Options to Increase Mother and Baby Unit Capacity: Analysis of responses to consultation

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Executive Summary

In Scotland, there are currently two regional Mother and Baby Units (MBUs), one located in Glasgow, and one in Livingston, which cater for women from across Scotland. Each can take up to six women and their babies. One of the recommendations of Perinatal Mental Health Network Scotland in their report 'Delivering Effective Services: Needs Assessment and Service Recommendations for Specialist and Universal Perinatal Mental Health Services' was to create an additional 2-4 Mother and Baby beds, either within existing services or by creating a new MBU in the north of Scotland. Delivering Effective Services also noted that an options appraisal should be conducted to help determine where the additional MBU beds should be sited.

The options appraisal will evaluate potential alternatives based on equity of access, affordability, safety and sustainability. As part of the process, the Scottish Government launched a public consultation in February 2022.

Respondent Profile

In total, there were 236 responses to the consultation, of which 16 were from organisations and 220 from individuals. Respondents were classified according to a wide range of different sub-groups. However, given the very small base sizes across many of these sub-groups, it is often not possible to make meaningful comparisons, although where possible, differences between sub-groups are highlighted throughout the report.

Key Themes

Overall, respondents were very supportive of the service offered by the existing MBUs and would like to see access to these extended to more service users. Views were positive about having an increased number of beds within MBUs and there were high levels of support for the creation of a new MBU in the north of Scotland, principally from respondents located outside the Central Belt who were from the north of Scotland, particularly the Grampian health board area. Aberdeen was the most frequently suggested location. That said, there were some concerns over the likely costs of setting up a new unit as well as concerns over staff recruitment and retention in creating a new unit from scratch. The key advantages to creating a new unit for women in the north of Scotland, aside from access to specialist staff across a range of disciplines and a nurturing environment, were reduced travel distances for service users and proximity to their local support networks. The creation of a new unit or adding beds to existing units is particularly

important given the numbers of respondents who disagreed that there are other ways to provide care for women with severe mental health issues and their infants. The specialist nature of a unit solely catering for mothers and babies is seen to be the best way forward, rather than a general mental health unit.

A number of key themes were evident across questions as well as across respondent groups. These are summarised below.

- A higher proportion of organisations claimed to be 'very' or 'quite familiar' with MBUs, when compared to individuals. Individuals with lived experience of mental health problems in pregnancy or after childbirth who received care and treatment in an MBU, and clinicians in MBU care had higher levels of familiarity with the MBUs than did other individuals.
- The qualitative findings suggest that awareness levels of MBUs are relatively low, both among professionals and the general public and the consultation findings suggest a need to increase awareness among both professionals and the general public.
- A key positive feature of an MBU is that a mother and her baby can be kept together, thus helping to foster the bond and build attachment between mother and baby within a safe and nurturing environment. They are also seen to offer benefits to the wider family with the potential for visits and the availability of family rooms. These elements of service are seen as extremely important and unavailable in other general adult mental health inpatient wards.
- The MBUs are seen to be staffed by well trained and knowledgeable staff who offer specialist perinatal care in a multi-disciplinary team, offering advice and support that are not perceived to be available in other general adult mental health inpatient wards or within community teams.
- The main disadvantage cited by respondents was of the distance some mothers have to travel to access services offered by an existing MBU. There was a perception that some mothers would refuse admission to an MBU because of the distance from other family members and their own support network. As such, significant numbers of respondents would prefer to see a new unit created in the north of Scotland than to have capacity increased in the existing units. While both options would increase capacity, it was felt that regardless of the logistics or cost of

creating a new unit, this would improve equity of access for all mothers, while extending the existing units would not.

- There were some calls for consistent admission criteria to be used across both existing MBUs as well as improvements to the discharge process.
- While the service provided within the MBUs was praised by respondents, and the capacity to access links to community health teams on discharge was also perceived to be very useful, there were some concerns about a lack of follow up services for some mothers and a lack of access to specialist support on discharge. Suggestions were made for upskilling existing staff and recruiting new staff to enable the setup and provision of specific perinatal mental health regional or community teams to meet the needs of more mothers with perinatal mental health issues.
- There was low awareness of the Mother and Baby Unit Family Fund (MBUFF) and only four respondents had used this, all from the Grampian health board area (although it is possible that other respondents who had used an MBU had done so before the MBUFF was launched). Given the distance some mothers had to travel to access services at an MBU, there were some requests for the cap of £500 to be extended and made more flexible. Another issue highlighted was that funds are paid in arrears and some women cannot afford to make financial outlays in advance of receiving funding.
- In relation to creating a new MBU unit in the north of Scotland, a few organisations and individuals felt creating a six bed unit would be more cost effective than a four bed unit, with a health board noting that units smaller than six beds are likely to be less viable. A small number of organisations felt that if there were times where this was not running at capacity, staff could provide specialist outreach services, for example, offering community-based support.

Introduction

Background

1. Mother and Baby Units (MBUs) are designed to provide specialist inpatient support for severe mental health difficulties during the perinatal period, with a focus on keeping mothers and infants together in order to support the mother-infant relationship and promote infant development. MBUs can admit women in late pregnancy and at any point until their baby is one year old.

2. In Scotland, there are currently two MBUs; one at St John's Hospital in Livingston (NHS Lothian) and one at Leverndale Hospital in Glasgow (NHS Greater Glasgow and Clyde). Each can take up to six women and their babies. Current data[1] shows that, while there has been an average of 114 MBU admissions per year to these two units, there were another 124 admissions per year to other in-patient mental health beds. Additionally, across health board areas not hosting an MBU, the data shows that women were more likely to be admitted to a non-Mother and Baby Unit if they required in-patient mental health treatment. It is possible that some of these women would have benefitted from admission to an MBU, however there is no data to evidence this assumption. There are a variety of reasons why it may not be clinically appropriate for a woman to be admitted to an MBU, for example when she is not the primary carer of the infant. A woman may choose alternative treatment, for example if she would prefer to be treated away from her infant.

3. One of the actions of the Mental Health Strategy 2017-2027 was to establish a Perinatal Managed Clinical Network in Scotland with the aim of improving both the recognition and treatment of perinatal mental health problems. The network was established in April 2017. Subsequently, PMHN Scotland published 'Delivering Effective Services: Needs Assessment and Service Recommendations for Specialist and Universal Perinatal Mental Health Services'[2] (March 2019) which assessed need and made recommendations for all tiers of service delivery for Perinatal and Infant Mental Health Services across Scotland. One of the recommendations to emerge from this was the need for an additional 2-4 Mother and Baby beds, either within

[1] https://www.pmhn.scot.nhs.uk/mbu-non-mbu-admissions-report/

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

existing services or by creating a new MBU in the north of Scotland. Delivering Effective Services also noted that an options appraisal should be conducted to help determine where the additional Mother and Baby Unit beds should be sited. Subsequently, the Perinatal and Infant Mental Health Programme Board was established to implement the recommendations of Delivering Effective Services. The Board's view was that in order to properly assess the need for additional inpatient beds, community specialist services should be established first.

4. In March 2019, the Scottish Government announced investment over four years to improve access to mental health services for expectant and new mothers. The Perinatal and Infant Mental Health Programme Board was established in March 2019 to help drive implementation of the Scottish Government's Programme for Government commitments on perinatal and infant mental health. This board provides strategic management and oversight of this investment and the delivery of the recommendations in Delivering Effective Services.

5. In February 2022, the Scottish Government launched a consultation on Perinatal Mental Health, which closed on 31 May 2022. This consultation sought views from stakeholders, including clinicians and those with lived experience, on the needs of women and families in Scotland in terms of perinatal mental health. Alongside the online consultation, a number of consultation events were held and findings from these have been included in analysis of consultation responses.

