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*The diffusion of joint mother and baby psychiatric hospital
admissions in the UK: An historical analysis*

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ABSTRACT

Title: The diffusion of joint mother and baby psychiatric hospital admissions in the UK:
An historical analysis.

Background: A key innovation in the provision of inpatient services to facilitate the care and treatment of women with severe postnatal mental illness was the introduction of joint mother and baby psychiatric hospitalisations, where both the mother and baby are admitted to hospital together. This study examined the history of the practice of joint mother and baby admissions across the UK and critically explored the processes relevant to the diffusion of joint admissions and patterns of service development to identify the possible and probable causes for significant differences in service provision across the United Kingdom (UK).

Aims: The study examined the documented history of the development of practice of joint mother and baby psychiatric hospital admissions across the UK and in doing so,

- a) Identified the pattern of service and practice development and the likely reasons for the pattern of the chronology.
- b) Identified the processes involved in the diffusion of joint mother and baby admissions in the UK, and explored why the practice was sustained (or not).
- c) Contributed new information to the continued development of innovation diffusion theory and research, and its application to health care service and practice development.

Methods: A historical method was used in the study and was reported through the use of historical narrative and analysis. Data was collated from primary and secondary sources of documented evidence which was used to inform the history of joint mother and baby admissions across the UK. Data was analysed using the

theoretical framework of diffusion of innovation (Rogers, 2003).

Findings:

Two versions of the same innovation were identified: joint admissions to side rooms of general adult psychiatric wards or annexed areas of the wards and joint admissions to specialist mother and baby units. Neither version of the practice followed the normal S-curve pattern of adoption in terms of frequency and rate of adoption. After a period of approximately 63 years there are 24 facilities for the provision of joint admissions in the NHS in the UK. The main influencers to the adoption of the practice was perception of risk, social networks internal and external to the NHS, the presence of clinical and political champions to drive the adoption and implementation of the innovation and policy entrepreneurship by clinicians working in the clinical field of perinatal mental health. The development of specific policy, guidelines and in Scotland, legislation, has resulted in a move during the last decade from joint admissions being diffused naturally to side room admissions being actively withdrawn and specialist psychiatric mother and baby units actively being disseminated. There is strong evidence that the diffusion process for specialist mother and baby units is still in motion at the time of reporting.

Conclusion:

Two competing versions of the same innovation had unusual patterns of diffusion. The influencers identified as relevant to the diffusion patterns of each version of the innovation were essentially the same influencers but they were used in different ways to affect change: rejection of one version of the innovation in favour of adoption of the other. The main influencers on the diffusion of joint admissions changed over the time line of the adoption pattern. Barriers to diffusion included the absence of evidence of effectiveness, the absence of economic evaluation, the position in service divisions of perinatal mental health

as a field of practice and the absence of succession planning across professional groups. Recommendations are made for future research.

CHAPTER 1: INTRODUCTION

The first chapter introduces the reader to the subject of the thesis. It provides a review of the relevant literature on the subject area of perinatal mental illness and outlines why it is an important area of study. In particular it considers the issue of hospital inpatient service provision. The study aim and objectives and the research questions are stated. An explanation of the theoretical framework that has been used to aid analysis of the findings from the study is provided and the literature on the use of the theoretical framework in health care service development research is reviewed as relevant to the study. The chapter is concluded with an explanation of the structure of the remainder of the thesis.

1.1 Perinatal mental illness and inpatient service provision

The importance of the availability of appropriate care and treatment for women with mental illness and their infants in the postnatal period has been demonstrated in evidence from research and from formal inquiries into significant events involving those women who have experienced this form of mental illness. 'Perinatal mental illness' is the overarching term used for mental illness¹ present during the period of pregnancy (antenatal period) or the first year after child birth (postnatal period). The ICD10 Classification of Behavioural and Mental Disorders included several discreet diagnoses of such illnesses (World Health Organisation, 1992). There is strong evidence that the presence of perinatal mental illness can have negative impact on the women affected, and as a consequence, a negative impact on their children (Cohn et al., 1990; Murray, 1992; Dawson et al., 2000). Severe perinatal mental illness is associated with significant impairment in social and personal functioning, as is mental illness out with the perinatal period. What makes the effects of particular importance in the perinatal period is the significant extent this impairment may have on the woman's ability to self-

¹ Use of the term 'mental illness' in the context of this study is a convenience reflecting the terminology prevalent in much of the literature over the period studied.

care effectively or to adequately care for children (Hipwell and Kumar, 1996; Howard, 2005). Research has suggested that a significant proportion of mothers with psychotic illness have parenting difficulties and lose custody of their baby into social or kinship care (Kumar et al., 1995; Ramsay and Kumar, 1996; Poinso et al., 2002). Perinatal mental illness has also been associated with detrimental effects on infant social and cognitive development (Murray et al., 1996). In a longitudinal study of children of mothers who had suffered from postnatal depression, cognitive delay and a range of emotional and behavioural difficulties were found to be significantly higher (Hay et al., 2001).

