visits from a trained expert in perinatal mental health to assess their mental well-being throughout the perinatal period.
Increase the provision of peer support, such as local support groups.
Assess the current referral standards for patients, with a particular focus on if the 'bar' is currently too high for perinatal mental health.
Work to reduce waiting-times for referrals to community mental health teams.
Improve local perinatal pharmacy services, including ensuring that pharmacy is a named profession within perinatal mental health multidisciplinary teams.
Establish national benchmarking for perinatal service provision.

Access and pathways

Improve the integration of services, including: • The transition for families being discharged from Perinatal Mental Health services into adult mental health services. • The transition into community care after being discharged from hospital after birth. • Closer connections between regional MBUs and local perinatal mental health teams.
Improve access to support available for partners, families, and significant others impacted by perinatal mental ill-health and/or bereavement.
Easier and more regular access to gynaecologists, without having to have a referral by a GP.
Automatic referrals (opt in/out service) for individuals identified as at-risk of developing perinatal mental health problems and an increased focus on 'reaching out' to mothers.
Creation of a 24/7 bereavement helpline for mothers, partners, and families.
Evaluate the current use of the Edinburgh Postnatal Depression Scale (EPDS) and determine where improvements can be made in assessing perinatal mental health.
Reduce waiting-times for psychological interventions where a referral has been made.
Evaluate national timescales around assessment and treatment for women in the perinatal period.

COVID-19

Restart mandatory face-to-face antenatal classes across all NHS Boards.

Reduce local variation for Health Visitors and Midwives performing home-visits rather than virtual appointments.

Improve access to face-to-face services where they are preferred and/or more appropriate.

Conduct ongoing reviews of the potential impact that COVID-19 policies may have on service provision for perinatal mental health, including:

- Visiting policy.
- Isolation policy for mothers and babies.
- Wearing of masks in ward environments.

Undertake a review of the impact that remote working has had on perinatal mental health services, including positive learning that the NHS can build on going forward.

Undertake a risk-assessment of virtual and remote appointments, including their impact on perinatal mental health and socioeconomic barriers to accessing remote services.

Undertake an assessment of the wellbeing impact that COVID-19 has had on NHS staff working in perinatal care.

Public awareness and education

Publish more online resources on key perinatal mental health topics and outline what support is available.

Expand the support available into helplines, online-hubs, and in-person hubs.

Encourage more open and honest conversations and aim to reduce the shame and isolation which new mothers can experience around their mental health.

Tackle stigma and fears around perinatal mental health, including concerns that mothers may have their children ‘taken away’ from them if they are struggling with their mental health or have a disorder.

Increase awareness and education on the impact that breastfeeding can have on a mother’s mental health.

Promote the Perinatal Mental Health Network more widely.

Improve accurate information on the use of medication in pregnancy and throughout breastfeeding.

At-risk and vulnerable women & equalities

Assess perinatal services to identify inequalities and gaps in current service provision.

Improve early identification for at-risk and vulnerable women, including women with a history of mental ill-health, those who have experienced post-birth trauma, and/or those who have suffered a bereavement.

Increase the support available for women identified as at-risk and vulnerable.

Improve the information available for women who have had a mental illness or have suffered from mental ill-health in the past.

Establish a whole-systems approach to health inequalities, the intergenerational transmission of mental health, adverse childhood experiences, and the impact of poverty on women, infants, and their families.

Improve the integration of universal, secondary, and tertiary care for women with co-morbidities, substance-abuse, and/or other complex health needs.

Annexe B - Private informal engagement event summary

The Committee met with individuals with experience of perinatal mental health issues on Monday 6 December as part of the its inquiry into perinatal mental health. The individuals were supported by the following organisations:

- Home Start Scotland,
- Aberlour,
- Fife Gingerbread, and
- Mind Mosaic

Below is a summary of points raised during the sessions.

Accessing support

- Lack of information of the support available or how to access support.
- Some individuals noted reticence in asking for help as they were unsure if their feelings were normal for the perinatal period or they didn't feel bad enough to get support.
- Lack of trust with healthcare professionals. A number of individuals noted a reluctance to share details with clinicians for fear that their babies would be taken away.
- Lack of support for single dads – an individual noted that services only seemed willing to speak with a woman.
- Lack of support for partners.
- Lack of support for working parents with services largely only available midweek during the day. Once referred, services were accessible out of hours on some occasions.
- Uncertainty for asylum seekers on knowing their rights and what support was available.