Respondent Profile

6. In total, there were 236 responses to the consultation, of which 16 were from organisations and 220 from individuals. Respondents were asked whether they were responding as an organisation or individual and were then assigned to respondent groupings to enable analysis of any differences or commonalities across or within the various different types of organisations and individuals that responded.

7. Each organisation was given a category based on its role; Health and Social Care Partnerships, NHS / Health boards, Professional Body / Association and Third Sector. Of the organisations responding, the highest numbers were in NHS / Health Boards (6 of 16 organisations).

8. Individuals were asked to state the capacity in which they were completing the consultation, for example, an MBU service user, non MBU service user, clinician in MBU care or clinician in general mental health community team care and so on. These respondents were also asked to provide details on their age and to provide postcode details so that the health board in which they live could be used in analysis.

9. The largest number of individuals (65) were women with lived experience of mental health problems in pregnancy or after childbirth who received care and treatment in the community from their GP, mental health service or other health professional including third sector services (service user). This was followed by 28 women with lived experience of mental health problems in pregnancy or after childbirth who did not access treatment or services. Only 14 respondents were women with lived experience of mental health problems in pregnancy or after childbirth who received care and treatment in an MBU (service user); and 4 were women with lived experience of mental health problems in pregnancy or after childbirth who received care and treatment in a general adult mental health inpatient ward (service user).

10. The majority of individuals were aged between 25 and 44. In terms of health board area, by far the largest numbers of respondents were based in the Grampian region (121) and 33 lived in the Highland region.

11. Tables A, B and C in Appendix 1 show the number of respondents in each sub-group.

12. A list of all organisations that submitted a response to this consultation is included in Appendix 2.

Methodology

13. Responses to the consultation were submitted using Citizen Space, the Scottish Government consultation platform, or by email. The Scottish Government also held a series of seven consultation events which were attended by a total of 25 individuals.

14. It should be borne in mind that the number responding at each question is not always the same as the number presented in the respondent group table. This is because not all respondents answered all questions. This report shows the number of respondents who commented at each question. Where closed questions were asked, the data is presented in numeric tables. However, most of the analysis was qualitative in nature and when referring to respondents who made particular comments, the terms 'a small number', 'a few' and so on have been used. As a very general rule of thumb it can be assumed that: 'a very small number' indicates around 2-3 respondents, 'a small number' indicates around 4-5 respondents; 'a few indicates around 6-9. Where 10 or more respondents have commented on a specific issue, we have expressed this figure as one in four / six / ten etc in an attempt to quantify the strength of views.

15. The researchers examined all comments made by respondents and noted the range of issues mentioned in responses, including reasons for opinions, specific examples or explanations, alternative suggestions or other comments. Grouping these issues together into similar themes allowed the researchers to identify whether any particular theme was specific to any particular respondent group or groups. In many instances the same issues were raised by respondents across all sub-groups and the report highlights instances where there are differences between sub-groups.

16. When considering group differences however, it must also be recognised that where a specific opinion has been identified in relation to a particular group or groups, this does not indicate that other groups did not share this opinion, but rather that they simply did not comment on that particular point.

17. While the consultation gave all who wished to comment an opportunity to do so, given the self-selecting nature of this type of exercise, any figures quoted within this report in relation to the findings from this consultation analysis cannot be extrapolated to a wider population outwith the respondent sample. In terms of specific health boards,

Highland and in particular Grampian are over-represented due to the higher numbers of individuals within these two areas who responded to this consultation; these respondents may also be more engaged with the topic of MBUs. Together these health board areas make up two in three of the overall respondent base.

18. Given the skewed base sizes across many of the sub-groups amongst health board areas, the different capacities in which individuals responded, and the small number of responding organisations, it is not possible to make many meaningful statistical comparisons. Where there is a clear bias, however, differences between sub-groups are highlighted.

19. A pro-forma was developed for use at the consultation events to record all points and issues raised. This contained six questions, five of which were very similar to those asked in the consultation paper. Questions 1 and 2 asked about the benefits and disadvantages of expanding one or both of the existing MBUs. Questions 3 and 4 asked about the benefits and disadvantages of creating a new unit. Question 5 asked for suggestions for another way that this duty could be fulfilled if not through expanding existing MBUs or creating a new unit in the north of Scotland. The final question asked what would help women and families with travel to an MBU.

20. These pro-formas were provided to Why Research for inclusion in analysis with the consultation responses. The findings from each event were included in analysis at the relevant questions. By and large, the same issues were raised in responses to the consultation and at consultation events. Where different issues were raised at consultation events, these are highlighted in the report.

Mother and Baby Units (MBUs)

21. Section 31 of the Mental Health (Scotland) Act 2015, 'Services and accommodation for mothers', imposes a legal duty on health boards 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 infant. It is widely accepted that suitable facilities are those provided in dedicated mental health MBUs, staffed by professionals with appropriate training and expertise.

22. MBUs sit within a range of interconnected services, recommended by Delivering Effective Services, which address the needs of women, infants and their families who experience mental ill health in the perinatal period. These include specialist community perinatal mental health teams, maternity and neonatal psychological interventions services, wider infant mental health provision, the third sector and peer support. These are complemented by universal maternity and primary care provision and by general mental health services.

23. The first question asked,

Q1: 'How familiar are you with the Mother and Baby Units (MBUs) that exist currently?'

24. As Table 1 demonstrates, a higher proportion of organisations claimed to be 'very' or 'quite familiar' with MBUs than individuals (75% of organisations compared to 31% of individuals). Conversely, a higher proportion of individuals claimed to be 'a bit' or 'not at all familiar' with MBUs (53% of individuals compared to only 12% of organisations).

25. Among specific sub-groups, individuals with lived experience of mental health problems in pregnancy or after childbirth who received care and treatment in an MBU and clinicians in MBU care had the highest levels of familiarity with MBUs. Levels of familiarity among other types of clinicians tended to be split between those who had low levels of familiarity ('a bit familiar' or 'not at all familiar') and those who were more familiar ('familiar', 'quite familiar' or 'very familiar').

Table 1: Familiarity with MBUs

	Very familiar %	Quite familiar %	Familiar %	A bit familiar %	Not at all familiar %
Organisations	**56**	**19**	13	6	6
Individuals	14	17	16	**25**	**28**

26. Respondents who claimed to be familiar with existing MBUs were then asked a series of questions, the first of which asked what they felt worked well in the MBUs.

What works well

27. A total of 138 respondents answered this question.

28. The most mentioned element – and cited by around half of these respondents – that was considered to work well was that a **mother and her baby can be kept together**. This helps to foster the bond and build attachment between mother and baby within a safe nurturing environment.

29. Another element considered to work well by around a quarter of the respondents answering this question was the **staff**. There were comments on them being **well trained and knowledgeable, offering specialist perinatal care as well as advice and training on perinatal mental health issues**. There were also some references by around one in ten respondents to the staff being dedicated and offering access to highly effective multidisciplinary teams.

30. Other elements that work well and which were each mentioned by around one in six respondents included the individualised care that is available on a one-to-one basis, the availability of specialist treatment and care and the safe and nurturing environment in which care can be accessed. Higher numbers of individuals with lived experience of an MBU commented on the safe and nurturing environment.

31. While many respondent comments focused on the specialist care available to mother and baby, around one in six respondents also referred to benefits for the wider family. These included other family members being able to visit and the availability of a family room. The advantage of this is that bonds can be built between the baby and other family members and the mother can be supported by her family network.

32. A similar number of respondents also mentioned the benefits of having links with services local to the mother on discharge. These included links to community perinatal mental health teams and other agencies offering advice and support. A professional body / association referred to good interagency working being central to the service available.

33. Other elements of the service felt to work well by smaller numbers of respondents (less than one in ten) included:

- The availability of nursery nurses to help the mother, or access to in-house childcare.
- The availability of peer support and organised activities which help mothers to develop friendships and engage with the other mothers and their babies.
- The purpose built environment.
- The MBU environment being less intimidating than some other hospital environments due to the small numbers of patients at any one time. Allied to this point, there were a small number of comments that the MBUs help to reduce the stigma that might be felt by some mothers due to the non-judgemental support that is offered.