Long term effects on the mental health of children have also been identified. Beardslee and colleagues (1983) found that children of a parent with affective illness had themselves a 40 per cent chance of developing an affective disorder by age twenty, as compared to a 20 to 25 per cent risk in the general population (Beardslee et al., 1983). Rubovits (1996) concluded that having one mentally ill parent gave a child a 70 per cent chance of developing at least minor adjustment problems by adolescence and in cases where there were two mentally ill parents, there was a 30 to 50 per cent chance of a child becoming seriously mentally ill (Rubovits, 1996).

First presentations of severe mental illness in the form of psychotic illness in the postnatal period are uncommon, with a rate in the region of two per 1000 births; however across the life span the first month after childbirth has been shown to be the period of highest hospital admission rates for women (Kendell et al., 1987). For women with severe illness, hospital admission to psychiatric² inpatient services for care and treatment is normally required. This level of care and treatment is necessary as the needs of these women are particularly complex in respect to the impact of the

² The terms 'psychiatric' and 'mental' are used interchangeably in the literature in reference to hospitals or establishments used for the admission of patients for reasons of mental illness e.g. psychiatric in-patient unit; mental hospital; psychiatric hospital; mental health unit. For the convenience of the reader, the terms 'psychiatric' and 'psychiatry' will be used in the context of this study when making reference to the field of practice or provision of services concerned with the care and treatment of those with mental illness.

mental illness on functional ability, cognition, and the potential risk to safety, health and wellbeing of the mother and/or her baby (Hipwell & Kumar, 1996). In addition to new onset psychotic illness, women who have a pre-existing mental illness may suffer an exacerbation of their condition with studies having reported relapse rates for bipolar illness almost 70 per cent in the postnatal period (Viguera et al., 2000). These women, along with others who have psychotic illness such as schizophrenia, episodes of severe depression, severe anxiety disorders or difficulties due to personality disorder, are the key groups likely to benefit from care and treatment provided by specialist perinatal mental health services (National Institute for Health and Clinical Excellence (NICE), 2007).

The percentage of mothers affected by mental illness shows some consistency internationally. The United States National Comorbidity Survey found that 68 per cent of women with mental health disorders were parents, compared with 57 per cent of men (Nicholson, et al., 1999; Nicholson, et al., 1998). Similar figures are reported in both the UK (Brown and Harris, 1978; Oates, 1997) and Australia (McGrath et al., 1999). There have also been studies which evidenced the increased incidence of depression in men during their partner's pregnancy and the first postnatal year, similar to incidence rates in women. A meta-analysis published in 2010 identified that depression was evident in over ten per cent of fathers during the antenatal and postnatal periods and was relatively higher around three to six months postnatally, with moderate positive correlation between paternal and maternal depression (Paulson et al., 2010). The evidence clearly demonstrates that the potential negative impact of perinatal mental illness is not just for the woman, but can also have wider long term consequences for the child and the family unit as a whole.

1.2 Joint mother and baby admissions and psychiatric mother and baby units

A key innovation in the provision of inpatient services that facilitated the care and treatment of women with severe postnatal mental illness was the introduction of joint mother and baby hospitalisations (Douglas, 1956; Main, 1958). Joint admissions as they are referred to, are

admissions of women to hospital for reasons of treatment of mental illness, accompanied by their infant (Main, 1958). This includes admissions of women with puerperal psychosis, other psychotic illness such as bi-polar disorder and schizophrenia, and those women with severe non-psychotic illness such as severe depression or anxiety disorders. Although wherever possible treatment at home is the preferred option, women with severe mental illness in the postnatal period are likely to require admission to psychiatric hospital for treatment of their condition. For some women, but not all, this will be admission to a specialist mother and baby unit where they can continue to be with their baby during the period of their hospital admission.

