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VISIT AND MONITORING REPORT

Perinatal themed visit: Results of the consultant survey

JUNE 2016

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Results of the consultant survey

Eighty one consultant psychiatrists across Scotland responded to our online survey; these views from senior psychiatrists working on the ground help us further explore issues around current perinatal mental health care. In 2015 there were 609 consultants psychiatrists in Scotland[1] (in all specialties, including locums). This survey therefore represents the views of around 13% of this group.

The survey was anonymous. We have summarised the themes that emerged from individual comments and have quoted some responses when we felt anonymity would not be compromised.

Who took part

Representation by health board

The majority (69 of the 81 respondents) told us which health board(s) they worked in.

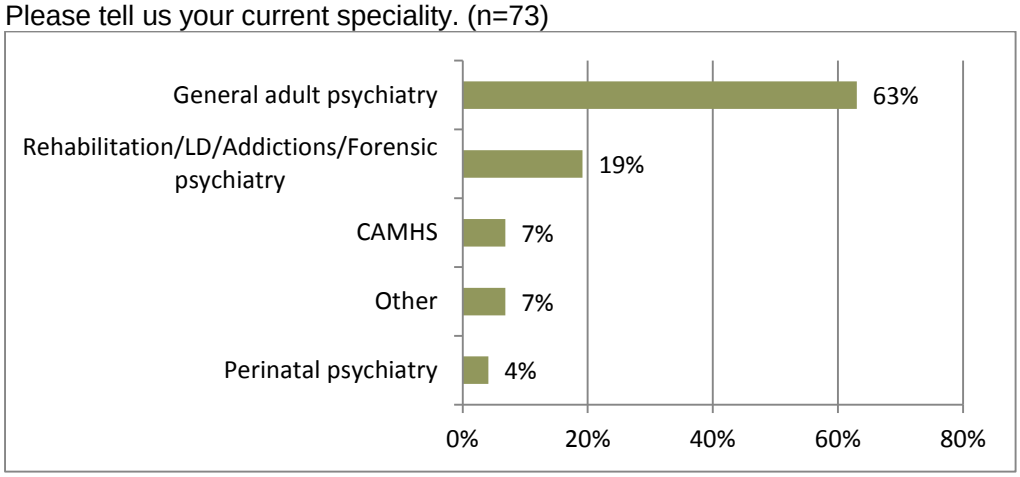
Ten of the 14 health boards are represented. Two large health boards (NHS Lanarkshire and NHS Tayside) appear completely unrepresented, however consultants from these areas may be among the 12 non-respondents for this question. Higher numbers of consultants were from Greater Glasgow and Clyde (25%, 17) and Lothian (22%, 15); as might be expected from the two largest health boards in Scotland. They are also the only two health boards with mother and baby units (MBU) and two of only five with community perinatal mental health teams. It is possible therefore, that this large group are already more aware and perhaps more informed about perinatal issues.

The possibility of geographical (and specialist bias) is important to bear in mind, particularly when questions about local service provision are considered.

Representation by consultant specialty

Seventy three consultants (90%) told us their current main psychiatric specialty.

Please tell us your current speciality. (n=73)



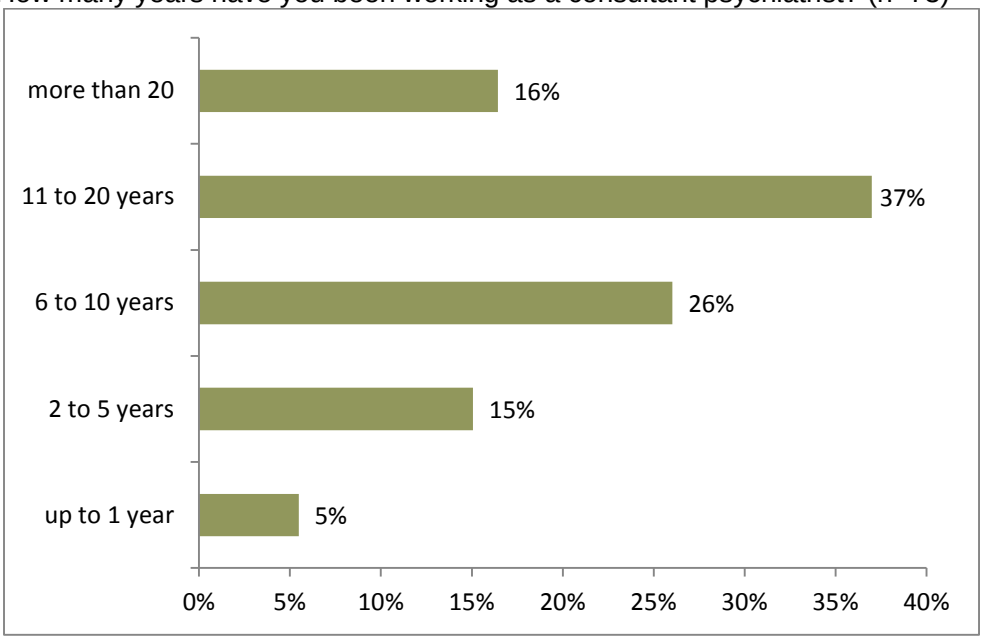
[1]Information from the Royal College of Psychiatrists in Scotland (based on March 2015 census)