34. There were a few positive comments from individuals who had experience of an MBU and a similar number had heard positive comments about the service but had no actual experience.

35. To sum up some of the elements that are perceived to work well, a third sector organisation which claimed to be 'very familiar' with the MBUs commented:

> "We believe it is vital that women with severe perinatal mental illness have access to a knowledgeable specialist perinatal team during inpatient care. MBU's are able to provide this specialist care where general psychiatric units are not. Women in our network tell us that being able to work with nursery nurses and psychologists to support their confidence in bonding and baby care is extremely beneficial in recovery. Women value OT input to engage in activities with their baby both within hospital and planning for when they go home. In addition, perinatal psychiatry specialists are more able than generalist psychiatrists to advise on recovery, and

the safety of medications during breastfeeding, and the efficacy of medications for perinatal illness."

36. One professional body referred to MBUs having developed the facilities to enable remote consultation and engagement with inpatient care. They suggested there is potential to develop this element of the service further to other non-regional partners and non-specialist inpatient units, in conjunction with specialist community perinatal services, albeit there will be some individuals who are not digitally included and would not be able to benefit from such a service.

What does not work well

37. Respondents who claimed to be familiar with existing MBUs were then asked to identify what does not work well; 151 respondents opted to provide a comment. The key response and mentioned by over half of these respondents was that the **existing units** (in Greater Glasgow and Clyde and Lothian Health Boards) involve some mothers having to **travel a relatively long distance to access the service**. This issue was particularly raised by four in five individuals who either had lived experience of mental health problems in pregnancy or after childbirth and received care and treatment within the community or those who did not access treatment or services. Allied to this, around a quarter of respondents noted the **distance from friends and family also means that mothers will be cut off from their support network** at home. Furthermore, around one in ten respondents noted that the **distance to the MBU can be damaging to other family relationships**; for example, other family members lose out on bonding and developing a relationship with the baby. There were also a small number of comments on the costs to family and friends who wish to stay nearby to support the mother and baby or the lack of accommodation for families.

38. Around a quarter of the respondents (and notably by four in five clinicians in maternity / neonatal care) also referred to the **difficulties of accessing a bed in a MBU** because of the limited number of available beds and a corresponding **lack of capacity**.

39. While there were some positive comments at the previous question about the benefits of having links with local services such as community perinatal mental health teams

and other agencies, there was a degree of criticism from around one in ten respondents about the lack of follow up from local services, a lack of perinatal knowledge locally or a lack of access to specialist support on discharge. Around one in twenty respondents also referred to a lack of communication between different services.

40. A lack of awareness or knowledge about the MBUs by GPs and some other professionals was cited by less than one in ten respondents. A very small number of respondents also referred to a lack of awareness of how to access mental health services or knowing about referral pathways and signposting of services.

41. Other elements that were not perceived to work well, and mentioned by small numbers of respondents included:

- Issues over the referral process and criteria for admission to an MBU. One individual commented that the two existing MBUs have differing criteria and thresholds for admission.
- Shortcomings in discharge planning.
- A lack of access or admission to an MBU or continuation of treatment after a baby is 12 months old.
- Inequity in access to care across different health boards as not all health boards have contractual agreements for the provision of mother and baby inpatient care.
- During periods of low occupancy, staff from MBUs are diverted to other non-perinatal wards. This was seen to be a lost opportunity for specialist staff to support other perinatal activities or provide outreach to other non-specialist settings.

Issues accessing the service

42. Respondents were then asked to say what can make it hard for a woman to access the service and 176 opted to provide comments; in many instances, elements of the service that can make it hard for a woman to access were cited by higher proportions of organisations than individuals. Linked to comments at previous questions, the key barrier – cited by around two in three respondents – was perceived to be the **location of the two existing MBUs** and the lack of a local MBU for many women. In line with this, there were also comments from around four in ten respondents that mothers

from outwith the area might not want to leave their family and be separated from their support networks and other children.

43. Other issues raised included a lack of childcare provision and support for other children or a fear of losing their baby by asking for perinatal mental health support and advice.

44. There were a few references to the family fund and that its current limit on £500 – regardless of location – can place limitations on families having to travel a distance to visit a mother in an MBU. One example provided was that a family in Cumbernauld travelling to the MBU in Glasgow could claim for daily visits for a month by bus but that a family in Aberdeenshire could barely cover one or two visits because of the costs of fuel and accommodation. There was also a comment that the family fund is paid in arrears and that upfront costs for some visitors are not affordable for many families. There is more information on a later question which specifically asks about the Mother and Baby Unit Family Fund (MBUFF).

45. In line with issues raised at previous questions there were also comments on:

- A lack of awareness and knowledge of the units, a lack of professionals knowing about referral pathways and thresholds for admission, together with a lack of signposting to the units.
- The stigma or shame that may be felt by some mothers in admitting perinatal mental health problems and asking for help.
- The limited availability of beds in the existing MBUs.
- A lack of accommodation for partners and / or other family members.
- Referral criteria being set too high or issues over the referral process such as the lengthy referral time.

Suggested improvements

46. The final part of this question then asked respondents what improvements they would suggest. A total of 162 respondents provided comments.

47. In the light of a number of comments to the previous questions, it is not surprising that a number of the comments made by respondents referred in some way to the

geographic location of units and the need for equity of access. Just over four in ten respondents requested an additional unit in the north of Scotland, with some of these referring specifically to the Highlands, NE Scotland or Aberdeen. Perhaps not surprisingly, the highest levels of support for an additional unit in the north of Scotland came from respondents based in the Grampian Health Board (three in five of these). As noted by one individual:

> "Adding beds to the existing MBUs is the cheapest/ easiest option for the NHS but it is NOT in the best interests of the remote and rural populations of Scotland. The dualling of the A96 will bring Inverness within an hour of Aberdeenshire, there is already a well trodden path (and ambulance service) from the Highlands & Islands into Aberdeen for medical treatment. It's the next biggest population centre and it makes sense to locate it there."

48. Around a third of respondents requested a **minimum of one more unit(s) elsewhere in Scotland** without reference to any particular geographic area(s). There were a small number of suggestions for an MBU within each health board area. Smaller numbers of respondents also asked for more beds or more MBUs without specifying any potential location(s) and a very small number suggested additional beds in the existing two MBUs.

49. There were a number of references to the **provision of additional support** in some shape or form. These included requests for more financial support for women and their families who have to travel a distance to an MBU; access to childcare provision for other children within the family; and improved accommodation for partners and other family members.

50. The **set up and provision of specific regional or community teams** was suggested by around one in seven respondents, with references to the potential to offer local outreach facilities or to have local centres offering outpatient services for perinatal mental health. Allied to this, there were also suggestions for **more midwifery and health visitor training and better perinatal education for staff** who support women through maternity services. There were also a small number of suggestions for better links across health boards and third sector providers. One health board suggested the Livingston MBU could employ a Band 7/8A PNMH (Perinatal Mental Health) clinician to be available in the Highland area and noted this

model has worked well in the NOS CAMHS Network (North of Scotland Child and Adolescent Mental Health Service).

51. Other references were in line with comments at previous questions, each noted by small numbers of respondents and including:

- Increasing awareness of perinatal mental health conditions was cited by around one in ten respondents. One individual referred to 'perinatal health champions' but felt this does not work in practice as many are professionals with no experience of perinatal health or with the necessary specialist training.
- Improvements to discharge planning; one example given was for the provision of step-down accommodation.
- Standard referral pathways.

52. The final question in this section of the consultation paper asked:

Q3: 'If you have lived experience of mental health problems in pregnancy or after childbirth, is there anything else you want to tell us about your experience of care?'