Referrals to statutory services

- In a number of cases individuals were referred successfully through the GP.
- However, GP appointments were very hard to access during the pandemic, especially for working parents. If an individual couldn't access the GP they can't get referred. If discharged from a service, individuals have to start at the beginning again and try to access the GP.
- Referrals were to a number of different services, for example psychiatrists, perinatal mental health teams, mental health hospitals, mother and baby units.

- Some services had long waiting lists.
- Some of these referrals were inappropriate and the services were unable to help with perinatal issues.
- There were multiple examples of being repeatedly referred into services, however, also repeatedly discharged without follow-on support or treatment.
- When the right service was referred, such as to local perinatal mental health teams, a number of experiences were positive and support made a difference.

Statutory services

- Services did not always take pre-existing mental and physical conditionals into account. Where this was the case, experiences were not positive.
- Initial assessments were not always tailored to the individual and not relevant to their circumstances, which left individuals feeling alone and unsupported.
- There was a postcode lottery of services. For example some individuals could not access support near their home, some had to travel long distances for support services, some had to travel long distances for basic maternity services, including giving birth. The availability for additional support midwives also depended on the geographical area.
- If individuals did not want to take prescribed medication, they were deemed as not engaging with services and discharged from the service.
- Individuals spoke of a standard number of support sessions. Once these were completed, individuals were discharged from the service without further support. They would end up back at the GP to be referred to other services. They reported starting to feel comfortable with services just as support was withdrawn and they would have to start again.
- Some individuals reported disparaging remarks from healthcare professionals about people with mental health problems, with assumptions made over alcohol and smoking.
- Lack of follow-up treatment following being discharged from services.
- Some individuals noted support while they were in hospital, but there was no support once discharged. Others noted good support from community midwives to then go on to have bad experiences in hospital.
- Many felt isolated and lonely within statutory settings or accessing statutory services from home.
- Participants noted a disconnect between health visitor, GP and mental health services.

Referrals to third sector services

- Midwives mentioned and recommended third sector support services, however this was not always taken up.

- One individual noted they only accessed support when the midwife helped them complete the application.
- Individuals noted a lack of information and awareness from statutory providers on third sector services and what support is available.

Third sector services

- All individuals noted positive experience with third sector services, even where services were not face-to-face due to the pandemic.
- It was felt that organisations had more time to talk to individuals.
- In particular, befriending services were noted to be very helpful, especially in combination with other services or medication.
- A number of participants noted that they would not have coped without the support offered by third sector organisations.
- Organisations were able to provide support for a range of people in a range of different circumstances – something statutory services were not as good at.
- Support was tailored to individuals, not a one size fits all.
- Once individuals accessed third sector services, it was then easier to access other services.
- Individuals were more willing to open up to a charity, not linked to NHS or social services.
- Quicker and easier to access services than statutory services.

Impacts of the COVID-19 pandemic

- Individuals didn't feel they could approach their GP during the pandemic.
- 6-week check-ups following the birth of a baby were not conducted as standard, some were undertaken over the phone. One individual noted 'but you can hide on a phone call'
- Prenatally, lots of appointments were stopped during the pandemic and scans cancelled. This left individuals feeling anxious, particularly when they could only go for scans on their own.
- Antenatal classes were stopped during the pandemic. Some online resources were available but this did not help individuals to feel prepared nor did it help with support networks.
- A number of individuals felt cheated or had a sense of loss in their birth experience due to the pandemic.
- Individuals noted a lack of continuity. One individual was unable to see the same midwife twice due to COVID-19, meaning midwives were unable to notice that support was needed pre and post-birth.

- Partners were not allowed in hospital during birth, or sometimes were only allowed in for short amounts of time. This impacted on isolation and loneliness, but also advocacy support.

- Parents had to travel long distances, only to have to choose between waiting outside in the car until the initial stages of labour were sufficiently advanced for both parties to be admitted or be admitted alone.

- Individuals noted nurses were very busy after the birth and didn't have a lot of time, this was particularly felt around breast-feeding support.

- Breastfeeding support through the pandemic was not particularly effective, being delivered either via online/phone consultations or else nurses being unable to touch mother or baby.

- Family Nurses and Health Visitors were found to be very supportive but didn't have time for longer or as many visits as was felt necessary.

- There was increased anxiety around the vaccine, hospital restrictions, shielding and isolation, and what to do when discharged from hospital. There was inconsistent or no guidance to support new parents.

- Individuals noted disjointed care when they came home from hospital. An individual also noted the lack of communication between services.

- Individuals were not always supported and the reason was always that it was due to the pandemic and they had to 'get on with it'.

- Individuals felt it was hard to build trust when consultations were not face to face.

- Some individuals felt that emerging from pandemic was almost as stressful as going into it.