The majority 63%, (46 of 73) were general adult psychiatrists. Almost a fifth (19%, 14) worked within other adult specialties: rehabilitation, learning disability, addictions or forensic psychiatry. A small number of consultants were child and adolescent psychiatrists (7%, 5); or for mother specialties (7%, 5) including eating disorder, psychotherapy, liaison and old age psychiatry. Three perinatal psychiatrists took part in the survey.

Representation by consultant experience

We were interested to know the length of experience respondents had working at consultant level.

How many years have you been working as a consultant psychiatrist? (n=73)

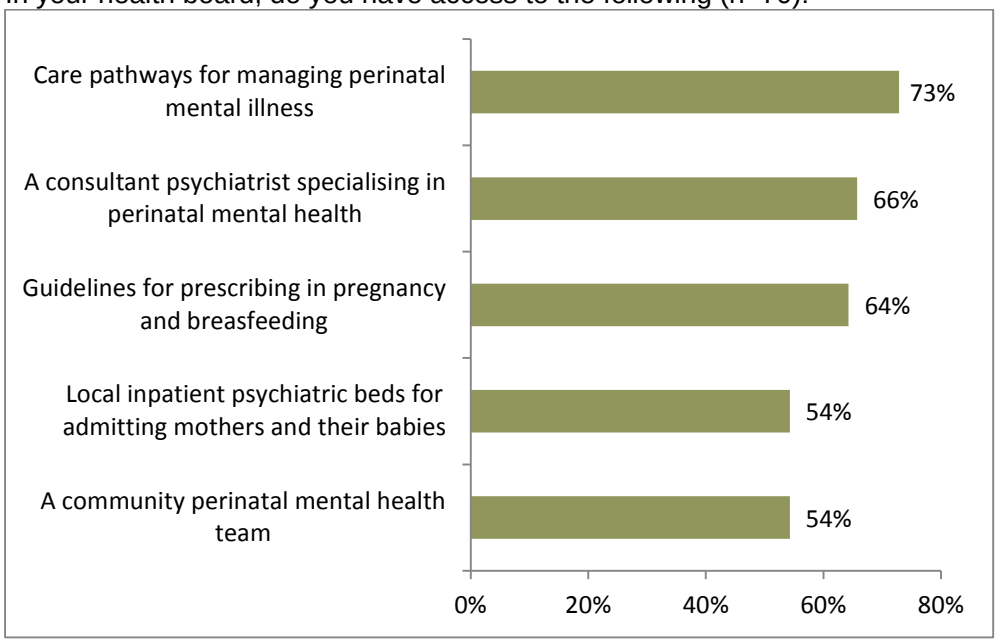


Ninety percent of consultants (73 of 81) answered this question. Respondents were almost equally divided between those who had been a consultant for up to 10 years (47%, 34 of 73) and those who had worked at this senior level for more than 10 years (53%, 39). Thirty seven percent, 27 had between 11-20 years experience.

Service provision

We asked consultants about their access to local perinatal expertise in their health board, perinatal care pathways, prescribing guidelines and local inpatient beds for mothers and babies.

In your health board, do you have access to the following (n=70):



Community perinatal mental health team

Just over half of the consultants (54%) had access to a community perinatal mental health team in their local area.

These consultants came from four NHS trusts: Greater Glasgow and Clyde, Lothian, Forth Valley and Grampian, which we know offer both community and inpatient perinatal provision (albeit not in specialist MBUs in the latter two cases). We are aware that NHS Lanarkshire also has a community perinatal mental health team, although no consultants completing the survey identified working in this health board.

Consultant perinatal specialist

Sixty six percent (46) of respondents said they had access to a local perinatal consultant specialist. Almost all positive responses were again from consultants working in the four health boards that offer existing perinatal services. It is encouraging that where perinatal services exist, consultants appear to know about this. It is however concerning that a third of respondents said they had no access to this expertise locally.

Local inpatient beds for admitting a mother and baby

Over half (54%, 38) of consultants said they had access to inpatient care locally for perinatal patients. Again, analysing results by health board, these responses suggested good knowledge about local provision among consultants working in health board areas where there were specialist inpatient perinatal facilities.

Perinatal care pathways

Almost three quarters (73%, 51) of respondents said they had access to a local integrated care pathway (ICP) for managing perinatal mental illness. We were impressed by this high number. On further analysis, we found that consultants from nine different health board areas responded positively to this question. This contradicted responses from the health board questionnaire, where only five health boards told us they had a perinatal ICP. The reason for this mismatch is unclear.