53. A total of 112 respondents – almost all of them individuals - made comments at this question. A number of key themes emerged from the answers as delineated below. **A large majority detailed negative experiences**.

54. The highest numbers of respondents – almost one in three – complained about a **lack of support**, albeit with some of these stating this was due to Covid lockdowns. Many of these individual respondents (mainly lived experience receiving care and treatment in the community or who did not access services) however cited other difficulties accessing support such as the following instance:

> "It's patchy to the point of being pointless. I was told by a psychiatrist that "women like me get better on their own" when I was a depressed, suicidal new mum. The second psychiatrist thought that being sent away to a mum and baby unit wouldn't work due to distance as we live in Aberdeenshire. There was no continuity of care and limited support available. Ultimately I'm still here because my husband stepped up." (Lived experience, care and treatment in the community)

55. A significant minority of respondents (one in five, all of whom were located in the NHS Grampian, Highland and Tayside Health Board areas) highlighted **concerns over the distances to MBU care**. There were several examples quoted of refusing treatment or a reluctance to seek help at MBUs because they were too far away; in this context a need to have friends and family nearby was regarded as a necessity. In connection with this, slightly smaller numbers of respondents (almost all from the Grampian Health Board area), advocated the need for a more local service, referring to a perceived lack of MBUs, perinatal health or mental health support services in Aberdeen, the north-east or far north of the country. The following example summed up these issues:

> "Mothers in the north of Scotland are missing out on essential care, opting to be treated in the adult acute ward at ARI or not be treated at all because the facilities are all in the central belt. The impact this has on families cannot be underestimated". (Lived experience, care in an MBU)

56. A significant minority of respondents (from across different sub-groups) reported problems with perceived **inexperienced and insufficiently trained staff**. In particular it was claimed by those with experience in general psychiatric wards or under the care of general adult mental health teams that they have missed out on appropriate care and that there is a need for up-to-date training of health professionals such as midwives and health visitors in mental health generally or perinatal mental health specifically. There were also a few remarks about a lack of specialist or in-depth assistance, with perceptions that health visitors, midwives, GPs or staff on general psychiatric wards cannot give the specialist help needed; in particular there were a few complaints specifically about a perceived lack of GP knowledge or understanding of the issues, with claims of them being too quick to treat mental health issues with prescriptions and medications, being unable to diagnose illnesses, and a perception that they are not interested in getting to the roots of problems.

57. A few or small numbers of respondents each also made the following comments about staff:

- A lack of staff - in particular a lack of access to health visitors and midwives - or too much reliance being placed on bank staff.

- Staff being too judgemental and unwilling to listen to patients.
- A lack of awareness amongst staff (GPs, health visitors) about support available to mums with post-natal depression (PND).

58. In connection with the last point, there were a few requests for more information about the specialist mental health help available, with several individuals unaware that it existed.

59. Roughly one in ten respondents (mainly lived experience receiving care and treatment in the community or who did not access services) claimed a **lack of early support or timely help**, citing an inability to get appointments or long waiting lists from services including psychological services. A very small number said they needed to go privately to get mental health support, psychiatric care or counselling.

60. There were also a few comments about a lack of support being available in certain specific circumstances, most notably after a child reaches a certain age (perceived by respondents who commented as being a few weeks) when it was perceived that the mother cannot be referred for post-natal depression. This was pinpointed as an issue as mental health problems do not necessarily happen immediately after birth. There were also requests for more perinatal care, comments about poor care on the postnatal ward and a need for continuing care to be provided after discharge from an MBU. Additionally, a couple of respondents said that there had been no space for them at an MBU.

61. Small numbers of other negative comments about experiences of mental health care were made as follows:

- A lack of continuity of care, with comments about the importance of building a relationship with staff, long periods between appointments, and feeling abandoned later on after good initial support from health visitors and doctors.
- Trauma and mental health problems being unrecognised at the time, with a perception that the definition of birth trauma is limited to still birth or miscarriage.

62. A small number commented that there is a reliance on third sector or charity support to cover gaps in NHS mental health services. There were also a small number of remarks stating that family support was essential in getting better, with a couple of comments regarding MBU admittance as being essential if no family support was

available; and a small number of requests for family members to receive more support themselves.

63. Amongst the large minority of comments about positive experiences received, a wide variety of facets were mentioned, each by a few or small numbers of respondents. These included the following:

- Positive comments about staff, with mentions of them being welcoming, attentive, non-judgemental, supportive, and providing good continuity of care.
- Positive comments about help from GPs, with smaller numbers of similar mentions about help from health visitors (e.g. giving an early referral) and midwives.
- Positive comments about specialist care offered, in terms of kindness, empathy, being judgement free; perinatal mental health nurses, perinatal psychiatrists and therapists were all specifically mentioned in this context.
- Positive comments about support from the charity LATNEM (Let's All Talk North East Mums) and other support groups e.g. *"If it wasn't for the support from LATNEM I wouldn't be aware of the mental health services in the north east"*. (Lived experience, care and treatment in the community). Almost all of these remarks were made by lived experience, care and treatment in the community respondents from the Grampian Health Board area.
- Positive comments about MBUs in Livingston and Glasgow, e.g. "If I had not been offered a bed in the mother and baby mental health unit in Livingston, I believe I would have taken my own life. The specialist care they offer is incredible, judgement free and delivered with huge kindness and empathy". (Lived experience, care in an MBU)

64. There were a small number of references citing the importance of early identification of issues and quick referrals in making sure the system works well.

65. A few respondents talked about the difficulty and time taken to admit they had mental health problems through fears of stigma, opening up or being separated from their baby. There were also concerns raised about mother and baby separation where there was hospital treatment which was not MBU based.

Options for the Provision of Additional Mother and Baby Unit Services

66. The consultation paper noted that Delivering Effective Services (2019) recommended that Scotland could benefit from an additional four Mother and Baby Unit beds. These additional beds could be created by expanding one or other of the existing Mother and Baby Units, or through creating a new, third, Mother and Baby Unit in the north of Scotland.

67. The north of Scotland was identified as a potential site for a third Mother and Baby Unit as there were concerns about equity of access for women who live significant distances from the existing Mother and Baby Units within the central belt. A Mother and Baby Unit in the north of Scotland would be sited in one of NHS Highland, NHS Grampian or NHS Tayside.

68. The next question asked:

Q4: 'What do you think is important to women and families when considering admission to an MBU?'

69. Almost all respondents (224) made comments at this question. A number of key themes again which often mirrored those espoused at the previous question. The largest numbers – one in two spread fairly evenly across all respondent types – wanted **access to their families** (partners, older children and / or other close relatives) **and family support network**, requesting, for example, open visiting arrangements. Being in close geographic contact with their families and friends was also desired, specifically in terms of bonding with new babies being seen as important for all family members; difficulties were perceived in this respect for those in the Highlands or those not in the central belt. Nearly as many respondents cited the location, distance or accessibility from home of the MBU as important. An NHS / Health Board summed up these factors thus:

> "Being as close as possible to family and loved ones, while also knowing that partners will be made welcome and to feel included and supported. Consideration to the wider needs of the wider family for example the potential stress that family members could place under by employers if there is prolonged time away from the

workplace and for mums with older children the possible lack of childcare, looking after pets etc. The distance from the unit; this could also include infrastructure with regards to accessibility of public transport for those who live locally."

70. Furthermore, a significant minority (one in ten) thought that **family support facilities within the unit** would be important, with suggestions for overnight accommodation and facilities for older children. Having the baby in situ was also pinpointed by similar numbers of respondents, for bonding and breastfeeding purposes for instance; there were also a couple of recommendations for support for babies as well as mothers within MBUs. A small minority cited concerns over the impact on other family members such as changed childcare arrangements.