- Access to GP services for young children was also noted to be difficult during the pandemic. Individuals reported the traumatising process for parents and children of administering PCR tests and being unable to see a GP or healthcare professional without a negative result. Help and support was often delayed until a negative result was reported.

- One organisation noted that the link between poverty and poor perinatal mental health increased during the pandemic.

- Participants noted that befriending services were useful in the COVID-19 context, with other support networks and groups being unavailable.

- Others noted some good outcomes using phone and online resources. Some individuals found digital resources better and felt comfortable going on a digital platform whereas they might not have opened the door to face-to-face support. Closed groups also provided safe spaces and peer support networks.

- Some noted that support during the pandemic was better than expected.

Recommendations for improvements

- Restart antenatal classes.

- More people to help in the hospitals and extra, lengthier support.
- Improved breastfeeding support, one participant noted being unable to breastfeed contributed towards their postpartum depression and guilt over feeling like a bad mother.
- Reduce waiting times for services.
- Improve access to services.
- More mother and baby units.
- More information and awareness about what to expect and what support is there.
- More information and awareness for GPs, health visitors, midwives and nurses.
- A team approach would help. You see professionals from different parts of different hospitals, your GP, CPN, your health visitor but they are not all communicating.
- Awareness raising of mental health issues such as psychosis.
- More support for people who have traumatic births – having someone on maternity wards who is a trained perinatal mental health professional would help.
- Information around social services so individuals know what their rights are.
- Change language, for example, the phrase ‘baby blues’ can be condescending and individuals can’t be open and honest about what they’re feeling.
- Update resources, for example, ‘Ready steady baby’ was found to be out of date and condescending.
- More information and support for breastfeeding and allergies.
- More joined up working with different teams, including third sector and statutory services working together creating the best pathways for families.

Annexe C - Minutes of meeting

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

Inquiry on Perinatal Mental Health:

The Committee took evidence from—

Selena Gleadow-Ware, Perinatal Faculty Chair, Royal College of Psychiatrists; Mary Ross Davie, Director for Professional Midwifery, Royal College of Midwives; Dr Arun Chopra, Executive Director (Medical), Mental Welfare Commission and; Professor Marian Knight, Professor of Maternal and Child Population Health, MBRRACE;

and then from—

Cat Berry, Group Facilitator and Volunteer Coordinator, Juno Perinatal Mental Health Support; Joanne Smith, Chair, Maternal Mental Health Scotland; Fiona Challacombe, Patron, Maternal OCD and; Clea Harmer, Chief Executive, Sands.

15th Meeting, 2021 (Session 6) Tuesday, December 14, 2021

Inquiry on Perinatal Mental Health:

The Committee took evidence from—

Kevin Stewart, Minister for Mental Health and Wellbeing, Scottish Government; Maree Todd, Minister for Public Heath, Women's Health and Sport, Scottish Government; Hugh Masters, Chair of the Perinatal and Infant Mental Health Programme Board, Scottish Government; Ruth Christie, Head of Children, Young People and Families Unit, Improving Mental Health and Wellbeing, Directorate for Mental Wellbeing and Social Care, Scottish Government; Kirstie Campbell, Head of Maternal and Infant Health, Improving Health and Wellbeing, Directorate of Children and Families, Scottish Government and; Carolyn Wilson, Unit Head, Supporting Maternal and Child Wellbeing.

Annexe D - Evidence

Written evidence

- Responses submitted to the Committee's call for views.

Official reports of meetings

- Tuesday 7 December 2021- evidence from organisations
- Tuesday 14 December 2021 - evidence from the Perinatal and Infant Mental Health Programme Board and the Scottish Government

1 Published responses for Perinatal Mental Health Inquiry - Scottish Parliament - Citizen Space

2 Mental health care for new mums - gov.scot (www.gov.scot)

3 SIGN 127 • Management of perinatal mood disorders

4 Confidential Enquiry into Maternal Deaths | NPEU > MBRRACE-UK (ox.ac.uk)

5 SIGN 127 • Management of perinatal mood disorders

6 Mental Health Strategy 2017-2027 - gov.scot (www.gov.scot)

7 Delivering Effective Services: Needs Assessment and Service Recommendations for Specialist and Universal Perinatal Mental Health Services

8 Mental health care for new mums - gov.scot (www.gov.scot)

9 Perinatal and Infant Mental Health Programme Board: delivery plan - September 2021 to September 2022 - gov.scot (www.gov.scot)