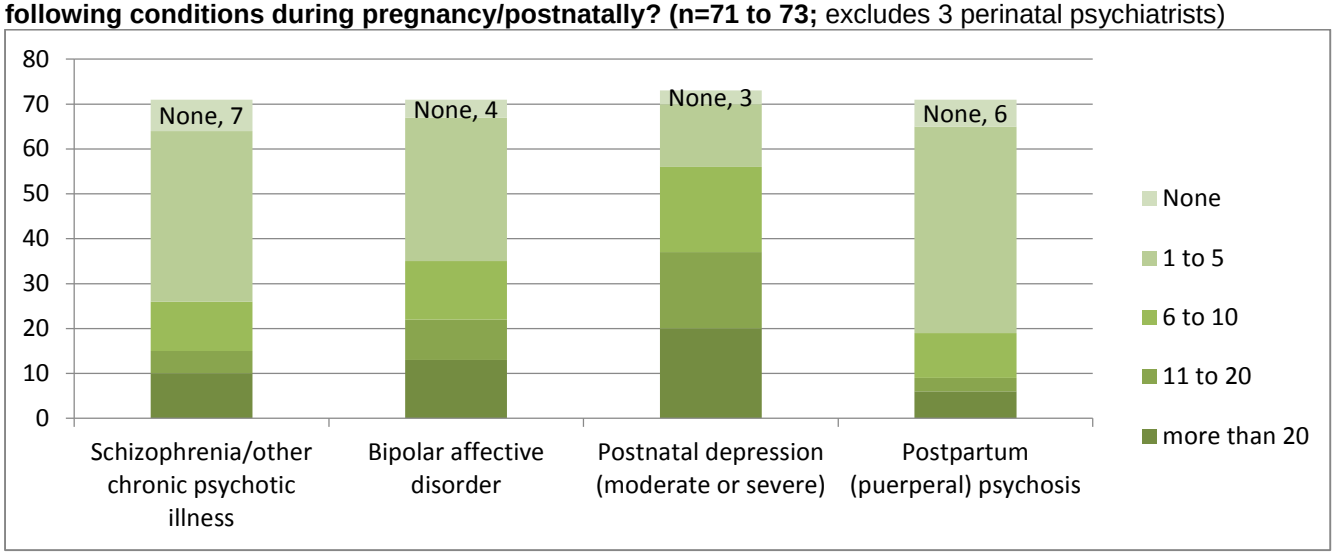
Guidelines for prescribing and breastfeeding

Nearly two thirds (64%, 45) of consultants told us they had access to local guidelines on prescribing in pregnancy and breastfeeding. This represented positive responses across nine health boards. Again, this seemed very encouraging, but was at odds with responses from Health Boards, among which only four stated that they had written guidelines for perinatal prescribing.

Experience and confidence in managing women during the perinatal period

We asked consultants about their experiences treating women with different conditions during pregnancy and postnatally. We have excluded the three perinatal psychiatrist from the analysis in this section to reduce bias and because we were interested in the experiences of non-perinatal consultants.

During your career in psychiatry, approximate ly how many times have you treated women with the following conditions during pregnancy/postnatally? (n=71 to 73; excludes 3 perinatal psychiatrists)



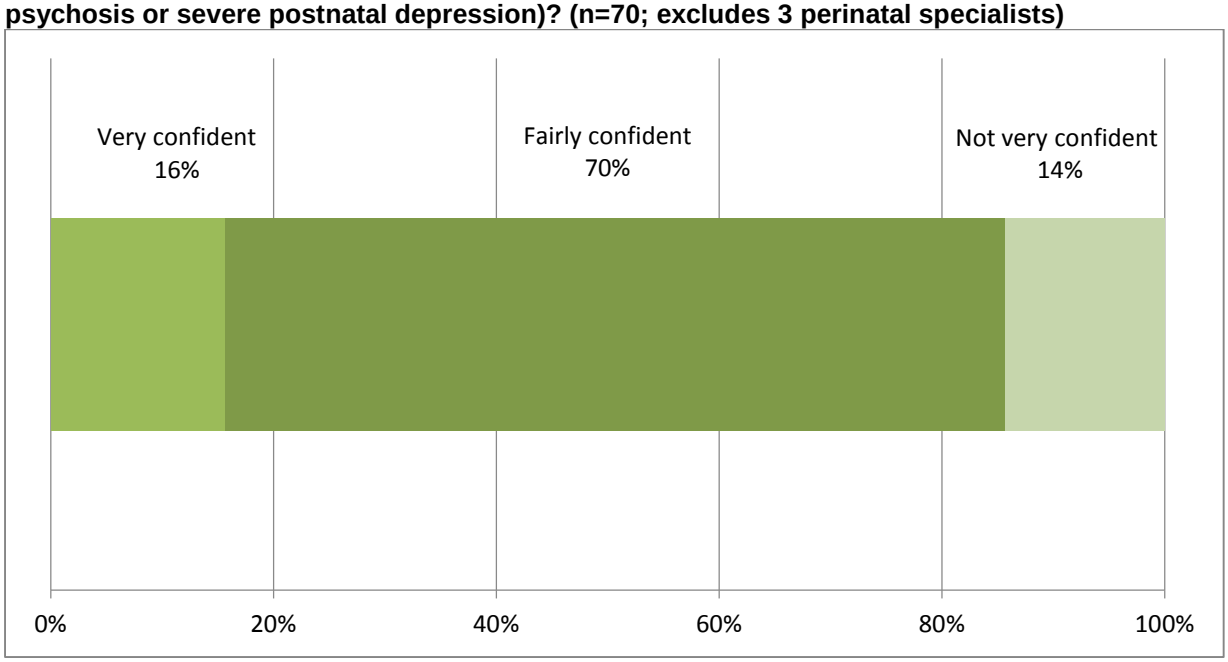
Some of these findings were surprising. For example, we might have expected consultants who are not perinatal specialists to have managed many more women with schizophrenia or chronic psychosis perinatally than to have treated women with postpartum psychosis (as postpartum psychosis is relatively rare in comparison), but the numbers for both conditions are quite similar.