Brockington (1996) provided a brief historical summary of how the practice of joint admissions developed since the account of the first admission in 1948. He described how the practice emerged following a request by a woman to bring her toddler son with her when she was being admitted to Cassel Hospital in Surrey as she had no other means of care for him. Her psychiatrist Thomas Main agreed on the basis of earlier experiences of clinicians in the paediatric field (Main, 1958 quoted in Brockington, 1996. 557). Although not explicitly stated, Main (1958) may have been referring to the earlier experiences of paediatricians where they identified a condition that developed in infants when the infants spent prolonged periods in hospital separated from their mother's care. Physicians in children's hospitals in the nineteenth century had referred to the condition as 'hospitalism' (Crandall, 1897). Spitz renamed the condition 'anaclitic depression' in the 1940s (Spitz, 1945). The studies of the effects of prolonged hospitalisation in children led to the introduction of the practice of mothers being encouraged to stay with their child in hospital during the period of their child's admission. This was thought to reduce the risk of the condition developing and led to improved outcomes for both the child and mother (Spitz, 1945).

Brockington (1996) provided further references to joint psychiatric admissions and cited several clinicians who were involved in implementing the practice and developing specific specialist mother and baby units (Brockington, 1996). Clinicians cited by Brockington (1996) included Baker and

colleagues (1961) who studied a cohort of women diagnosed with schizophrenia, and separated from their infants during admission. It was found that only 50 per cent of them resumed the care of their child on discharge from hospital. They subsequently set up a specialist eight bed unit and conducted a comparative study of women admitted with their infants, and women who were admitted alone. The women who received joint admissions had better outcomes with shorter length of admission, lower rate of relapse, more positive response to treatment, and all continued to care for their children after discharge compared to only 35 per cent of the comparison group of women who were admitted to hospital without their infants (Baker et al., 1961).

Brockington's narrative highlighted the issue of the slow development of services and referred to the lack of perinatal mental health services that demonstrated a comprehensive therapeutic and preventive approach (Brockington, 1996. 560). There have been several surveys conducted on the topic of hospital inpatient service provision for perinatal mental health care in the UK (Aston and Thomas 1986; Kumar et al., 1986; Shawcross and McRae 1986; Cassell and Coleman 1990; Prettyman and Friedman 1991). The most recently published survey was a cross sectional survey of alternatives to standard acute inpatient care for women with perinatal mental illness which was conducted in 2005 in England (Elkin et al., 2009). The results of this study are detailed later in the thesis in Chapter 3.

No published studies were found which assessed the cost effectiveness of specialist psychiatric mother and baby units. The absence of this type of evaluation is discussed later in the thesis in relation to any relevance this may have to the slow spread and development of the practice.

Development of the practice of joint admissions appeared to have been largely unplanned at least at a national level across England and Wales (Cassell and Coleman, 1990; Elkin et al., 2009). Over the time period that mother and baby admissions have been practiced, they appear to have more frequently taken the form of 'side room' admissions rather than admissions to specialist psychiatric

mother and baby units until the last decade. Side room admissions were admissions of mothers with their infants to general adult psychiatric wards in hospitals. They were accommodated within single rooms and the baby would sleep in a cot in the same room with the mother. This arrangement for joint admissions appeared in the literature in the 1960s (Fowler & Brandon, 1965; Hamilton et al., 1969) but there was neither universal adoption of the practice or a national evaluation of the model.

A systematic review was carried out by Irving and Saylan (2007) to identify evidence on the effectiveness of mother and baby units in addressing the problems faced by both mothers with mental illness and their babies in comparison to standard care in general adult wards for mothers alone. The authors could not identify any randomised controlled trial based evidence for the effectiveness of the units and noted the literature on the subject generally consisted of anecdotal or descriptive studies. They concluded that the lack of data was of concern as mother and baby units were espoused as the 'gold standard' of care for mothers and their babies (NICE, 2007) yet their effectiveness had not been validated. They suggested that more robust quantitative research on efficacy was urgently needed (Irving and Saylan, 2007).

Looking for evidence surrounding the practice from a clinical governance and policy perspective during the period from 1948 until early 2000, there appears to have been an absence of policy, statutory frameworks and no obvious governance arrangements to ensure standardized or efficient and effective practice across the UK. This may in part explain the variances apparent across geographic areas and between services. This is explored further in the analysis section of the thesis in Chapter 8.

The published literature and the experience of practitioners working in the field of perinatal mental health care clearly concludes that adoption of the practice of joint admissions is not universal, has taken more than one form, has not been evidenced robustly for effectiveness, and has developed

at different rates in different health board and health authority areas across the four areas of the UK. The lack of robust empirical evidence to their effectiveness may be a contributory factor to this apparent inconsistent pattern of service provision. Although there have been several published surveys in the general area of the provision of psychiatric mother and baby units and joint admissions, there are no published studies on the patterns of the adoption of joint mother infant admission practices, on what has influenced the development, or why the practice has not developed in many geographic areas.