71. One in four respondents, including more than half of the responding organisations, focused on the **quality of care provided or the type of support available**; it was mooted that this should include comprehensive round the clock treatment, readily available specialists to provide appropriate care, properly organised care and treatment plans and individual-centred care. In connection with this, a significant minority requested **good communication** regarding care, specifically in terms of the support offered, evidence-based pathways, honesty about outcomes, communication with the wider family and medical and pharmaceutical knowledge and options; it was intimated that these kinds of information would help take away fears over support implications.

72. Other points were made about perceived important aspects about treatment and care by a few or small numbers of respondents as follows:

- Ongoing or follow up discharge planning (e.g. what outpatient, community care or local support can be offered after leaving the MBU, since recovery can be slow).
- The predicted length of time spent at the MBU (e.g. for the greatest therapeutic gains).
- Ease of access to services in terms of transport and parking.
- Speed of access to treatment (e.g. availability of beds, length of time a referral will take).

73. Significant minorities (roughly one in eight) across the full range of respondents desired a welcoming environment at MBUs in order to feel comfortable, with suggestions that they should be as homely as possible and supportive of the mother and baby bond; small units were suggested to aid this.

74. Similar numbers wished for a safe environment, including requests for privacy and safe places to talk, and a desire to be safe in the knowledge that the child will not be taken away. Reassurances that staff are there for support were also requested.

75. A few respondents each wanted to see the following characteristics regarding staff at MBUs:

- Empathetic, listening, kind, compassionate and understanding staff (so as to be able to trust them, and feel listened to and understood).
- Not being judged / perceived as being a bad mother (e.g. not being in fear of being stigmatised).
- Well trained, experienced staff (in specific conditions, or in perinatal mental health).
- Ability to see familiar professionals while at the MBU (e.g. health visitors, social workers, community teams); there were also a couple of requests for patients to have a single identified contact or key worker.

76. A few respondents across most types cited the importance of cost implications against benefits from treatment, noting the financial costs incurred by family members visiting, travelling or staying nearby. A very small number wished to see financial support for these purposes.

77. Finally a very small number of individuals stated a preference for mothers to be supported at home or a local maternity unit, with admission to an MBU only if these patients cannot receive care in a community setting.

78. The next question asked:

Q5a) What do you imagine would be the benefit(s) of increasing the number of beds in existing units (choose all that apply)

- **Access for women and families across Scotland**
- **Cost**
- **Safety**
- **Sustainability of the service**
- **Other**

Q5b) Can you tell us your reasons for thinking this?

79. As demonstrated Table 2, access for women and families across Scotland (69%), sustainability of the service (58%) and safety (52%) were all perceived to be benefits by more than half respondents.

Table 2: Benefits of increasing the number of beds in existing units

	Total		**Organisations**		**Individuals**	
	Number	%	Number	%	Number	%
Access for women and families across Scotland	163	69	9	56	154	70
Sustainability of the service	137	58	12	75	125	57
Safety	123	52	13	81	110	50
Cost	93	39	7	44	86	39

80. There were a small number of references to improved outcomes for mothers and their babies, fewer mothers on general mental health wards separated from their babies and increased specialist knowledge or expertise in Scotland. That said, a few respondents also commented on a need for more MBUs to benefit both families and professionals rather than just expanding the number of beds in existing units.

81. A total of 163 respondents then opted to provide reasons for their response about the benefits of increasing the number of beds in existing MBUs. The key benefit across almost all respondent sub-groups and offered by around a third of respondents was

that this would **enable more women to be able to access the service and the support it offers** when it is needed. Linked to this, around one in ten respondents noted that women in general mental health wards do not receive the same level of specialist care and that being separated from their baby can increase the amount of stress for the mother.

82. Around a quarter of respondents across most respondent sub-groups noted that it would be **more cost effective and sustainable to increase the number of beds in existing MBUs**, although some noted a proviso that this has limited value to women living outwith the existing areas or that cost should not be a priority when making decisions about where to create new beds. Allied to this point, around a third of respondents noted a desire to have **new units in different geographic areas** in order to create equity of access for all women. Slightly higher proportions of those wanting to see new units in different geographic areas were respondents based in greater Glasgow and Clyde, Highland and Grampian health board areas.

83. Other benefits noted by smaller numbers of respondents were that this would:

- Offer access to skilled staff with specialist expertise rather than general mental health wards where there is a lack of expertise. The opposite of this was that health professionals in the rest of Scotland would not have the opportunity to upskill.
- Offer expansion and sustainability to the current workforce and offer centres of excellence with nearby access to related specialist services.
- Make existing MBUs more sustainable.
- Offer easier access to the required specialist staff in the central belt.
- Help to increase awareness of MBUs and reasons for accessing their services.
- Offer support in development of the mother and baby relationship and lead to positive outcomes for both.

84. Respondents at one of the consultation events noted that managing only two units would be more sustainable. There would continue to be a regular flow of patients which might not be possible in a new unit.

85. Having ascertained the benefits of increasing the number of beds in existing units, the next question asked:

Q6a) What do you imagine would be the challenges / drawback of increasing the number of beds in existing units (choose all that apply)

- **Access for women and families across Scotland**
- **Cost**
- **Safety**
- **Sustainability of the service**
- **Other**

Q6b) Can you tell us your reasons for thinking this?

86. As shown in Table 3, the key challenge / drawback of increasing the number of beds in existing units was perceived to be cost (cited by 53% of all respondents). This was followed by access for women and families across Scotland (42%), sustainability of the service (22%) and safety (18%). The highest numbers of respondents citing access for women and families across Scotland as a challenge or drawback were based in the Highland health board area (three in five).

Table 3: Challenges / drawbacks of increasing the number of beds in existing units

	Total		**Organisations**		**Individuals**	
	Number	%	Number	%	Number	%
Cost	125	53	8	50	117	53
Access for women and families across Scotland	100	42	8	50	92	42
Sustainability of the service	53	22	6	38	47	21
Safety	42	18	2	13	40	18

87. Only small numbers of respondents referred to any other challenges / drawbacks of increasing the number of beds in existing units. These included staff recruitment and retention, resources to support an increase in the number of beds, finding suitable premises and continuing the staff:patient ratio that is currently offered in existing units. A small number of respondents also noted that increasing the number of beds in existing units would not increase the geographical coverage of the units.

88. A total of 146 respondents made comments to question 6b. By far the largest numbers – exactly half from across all types– made the point that **increasing the number of beds in existing units does not tackle the issues faced by those in the north of Scotland or outside the central belt**. These respondents cited problems previously discussed such as geographical, financial and travel barriers and existing units still being far apart from families making access difficult, thereby exacerbating fears over isolation from relative support networks. Further comments expressed a desire for a unit further north or more local geographical cover generally. There were also a very small number of comments surmising that it would not be as easy for patients to work with the community network once home.

89. Again relating to women and family access, a significant minority of respondents (one in eight) from across the all types foresaw that **women would not accept an MBU place if it was too far from home**, thereby putting their safety at risk if they did not receive the most appropriate care for their needs.

90. Relating to cost issues, nearly one in five respondents foresaw **funding challenges** in increasing the number of beds. Respondents raised ongoing government funding issues relating to the health system generally and for mental health in particular, with a couple of fears expressed that funding more MBU beds may lead to cuts in other areas.

91. Similar numbers predicted **increased staffing and service costs** arising from catering for more beds. Small numbers foresaw increased costs arising from the necessity of training or recruiting staff; a few pointed out the costs from additional building work and refurbishment in order to set up new bed areas and extensions to existing units.

92. A few respondents however thought that the extra support for new mothers will be cost beneficial in the long run, pointing out reduced risk factors through improved outcomes, thereby helping to reduce costs in other services such as child development and community mental health; a couple of respondents commented that the long term costs of not treating conditions appropriately has been demonstrated.

93. Regarding safety drawbacks, there were a few concerns that expansion of beds would adversely affect the quality of service delivery, due to a perception of having to

cope with more patient demand with more thinly spread resources. A very small number focused on the need to ensure an appropriate staff to patient ratio.