Over three quarters (77%, 56 of 73) of consultants had treated more than five women with moderate or severe postnatal depression and 88% (64 of 73) of respondents had experience of treating women with each of the above disorders during pregnancy.

This suggests that most psychiatrists have seen how these illnesses can present in pregnancy, which is encouraging. A small number of consultants had not so far treated women with each of these illnesses during pregnancy, which we would also expect given that 20% of respondents had only worked as a consultant for up to five years.

We asked consultants how confident they felt treating women with severe postnatal illness (postpartum psychosis or severe postnatal depression). Again, we excluded perinatal specialists from the analysis.

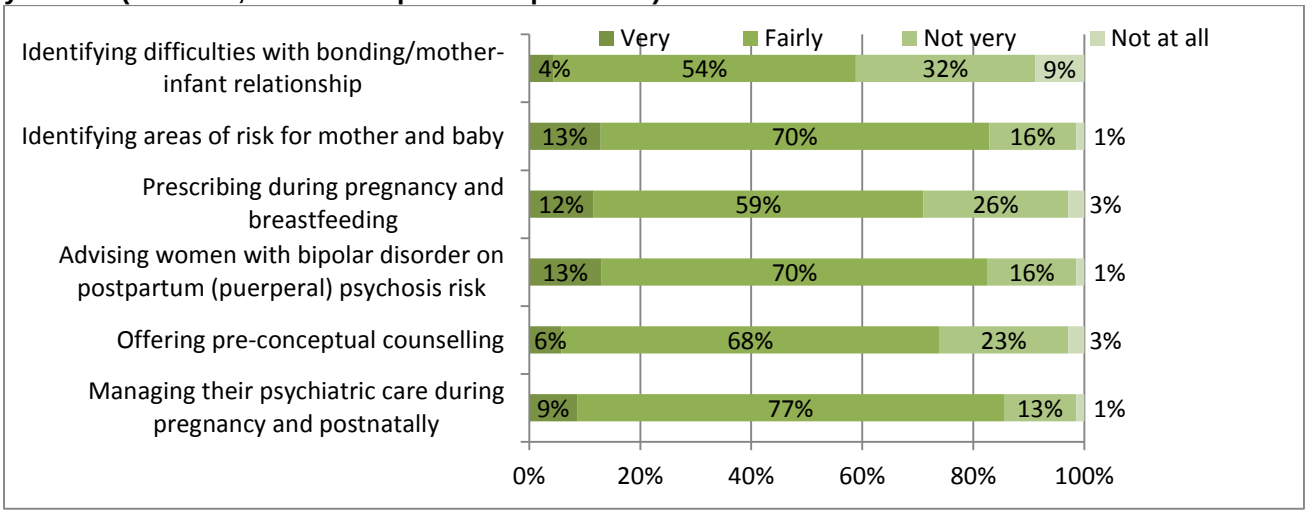
How confident do you feel recognising and treating severe postnatal illness (postpartum (puerperal) psychosis or severe postnatal depression)? (n=70; excludes 3 perinatal specialists)



These results suggest that 86% of consultants who responded feel confident treating these conditions. This would seem to correspond with the proportion of consultants who reported treating these perinatal illnesses at least once before. Perinatal psychiatrists themselves often indicate that it takes some time working within the specialty to gain confidence treating these conditions, given the level of risk, severity and unpredictability these illnesses can present, so we were somewhat surprised by these results.

We asked consultants how confident they would feel managing women who they routinely see on their caseload, in relation to pregnancy and perinatal issues. The results are charted below:

Thinking about women who are routinely under your care for their mental illness, how confident do you feel: (n= 68-70; excludes 3 perinatal specialists)



These results suggest that consultants generally feel confident managing issues relating to pregnancy in their general adult female population.