10 Perinatal and Infant Mental Health Programme Board Delivery Plan September 2021-September 2022 (www.gov.scot)

11 Scottish Parliament Official Report: 7 December 2021

12 Scottish Parliament Official Report: 7 December 2021

13 Scottish Parliament Official Report: 7 December 2021

14 Scottish Parliament Official Report: 7 December 2021

15 Response 733431786 to Perinatal Mental Health Inquiry - Scottish Parliament - Citizen Space

16 Scottish Parliament Official Report: 14 December 2021

17 Delivering Effective Services: Needs Assessment and Service Recommendations for Specialist and Universal Perinatal Mental Health Services

18 Outcomes for women admitted to a mother and baby unit: a systematic review (nih.gov)

19 Perinatal themes visit report: Keeping mothers and babies in mind (www.mwcscot.org.uk)

20 What's a Mother and Baby Unit like? (maternalmentalhealthscotland.org.uk)

21 Perinatal mental health services: needs assessment and recommendations - gov.scot (www.gov.scot)

22 Perinatal mental health services: needs assessment and recommendations - gov.scot (www.gov.scot)

23 Scottish Parliament Official Report: 7 December 2021

24 Scottish Parliament Official Report: 7 December 2021

25 Scottish Parliament Official Report: 7 December 2021

26 Scottish Parliament Official Report: 14 December 2021

27 Perinatal mental health services: needs assessment and recommendations - gov.scot (www.gov.scot)

28 Perinatal and Infant Mental Health Programme Board: delivery plan - September 2021 to September 2022

29 Perinatal mental health services: needs assessment and recommendations - gov.scot (www.gov.scot)

30 Maternal Mental Health Alliance Map of Specialist Community Perinatal Mental Health Teams (Scotland)

31 Response 466886372 to Perinatal Mental Health Inquiry - Scottish Parliament - Citizen Space

32 NHS Lanarkshire written submission

33 Response 244551817 to Perinatal Mental Health Inquiry - Scottish Parliament - Citizen Space

34 Letter from Minister for Mental Wellbeing and Social Care and Minister for Public Health, Women's Health and Sport

35 Letter from Minister for Mental Wellbeing and Social Care and Minister for Public Health, Women's Health and Sport

36 Scottish Parliament Official Report: 15 June 2021

37 Response 237830582 to Perinatal Mental Health Inquiry - Scottish Parliament - Citizen Space

38 Response 868645996 to Perinatal Mental Health Inquiry - Scottish Parliament - Citizen Space

39 Report of the Moray Maternity Services Review: Report

40 Scottish Parliament Official Report: 7 December 2021

41 Response 124778641 to Perinatal Mental Health Inquiry - Scottish Parliament - Citizen Space

42 Response 213756991 to Perinatal Mental Health Inquiry - Scottish Parliament - Citizen Space

43 Response 124778641 to Perinatal Mental Health Inquiry - Scottish Parliament - Citizen Space

44 Scottish Parliament Official Report: 7 December 2021

45 Scottish Parliament Official Report: 14 December 2021

46 Scottish Parliament Official Report: 7 December 2021

47 Response 357754575 to Perinatal Mental Health Inquiry - Scottish Parliament - Citizen Space

48 Response 37281971 to Perinatal Mental Health Inquiry - Scottish Parliament - Citizen Space

49 Scottish Parliament Official Report: 7 December 2021

50 Scottish Parliament Official Report: 14 December 2021

51 Perinatal and Infant Mental Health Programme Board: delivery plan - September 2021 to September 2022

52 More support for perinatal and infant mental health - gov.scot (www.gov.scot)

53 Scottish Parliament Official Report: 14 December 2021

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57 Response 443050921 to Perinatal Mental Health Inquiry - Scottish Parliament - Citizen Space

58 Response 859436461 to Perinatal Mental Health Inquiry - Scottish Parliament - Citizen Space

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63 PMHN-Needs-Assessment-Report.pdf (scot.nhs.uk)

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71 Standards of proficiency for midwives, Nursing and Midwifery Council

72 Response 739833652 to Perinatal Mental Health Inquiry - Scottish Parliament - Citizen Space

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82 Letter from Minister for Mental Wellbeing and Social Care and Minister for Public Health, Women's Health and Sport

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107 NBCP in Scotland | SANDS (nbcpscotland.org.uk)

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109 Letter from Minister for Mental Wellbeing and Social Care and Minister for Public Health, Women's Health and Sport

110 Letter from Minister for Mental Wellbeing and Social Care and Minister for Public Health, Women's Health and Sport

111 Response 1033758413 to Perinatal Mental Health Inquiry - Scottish Parliament - Citizen Space

112 Maternity Bereavement Experience Measure (MBEM) | Sands - Stillbirth and neonatal death charity

113 The best start: five-year plan for maternity and neonatal care - gov.scot (www.gov.scot)

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