94. Regarding sustainability, roughly one in eight respondents (and in particular half of clinicians in the maternity / neonatal care field) voiced **concerns over adequate staffing** for the units, given that staffing in general is currently a challenge; a few respondents were particularly worried over the provision of specialist, trained staff, pointing out that nursing staff will require specialist training. There were also a small number of concerns about new beds not being used, in which case they might be removed; it was deemed essential to let service users know about these.

95. A couple of potential other drawbacks were pointed out by very small numbers of respondents as follows:

- Concerns over a possible lack of personal attention at a bigger unit, combined with worries that the larger size of unit can make it harder to recover when there are more mothers present e.g. *"Creating a more hospital feel than a secure facility where people can try to live a normal life…"* Clinician, Maternity / Neonatal Care
- Concerns over the capacity or space to expand current MBU building facilities, with it postulated that there would be a need to reconfigure neighbouring wards or build a brand new unit instead; both the existing MBUs in NHS Lothian and NHS Greater Glasgow and Clyde were mentioned in this respect.

96. Additional disadvantages noted at the consultation events included continued delays in access to a unit, that consideration needs to be given to safety because of adverse weather when travelling to the central belt from further afield and concerns over continuity of care for the mother on her return home. There were also references that geographical travel costs would be passed onto the relevant health boards and that midwives need access to professional advice and support, for example, in being able to authorise patient transfers.

97. Having asked for views on the benefits and challenges / drawbacks of increasing the number of beds in existing units, the next questions went on to ask about the benefits and challenges of developing a new unit in the north of Scotland. Question 7 asked:

Q7a) What do you imagine would be the benefits of developing a new unit in the north of Scotland (choose all that apply)

- **Access for women and families across Scotland**
- **Cost**
- **Safety**
- **Sustainability of the service**
- **Other**

Q7b) Can you tell us your reasons for thinking this?

98. As Table 4 demonstrates, the **key benefit** and cited by almost all respondents (96%) **was access for women and families across Scotland**. Around two in three respondents (67%) cited safety as a benefit, followed by just under half (46%) referring to sustainability of the service. Cost was cited by least numbers of respondents (19%). In terms of sub-group differences, organisations focused more on cost, while individuals focused more on safety and sustainability of the service.

Table 4: Benefits of developing a new unit in the north of Scotland

	Total		**Organisations**		**Individuals**	
	Number	%	Number	%	Number	%
Access for women and families across Scotland	227	96	15	94	212	96
Safety	159	67	8	50	151	69
Sustainability of the service	109	46	4	25	105	48
Cost	46	19	5	31	41	19

99. Only a very few respondents mentioned any other benefits of developing a new unit in the north of Scotland. These focused on women being able to stay near their existing support networks, support for mothers and their babies to be kept together, less distance to travel to access and MBU, better patient outcomes and the development of specialist skills for staff.

100. A total of 150 respondents opted to provide commentary in support of their initial response. The key benefit, identified by around a third of respondents fairly evenly

spread across all respondent sub-groups, was that **mothers and their babies need access to local care** and that a new unit would remove the barrier of distance to be travelled. That said, a few respondents – mostly organisations – felt that there would need to be more than three MBUs across Scotland to offer good geographic coverage of this service. At a consultation event, a respondent noted this would offer quick access to care if there is a need to return to the unit at short notice when out of the unit on a pass.

101. Just over a quarter of respondents noted that **mothers would be close to other family and friends** which in turn makes family visits easier and reduces the stress on partners and families; and around one in ten noted that mothers would not be isolated from their support networks.

102. The **availability of beds across a greater area of Scotland** was cited by around a quarter of respondents, with reference to more women being able to access the service and having more admissions from outwith the central belt. Around one in five respondents also noted that some women choose not to use the existing units because of the distance to travel which in turn increases the risk to a mother suffering from perinatal mental health issues.

103. A respondent at a consultation event also noted that it would help to make the discharge process easier as mothers would not have to stay in hospital longer than necessary because it is too far to travel home to see how they cope.

104. Around one in five respondents commented on the need for equity of access for all women across Scotland, with reference to the current two unit scenario being a postcode lottery for many women.

105. Other benefits outlined by around one in ten or less respondents included:

- Increased safety for mothers and their families.
- Less pressure on family members in terms of travel and reduced travel costs.
- Helping mothers and their babies to develop a relationship as they are kept together, and improved outcomes for mother and baby.
- Increased specialist knowledge across Scotland, with more professionals having opportunities to upskill and develop their expertise in perinatal mental health.

Linked to this, less pressure on local community mental health services and fewer women having to use non-MBU mental health services.

- Better knowledge of what local support and advice is available on an ongoing basis to mothers on discharge, although a consultation event respondent noted the need for family specialists to assist on offering advice and support.
- Longer term savings to the NHS as mothers are more likely to recover rather than being reliant on the NHS long term for support and advice.
- Improved quality of care in the north of Scotland.

106. In summarising some of the benefits of an additional unit in the north of Scotland, a professional body / association noted:

> "Development of inpatient specialist knowledge, training and workforce would strengthen the provision of community services. Conversely, for a mother and baby unit to be successful, it needs to be embedded in sustainable, well-resourced community services, that have a sustainably recruited workforce that is retained over time, including substantive perinatal psychiatry posts. The existence of an experienced and well-developed community perinatal service is likely to improve appropriate inpatient admission experience and facilitate timely admission."

107. Having asked respondents to provide their views on the benefits of developing a new unit in the north of Scotland, respondents were then asked about potential challenges / drawbacks to this new service. Question 8 asked:

Q8a) What do you imagine would be the challenges / drawback of developing a new unit in the north of Scotland (choose all that apply)

- ○ **Access for women and families across Scotland**
- ○ **Cost**
- ○ **Safety**
- ○ **Sustainability of the service**
- ○ **Other**

Q8b) Can you tell us your reasons for thinking this?

108. As Table 5 shows, the **key challenge / drawback** of developing a new unit in the north of Scotland **was cost** (cited by 71% of respondents fairly evenly across all sub-groups). A quarter of respondents referred to sustainability of the service (highest among organisations); and less than 5% referred to access for women and families across Scotland or safety being a challenge / drawback.

Table 5: Challenges / drawbacks of developing a new unit in the north of Scotland

	Total		**Organisations**		**Individuals**	
	Number	%	Number	%	Number	%
Cost	167	71	13	81	154	70
Sustainability of the service	59	25	9	56	50	23
Access for women and families across Scotland	10	4	5	31	5	2
Safety	8	3	4	25	4	2

109. Very few other challenges / drawbacks were cited by respondents at this question although staffing, a lack of experienced staff and staff training were concerns for small numbers of respondents.

110. A total of 119 respondents provided comments in support of their initial response at Question 8a. The **key challenge / drawback cited by a significant minority of respondents (two in five spread fairly evenly across sub-groups) was the cost, planning and setting up of the new unit**. A few respondents noted that this new unit would have to be created from scratch. Conversely, a few respondents felt that provision of a unit in the north of Scotland and the quality of the service should be a priority that outweighs any costs in setting up a new unit, although there were some acknowledgements of the lack of resources within the NHS at present. This latter issue was noted primarily by respondents within the Grampian health board area.

111. Around a third of respondents across most sub-groups also referred to the issue of **staff recruitment and retention**, with a small number of comments that recruitment and retention of staff is already challenging in some specialist areas in the north of Scotland. A small minority of respondents – one in ten, primarily organisations – also commented on a lack of staff with specialist perinatal mental health experience across the north of Scotland. For example, one respondent noted that currently there is no

specialist perinatal psychiatrist in their health board area. Linked to this issue, a small minority of respondents also referred to issues with staffing costs and staff training, particularly if staff have no skills or experience within the area of perinatal mental health.