- The majority of consultants (86%, 59 of 69) said they felt confident managing the care of their patients during pregnancy and postnatally.
- Almost three quarters of respondents (74%, 51 of 69) said they felt confident offering pre-conceptual counselling to women; that is giving advice to women with pre-existing mental illness who are planning a pregnancy (about medication, risks associated with perinatal illness and helping inform their decision making).
- A high proportion (83%, 57 of 69) of consultants told us they felt confident advising women with bipolar affective disorder about the risks associated with postpartum psychosis.
- A high proportion (83%, 58 of 70) also felt confident identifying areas of risk for mother and baby.
- Slightly lower, but still significant numbers of consultants said they felt confident prescribing for women who were pregnant or breastfeeding (71%, 49 of 69).
- The only area where respondents felt less confident was in identifying difficulties with the mother-infant relationship, but even so, more than half (58%, 40 of 68) felt confident in this area.

When we carried out further analysis looking at these results by the number of years in consultant practice, we found most responses remained consistently high throughout the groups, with the exception of consultants in post less than a year, who were candid about their lack of confidence in this area.

Overall, these findings were surprising. They suggest that consultants who are not perinatal specialists generally feel quite confident managing women during pregnancy and postpartum. We wonder if this may explain, in part, why women are sometimes not referred to specialist services for their perinatal care.

These are some of the comments from (non-perinatal) consultants on issues of perinatal expertise:

> *"This is a very important area and needs specialist training and education of the multidisciplinary team in terms of psychological and pharmacological management as well as risk management."*

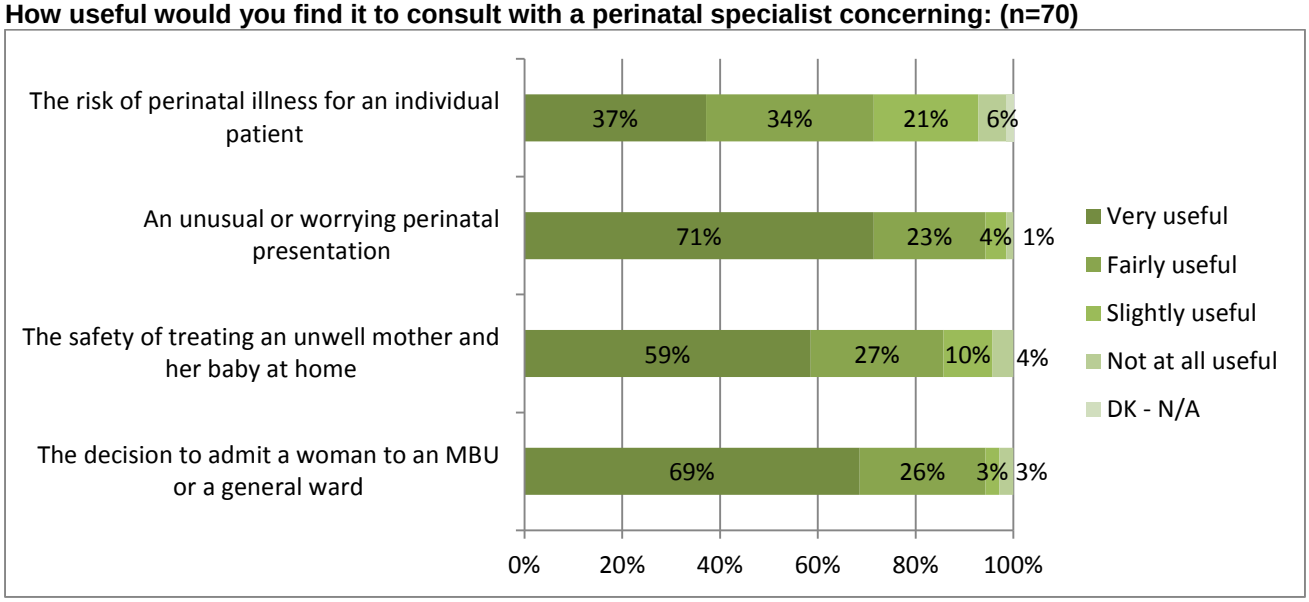
> *"It needs to be done by a specialist and there needs to be at least a consultant with a special interest in all Trusts and Boards to either treat or facilitate liaison with one of the major units. Pregnancy is a very high risk time both for mother and baby and needs increased intensity of input both in hospital and community surveillance. Liaison with specialist midwives and social services is better if the same psychiatrist works with them regularly."*

> *"The recent confidential enquiry reveals that a substantial proportion of General Adult Psychiatrists not only do not know how to safely manage perinatal cases but think that they do. I have witnessed this locally: risk assessments that would be entirely appropriate in a General Adult Psychiatry context but which miss vital perinatal-specific factors, when pressed the General Adult service doesn't accept that anything was wrong."*

Role of specialist perinatal expertise

We asked consultants how useful they would find it to consult a perinatal specialist in some areas of patient care.

How useful would you find it to consult with a perinatal specialist concerning: (n=70)



- 93% (65 of 70) said it would be useful to get advice about the risk of perinatal illness for an individual patient.
- 99% said it would be useful to get advice on an unusual or worrying perinatal presentation.
- 96% said it would be useful to get advice about the safety of treating and unwell mother and her baby at home.
- 97% said it would be useful to get advice about the decision to admit a woman to an MBU or general adult ward.

These results indicate that the vast majority of consultants surveyed thought that access to perinatal expertise would be useful when making decisions about patient care.

We then asked consultants if this specialist advice was currently available to them.

In your opinion is this expertise currently available to you: (excludes 3 perinatal specialists)

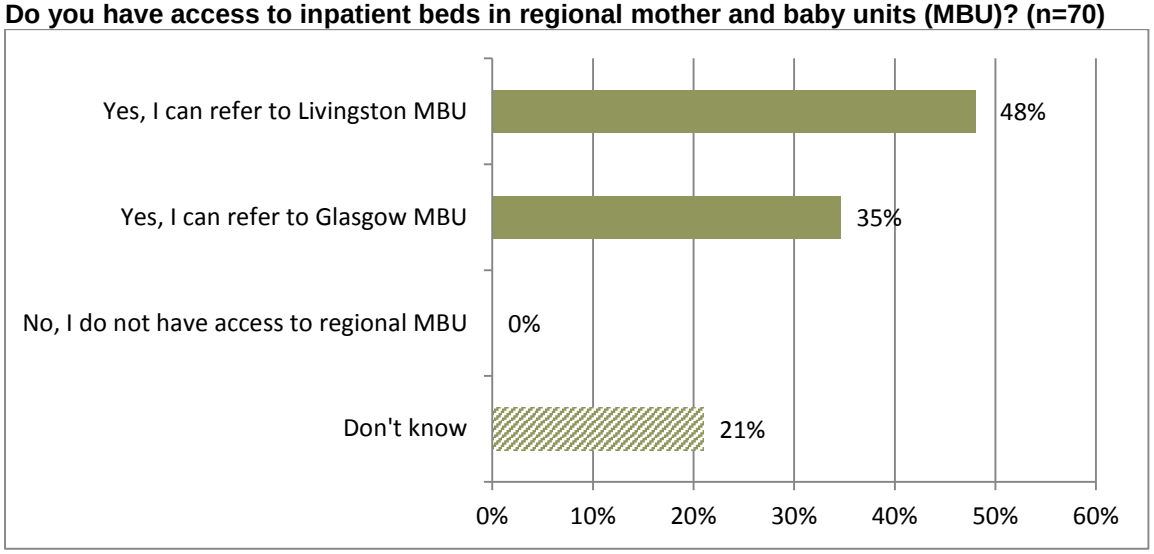
	Within your local NHS board		Via regional perinatal services (e.g. MBUs)	
	No.	%	No.	%
Yes	41	59%	55	81%
No	23	33%	1	1%
Don't know / N/A	6	9%	12	18%
Total	70	100%	68	100%

It is striking that a third of consultants did not have access to perinatal expertise locally. It was encouraging however, that 81% felt that specialist advice was available via their regional MBU.

Referring to mother and baby units

We asked consultants if they had access to inpatient beds in the regional mother and baby units.

Do you have access to inpatient beds in regional mother and baby units (MBU)? (n=70)



In total, 83% (64) of consultants told us they had access to regional MBU beds. Of these, 5% (3) respondents indicated they could refer to both Livingston and Glasgow. When analysed geographically, these responses corresponded with information from health boards. In the four health boards that do not have a service level agreement with an MBU, in practice patients may be referred to either unit on a case by case basis. The 21% (17) of consultants who were unsure about access to MBU beds were from at least six different health boards.

We then asked consultants if they had ever referred a woman for MBU admission.

- Almost two thirds of consultants said they had (64%, 45 of 70).
- Over a third of consultants (34%, 24 of 70) said they had not.
- When we analysed these results by health board, consultants from nine health boards had made MBU referrals in the past.

We asked; "If a woman requires treatment for postnatal illness, would you routinely discuss the option of admission to an MBU?"

- 81% (57 of 70) of consultants said they would discuss the option with the patient and their family (9%, 6, said they would not). The reasons for this were not clear.
- 81% (57 of 70) said they would discuss it with the MBU team, 6%, 4 said they would not.

We also asked "If a woman, who is normally the main carer for her baby, initially opts for admission to a general adult ward without her baby, would you continue to revisit with her the option of MBU admission?"

- 90% (63 of 70) of respondents answered yes, 1%, 1 said no.