112. While travel to the existing units in the central belt was perceived to be an issue for many potential patients in the north of Scotland, a small minority of respondents noted there could still be **issues with travel to an MBU within the north of Scotland** for some individuals. A few respondents also noted that public transport links across the north of Scotland are poor. At consultation events, concerns were raised over transportation links and travel safety.

113. A few respondents referred to the importance of equity of access and the need for the north of Scotland to have the same services and resources as the central belt. In terms of location of a new unit, there was a suggestion that that bigger health boards may have more capacity for specialist staff and good links with bank staff access.

114. A professional body / association noted that MBU beds would need to have access to wider perinatal expertise as well as community support and care and that there will be a need to ensure this is developed if it is not already available. A health board noted that if there are not good community perinatal services, this could create problems with the admission and discharge of patients.

115. A small number of respondents noted that it is recommended that an MBU should have a minimum of six beds, rather than a four bed unit as suggested. A six bed unit was perceived to be more cost effective, assuming the demand is there, with a health board noting that units smaller than six beds are likely to be less viable. One health board commented that it might be difficult for staff to develop or maintain clinical expertise if the unit does not run at full capacity. One individual noted:

> "The pool of staff for perinatal is small so recruitment and retention of staff is a long term concern. A remote unit may often not be full given the geography of the unit so this leads to safety concerns – how can an empty ward provide a therapeutic peer support environment. Potential high staff turnover leads to concerns about sustainability of the service. Having 3 MBU's with few admissions at certain times of the year will impact on recovery of patients."

116. The next question went onto ask:

Q9) 'Do you think there is a different way to provide care for those women with severe illness, and their infants, who might otherwise need to be admitted to hospital?'

117. 184 respondents commented at this question. The **largest numbers** (approximately two in five respondents spread fairly evenly across all types) **disagreed that there are other ways to provide care for women with severe illness and their infants**. These respondents said that a specialised unit solely catering to mothers and babies is the best way forward for those who would otherwise need hospitalisation, pointing out the advantages of trained staff giving 24 hour care in a therapeutic and safe environment.

118. Further comments were made by one in ten respondents about the **need to keep mothers and babies together** where possible, and voicing disagreement that proper care at home or in the community was possible for severe conditions (e.g. suicide risk or psychosis), since adult mental health teams do not have the capacity for this. Small numbers of comments advocated the need for expanding MBU beds in terms of both number and location, along with very small numbers voicing a need for more support on discharge from MBUs to help prevent readmission.

119. However, a **large minority of one in four respondents from across sub-groupings did advocate the use of more intensive community-based support in general**, albeit with some stating that this should be an option only if the illness was not too severe. To this end there were requests for more community care resources, though there were also notes of recent investment in this area. Many of these respondents did not go into further detail, but a significant minority described specific forms this might take, pinpointing more specialised community and local mental health care as a possible option, with more community health teams, community perinatal nurses and community on call perinatal teams all also specified in this respect. A few respondents postulated a need for extra training regarding perinatal mental health for staff working in home care services (e.g. GPs, midwives). Respondents at a consultation event also noted that not all localities will have access to a community perinatal health team and this could impact on women presenting in crisis. There was a suggestion of a need for intensive crisis teams and a better skills mix within the community.

120. A significant minority (one in five) perceived **care at home as being an option**, again with some suggestions that this should depend on the severity of the illness. Further to this, there were calls to improve the home support facets currently available, such as providing intensive home visiting, daily therapies, 24 hour support availability and proper care linkage between GPs, crisis teams, specialists in existing units and third sector organisations. The main advantage foreseen was that staying at home would ensure the family unit remained together.

121. The other main theme espoused by one in six respondents (and more than two in five organisations) was the need for **easier and quicker access or referrals to services and support**. This was seen as a preventative approach to help head off worse problems thus reducing the need for hospital or MBU admissions.

122. A few respondents suggested the following additional ways to provide care[3]:

- (Local) Day care or satellite units providing daily or outpatient care and support, with intensive support available, for instance within local hospitals, or taking the form of baby clinics where patients can converse with other mothers.
- Further use, development or expansion of Perinatal and Infant Mental Health Teams (PNIMHT) across the country.
- More provision of support and education to families and personal support networks (e.g. about how to recognise problems and risks, or to enable being at the forefront of clinical decision-making).
- Examine how other countries provide perinatal mental health care (from a consultation event).

123. Additionally, small numbers of respondents suggested implementation of a 'house' setting for care as opposed to a hospital setting, with the advantages of a less clinical appearance and less stigma being attached to these; and incorporating more specialist care into local maternity units or hospitals (thus allowing mothers to stay rather than be moved before or after birth).

[3] It should be noted that the suggested alternatives could be used alongside MBU provision (e.g. to prevent needs escalating) rather than as a direct alternative to inpatient provision

124. A very small number of other mentions were made of hospitals being the most effective means of care; and of a need for more crisis teams within perinatal services.

125. At some consultation events, attendees were asked what would help women and families with travel to an MBU, either an existing unit or a new unit. A need was noted for improvements to transport times for the non-emergency transport service. The use of multi-disciplinary meetings involving both patients and their partners was also suggested as a useful element of support. On a more logistical level, there was a suggestion for mothers to have access to carry cots.

The Mother and Baby Unit Family Fund (MBUFF)

126. The consultation paper noted that the Mother and Baby Unit Family Fund (MBUFF) was established in 2020 to provide a contribution towards the cost of visiting a mother and baby being treated in an MBU for perinatal mental illness. This is to facilitate support for the woman and baby in the unit, support continued family bonding and allow staff in the unit to work with the family group. Partners, fathers and main carers, in addition to existing children up to school leaving age (16), can make claims for reasonable accommodation, travel expenses and a flat rate contribution of £8.50 per person per day for food and non-alcoholic drinks. Claims can be submitted incrementally during an ongoing MBU stay (e.g. weekly) or in full for the entire stay, up to three months, following discharge.

127. Respondents were asked:

Q10: 'Are you aware of the Mother and Baby Unit Family Fund (MBUFF)?'

128. As Table 6 shows, just under a quarter of respondents (24%) were aware of the Mother and Baby Unit Family Fund, and just over three quarters were unaware. Awareness levels were highest among organisations and lowest among individuals (69% of organisations compared to 21% of individuals).

Table 6: Awareness of the Mother and Baby Unit Family Fund (MBUFF)

	Total		**Organisations**		**Individuals**	
	Number	%	Number	%	Number	%
Yes, aware	57	24	11	69	46	21
Not aware	179	76	5	31	174	79

129. The Scottish Government was keen to find out how organisations and individuals had heard about the fund and asked:

Q11: 'If you are aware of the fund, how did you find out about it?'

130. As demonstrated in table 7, clinicians were a key source of awareness, followed by the website and other service users.

Table 7: Source of awareness of the Mother and Baby Unit Family Fund (MBUFF)

	Total		Organisations		Individuals	
	Number	%	Number	%	Number	%
From clinicians	19	33	4	36	15	33
From the website	11	19	1	9	10	22
From other service users	11	19	1	9	10	22

131. A range of additional sources of awareness were also cited, each by small numbers of respondents. These included third sector organisations, from work within a perinatal unit, the Scottish Government and PIMH Programme Board.

132. Respondents were then asked if they or a family member had been treated in an MBU since October 2020, whether the fund was used. Only four individuals had used this fund and these were all in the Grampian health board area.

133. The next question asked:

Q13: 'What, if any, are the barriers to using the Mother and Baby Until Family Fund?'

134. A total of 59 respondents opted to answer this question. The **key barrier** given – by around four in ten of these respondents – was of a **lack of awareness of the MBUFF**. Around a third of respondents felt a barrier to using the Fund was because it is paid in arrears and that not all individuals can afford to make upfront payments from their own pockets.

135. The **cap of £500** was also noted as a barrier by around one in five respondents with comments that this is not enough for those travelling long distances. Some of these respondents suggested a greater cap than £500.