We also asked consultants if, in their experience, there had been any barriers to referring a woman to the regional MBU. Most said not, but some consultants told us they had encountered difficulties. Comments included:

> *"No - I have had a very positive experience of working with the MBU (locally) over the past number of years. Advice from the perinatal specialist consultant is always prompt and very helpful."*
>
> *"Have excellent relationship with local perinatal service. As a tertiary service they are refreshingly available and helpful - none of this 'don't fit our referral criteria' which is often the case with other tertiary services."*
>
> "*Only in the sense that women can prefer local admission without baby over admission out of health board area with baby. The MBU does not put up barriers to admission if admission is appropriate."*
>
> *"Geography - including separation from other family members and known professionals. Insufficient bed numbers."*

"Not very easy. We are a LONG way from either. The unit was full when I wanted to admit someone."

"Distance from NHS Grampian."

"For me there were diagnosis specific barriers....when I had to refer a young woman with a severe binge/purge anorexia I encountered problems. I was involved with both MBUs."

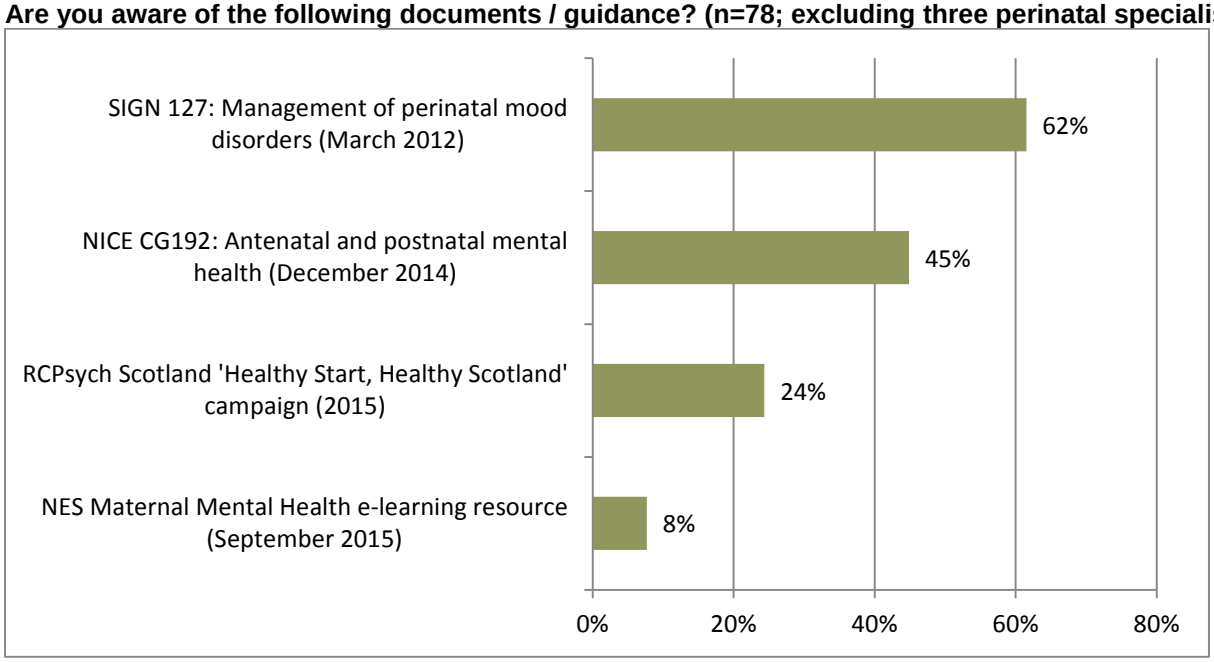
"On one occasion the MBU did not take on board the information that the treating responsible medical officer (RMO) and community mental health team (CMHT) had from knowing the patient over many years. On (discharge) from the MBU this led to significant issues in the therapeutic relationship between the patient and the treating RMO and CMHT. This has reduced my confidence in the MBU. They are only involved with patients for a snapshot and the life-long care is provided by local services. It is important that consideration is given to preserving the treating teams role and relationship and information from a chronic perspective is considered with respect."

These range of comments raise important issues from the perspective of referring consultants: geographic issues with distance from MBU being a significant barrier in some cases, instances when beds have not been available, diagnostic criteria for admission and the importance of information sharing and good working relationships between services.

Training

We asked consultants about their awareness of clinical guidelines or recent publications in the field.

Are you aware of the following documents / guidance? (n=78; excluding three perinatal specialists)



It was positive that 62% (48 of 78) of consultants were aware of the perinatal SIGN guideline. However, almost one quarter (24%, 11 of 46) of general adult psychiatrists who answered this question did not indicate an awareness of SIGN 127[2].

We had not expected large numbers of consultants to be aware of the other recent developments, such as the e-learning resource, but it was encouraging that almost a quarter were already aware of the Royal College of Psychiatrists campaign "Healthy Start, Healthy Scotland[3]", even though it was relatively new when we carried out this survey.

It seems important that awareness of the e-learning resource is widened among consultants (and cascaded to their professional teams).

We asked consultants if they had previously received teaching in perinatal mental health. Eighty one percent (54 of 67) said yes, 16% (11 of 67) said no. Comments were invited and those who did comment mainly referred to receiving teaching as a higher trainee.

> *"Many years ago and probably at too low a level i.e. higher trainee level."*

> *"I am of a generation where one's own education was based on experience."*

A few consultants also told us they had attended conferences or local teaching events on perinatal mental health, which we found encouraging.

> *"Case presentations from MBU at our local teaching, which have taught the importance of identifying post-natal psychosis and assessing risk."*

We asked: If a training event were made available, how interested would you be?

- 83% (58 of 70) of respondents indicated that they would be interested (40% said they would be very interested, while 43% indicated they would be fairly interested). One CAMHS consultant felt it was not applicable. We also analysed the responses by length of time practising:
    - All new consultants were interested in a training event
    - There was less interest among consultants with more than 20 years experience.

These results overall are encouraging and provide good evidence that more training events to share knowledge about perinatal mental health care would be welcomed by the majority of consultants.

[2] http://www.sign.ac.uk/pdf/qrg127.pdf
[3] http://www.rcpsych.ac.uk/workinpsychiatry/divisions/rcpsychinscotland/healthystart,healthyscotlan.aspx

Additional comments

At the end of the survey, when we asked consultants if they had any other comments about perinatal mental health care, some important themes emerged.

Diagnosis

Some consultant psychiatrists highlighted groups of patients where there may be particular gaps in provision.

Two respondents spoke of women with eating disorder, and told us:

> *"People with anorexia nervosa often can't conceive but it is surprising that some do. The postnatal period can be a time of high risk both for mood problems, as well as anorexic behaviours. It would seem sensible for the MBUs, who I understand will only admit these types of patients very infrequently, to have access to some specialist eating disorder in-reach support so that effective care plans can be put into action immediately."*

> *"Would love to be involved in arranging a day training/conference on eating disorders and perinatal psychiatry and have already broached this (with local perinatal consultant)."*

One consultant highlighted that women with personality disorder can fall through the gaps:

> *"The exclusion of personality disordered patients is a concern as they often generate great anxiety in social work and health visitor and would benefit from greater specialist input regarding risk."*

Another spoke about stigma and the challenges of supporting vulnerable women:

> *"A few years ago I had a spell whereby five of my patients were pregnant. I sought help with regard to supporting and teaching the mother and help to maintain the bond without success - not within the remit of local maternity services or MBU. None of the mothers were able to keep their child.... (In one case a mother) was discharged from labour ward, despite having a complicated delivery and in the view of the obstetrician needing post-delivery care, because "she would upset the other mothers" on the postnatal ward. It may be that even with support and training these mothers would have been incapable of providing for their needs of their babies, but I am still upset that there was no way we could give them a trial. Stigma within maternity services needs addressed."*

The challenges in providing services that are accessible for vulnerable women like these is an area that the perinatal faculty at the Royal College of Psychiatrists[4] have recognised and identified for further consideration. Where issues of stigma within maternity services exist,

[4] http://www.rcpsych.ac.uk/workinpsychiatry/faculties/perinatal.aspx

perinatal mental health teams have an important liaison role in offering advice, tackling discrimination and promoting equal standards of care for women with mental illness. This again underlines the importance of having a specialist perinatal mental health service in every health board.

Inequity in service provision

Some consultants highlighted the problem of geography and lack of specialist services in some areas.

One consultant with around 20 years experience said:

> *"I found that often women opted for local psych inpatient treatment even though it meant being separated from infant due to distance (from MBU) for family and a wish to continue to be managed by the local service."*

Other consultants said:

> *"There needs to be much better equity of access to specialist community perinatal mental health teams across Scotland."*

> *"There is no 'one size fits all' model of care appropriate here. There is no concept of what kind of service is optimal for large health board areas with relatively low birth rates.... A managed clinical network would be ideal with a standardised approach where possible, for example with reasonable patient information leaflets and guidance for staff etc. Investment in some areas will be necessary to reach equity across Scotland."*

A number of consultant general adult psychiatrists from the north of Scotland also took time during the themed visit, to share with us the detail of some of the complexities they face. They highlighted a range of issues that impact on patient care, including:

- Limited local resources
- A lack of specialist staff
- Small numbers of patients

Practical and logistical difficulties were also highlighted to us, including issues such as how to safely transport an acutely unwell woman several hundred miles in an ambulance (including whether services met in the middle to "hand over" the patient). We were told that sometimes, it seemed safer to the treating team to first treat a woman locally in an acute adult ward until she was more stable. Once stable, they were sometimes unsure if there was any benefit in transferring the patient to an MBU, rather than completing her treatment nearer home.

These issues are very complex. They also highlight how, in the context of acute perinatal illness, the focus of care can easily shift from that of both mother and baby to the needs of the mother alone. Keeping both mother and baby in mind is challenging. Safely and thoughtfully supporting a mother and baby's relationship during an episode of maternal mental illness is a reason for having mother and baby units and why skilled, specialist multidisciplinary perinatal teams are so important.

We discuss equity of access to specialist care and national service provision further in the full themed visit report.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