136. A smaller number of respondents referred to the application process being difficult to complete, particularly for any individuals with literacy issues or a lack of IT skills. There were also a small number of references to the use of ambiguous wording such

as 'reasonable overnight accommodation'. There were also one or two mentions that there is a need to seek pre-approval for expenditure on some items and a lack of clarity about the criteria to obtain funding.

137. The stigma of having to ask for financial help was noted as a barrier by around one in ten of these respondents. Other barriers noted by less than one in ten respondents included:

- Problems with fitting visiting around school activities and other school children; and not being able to claim for childcare for other children.
- A loss of earnings for some family members or a lack of capacity to take time off work for visiting an MBU.
- Delays between applying to the Fund and being reimbursed.
- Having to provide receipts for everything.
- Not being informed about the Fund prior to admission to enable families to make informed choices about accessing an MBU.
- The availability of funds in crisis situations such as an acute admission process out of hours.
- One health board noted that some patients and their families do not like to apply for the fund because of a belief that others are more in need.

138. The final question about the Mother and Baby Unit Family Fund (MBUFF) asked:

Q14: 'How could the MBUFF be improved?'

139. A total of 55 respondents provided commentary in response to this question and many of these echoed barriers raised in the previous question.

140. The key improvement identified by around two in five of these respondents was to **increase awareness of MBUFF**, among both professionals and patients. The highest numbers of respondents referring to this issue were women with lived experience of mental health problem in pregnancy or after childbirth who received care and treatment in the community and those within the Grampian and Tayside health boards.

141. Around one in five respondents referred to **immediate access to the fund** in the form of upfront payments for items such as rail fares or fuel cards. One individual summarising some of the points raised commented:

> "Change it from being a reimbursement system to an upfront grant allowance. So based on location a weekly or monthly allowance could be calculated by the NHS and provided as an allowance. If the worry is this could end up costing a lot more then you could still ask for receipts to be provided post discharge and any unspent money returned. This would make it as easy as possible for families when the issues are acute and switch their admin burden to after discharge where they are likely to have more capacity for it. Give specifics around how much is acceptable for accommodation costs. Again be specific about what is acceptable for taxi fares rather than ask for pre-approval. e.g. a taxi between Livingston train stations and the MBU in Livingston is acceptable, a taxi from Waverly station isn't. Or a taxi journey of X miles is acceptable."

142. A similar number of respondents also referred to changes to the capped amount of £500 and suggested an increase in this amount, with a small number of comments that this should also cover loss of earnings. Linked to this, there were also some suggestions for flexibility in the operation of the fund, for example, weighting the available funding level or offering a sliding scale based on the distance to be travelled and the length of admission. One individual suggested this could be offered in the form of a loan to be paid back over time.

143. Informing patients about the fund prior to admission was suggested by a few respondents so that families can make informed choices about whether to access the service.

144. There were also a few suggestions to:

- Clarify the criteria for funding applications.
- Offer practical support and help to patients and their families in claiming from the MBUFF.
- Timely reimbursement.

- Offering this to all patients to help remove any stigma associated with applying to this fund.

145. An organisation within the NHS suggested the introduction of peer support will help to address issues of stigma and increase opportunities to support patients and their families in accessing the Fund.

146. The final question in this consultation offered respondents the opportunity to provide any additional comments they had, and asked:

Q15: 'Finally, is there anything else that you would like to share about this issue?'

147. 98 respondents commented at this question. A large minority (more than one in three) made or reiterated requests for MBU facilities in other areas of Scotland, almost all of these being for the north or northeast of Scotland, with a small number advocating Aberdeen specifically, and one request for an MBU in Inverness.

148. Similar numbers made more general requests for more MBUs; comments included needs for:

- Greater ease and equity of access to avoid a "postcode lottery" for care.
- No geographical restrictions, with complaints about having had to travel long distances.
- The importance of MBUs for mother and baby wellbeing, with positive remarks about the vital service provided (e.g. "Many mums will be healthier and happier if they can get the help they need without having to be parted from their baby and put in a general mental health hospital" Lived experience, care and treatment in the community).

149. A small number of respondents recited positive experiences of MBUs, for instance in terms of expert staff.

150. A large minority of respondents (nearly one in three) made requests for more or improved mental health or perinatal mental health services, in terms of awareness of post-natal depression (PND), earlier interventions and knowledge of how to care for pregnant or postnatal women.

151. A significant minority (one in eight) saw a need for a more equitable spread of perinatal care services in order to facilitate access to services needed, with reiterations that distance should not be a barrier. The north and north-east of Scotland was again singled out (mainly by respondents in the Grampian and Highland Health Boards) as being relatively under-resourced for pre and postnatal mental health care in general.

152. There were also a few requests for more information and publicity regarding care services and MBUs; and a few mentions of a need to get as much data as possible in terms of user feedback about services.

Appendix 1: Respondent Groupings

Table A: Organisations

	Number	%
Health and Social Care Partnership	4	2
NHS / Health Board	6	3
Professional Body / Association	3	1
Third Sector	3	1
Total organisations	**16**	**7**

Table B: Individuals: Experience

	Number	%
Woman with lived experience of mental health problems in pregnancy or after childbirth who received care and treatment in an MBU (service user)	14	6
Woman with lived experience of mental health problems in pregnancy or after childbirth who received care and treatment in a general adult mental health inpatient ward (service user)	4	2
Woman with lived experience of mental health problems in pregnancy or after childbirth who received care and treatment in the community from their GP, mental health service or other health professional including third sector services (service user)	65	28
Woman with lived experience of mental health problems in pregnancy or after childbirth who did not access treatment or services	28	12
Family member of a woman with lived experience of mental health problems in pregnancy or after childbirth (service user)	13	6
Clinician MBU care	5	2
Clinician general mental health inpatient care	1	*
Clinician perinatal mental health community team care	12	5
Clinician general mental health team care	4	2
Clinician primary care	5	2
Clinician maternity / neonatal care	20	8
Clinician (other)	12	5
Member of the public with no lived experience of mental health problems in pregnancy or after childbirth	16	7
Other	14	6
Not answered	9	4
Total individuals	220 **	100

* denotes less than 1%; ** may not add to 220 as respondents could choose more than one category

Table C: Individuals: Age / Health Board Area Lived in

	Number	%
Age		
Under 24	9	4
25 – 34	70	32
35 – 44	83	38
45 – 54	34	15
55+	21	10
Prefer not to say / not answered	3	1
Total individuals	220	100
Health Board area		
Ayrshire & Arran	5	2
Borders	1	*
Dumfries & Galloway	1	*
Lothian	7	3
Fife	1	*
Forth Valley	4	2
Grampian	118	54
Greater Glasgow & Clyde	15	7
Highland	32	15
Lanarkshire	5	2
Orkney	-	-
Shetland	-	-
Tayside	19	9
Western Isles	-	-
Not provided / outwith Scotland	12	5
Total individuals	220	99 **

* denotes less than ½%; ** figures do not add to 100% due to rounding

Appendix 2: Respondent Organisations

Aberdeenshire Council

Action on Postpartum Psychosis

British Association of Perinatal Medicine

NHS Greater Glasgow and Clyde

LATNEM (Let's All Talk North East Mums)

MBU Clinical Forum, Perinatal Mental Health Network Scotland

Midlothian Sure Start

NHS Forth Valley

NHS Grampian

NHS Highland

NHS Lothian

North Ayrshire Health & Social Care Partnership

North Lanarkshire HSCP

RCPsychiS

Renfrewshire HSCP

Social Work Scotland

How to access background or source data

The data collected for this consultation analysis:

☐ are available in more detail through Scottish Neighbourhood Statistics

☒ are available via Citizenspace where respondents indicated permission for their responses to be published. Responses where the respondent declined to give permission for their response to be made public will not be available.

☐ may be made available on request, subject to consideration of legal and ethical factors.

☐ cannot be made available by Scottish Government for further analysis as Scottish Government is not the data controller.

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