1.3 International context

Although this study is focused on the development of joint admission practice and services in the UK, in order that this is understood in a wider context, a summary of the literature on the provision of similar services elsewhere in the world has been included.

Other than the UK, the United States of America (USA) was the first country to report on the practice of joint mother infant admissions. There were several publications on the subject during the 1960s and 1970s. In the USA the practice appeared to have first taken place in the early 1960s where mother and infant pairs were admitted to adult psychiatric wards (Grunebaum et al., 1963; Grunebaum and Weiss 1963; Grunebaum et al., 1975; Luepker, 1972; Rau and Kaye, 1977). There was then a gap in the published literature on the specific subject of joint admissions by American authors until the mid-1990s when Wisner and colleagues reported on difficulties faced by clinicians due to the lack of inpatient mother and baby units (Wisner et al., 1996). This would indicate that after the initial enthusiasm for the practice in New York and Massachusetts in the 1960s and early 1970s, no further specialist units were developed, and the early units had not been sustained.

Around the same time as the practice was being implemented in America, in 1960 the practice was also being introduced in France. A brief chronology of the development of psychiatric mother and baby units in France and Belgium was provided by Cazas and Glangeaud-Freudenthal (2004).

They reported that the first joint admissions took place in France in 1961 and were the work of Racamier, a French Psychiatrist and Psychoanalyst. The first specialist mother and baby unit did not open in France until 1979 in Creteil near Paris. In 2003, it was reported that there were 17 mother and baby units in France, six in the Paris area and 11 more dispersed across France (Masson, 1977; Dugnat, 1988; 1992; Durand and Marcilly, 1992; Durand et al., 1994; Colloque de Creteil, 1993; Cazas and Glangeaud-Freudenthal, 2004).

The facilities varied in size from between two and 15 beds (Cazas and Glangeaud-Freudenthal, 2004). The units with six beds or more were separate units whilst the facilities with a smaller number of beds were annexed to either general adult psychiatric wards or to child psychiatry units. There was also one unit in France that was located within a paediatric unit (Cazas and Glangeaud-Freudenthal, 2004). It was far less common in France than in the UK for units to be provided within the context of adult psychiatric services. In France most units were under the clinical direction of child psychiatrists or child psychotherapists and there were also examples of units being jointly provided by adult psychiatrists and child psychiatrists. This was a different model to those in the UK where services were largely developed within the context of general adult psychiatric settings, and generally not within children's psychiatric services. In the UK there was one example of a family residential unit opened in 1975 that was part of the child and family psychiatric service at Stratheden Hospital in Fife, Scotland but the function of this unit was largely aimed at addressing disorders in children or difficulties within the context of the functioning family unit of parents and siblings (Haldane et al., 1980). It was not a mother and baby unit per se and was therefore not included as evidence for the purpose of this study.

New Zealand first reported on joint admissions to a general adult psychiatric ward in Auckland in 1965 (Lindsay, 1975; Lindsay and Pollard, 1978). New Zealand currently has a six bed psychiatric mother and baby unit in Christchurch which serves the population of the South Island. There is no inpatient provision for joint admissions on the North Island.

The Netherlands started joint mother and baby admissions in 1967 (Klompenhouwer et al., 1991). In 2011 a five bed unit was still being provided at the Rotterdam University Hospital.

A paper published by Molnar and White (1972) described a psychiatric inpatient program in Hamilton, Ontario in Canada in which at least two family members, usually the mother and child, were admitted to the general adult psychiatric hospital to “lessen the patients' break with family and community” (Molnar and White, 1972). The mothers were mostly diagnosed as suffering from postnatal depression rather than psychotic illness. The emphasis of the program was on identification of adaptation problems and treatment by means of social, behavioural, physical, and psychotherapeutic intervention. A further article by Stewart (1989) reported on a comparison study of a group of 32 psychiatrically ill postpartum women who were admitted to a general hospital psychiatric unit with their infants in Toronto, Canada. The comparison group were 26 psychiatrically ill postpartum women hospitalized on the same unit who refused admission of their infants. The study took place over a two year period (Stewart, 1989). The women admitted with their infants were more likely to be older, living with the infants' father, in a stable residence and job, in hospital for a longer time, and caring for their babies at two year follow-up in contrast to the comparison group who were admitted without their infants. The two groups were also found to be diagnostically different, with joint admission mothers likely to suffer from an affective psychotic illness, while the mothers who were admitted without their infant were more likely to suffer from personality disorder or substance abuse (Stewart, 1989).

A history of joint mother and baby admissions in Jerusalem was provided by Maizel and colleagues (Maizel et al., 2005). They described how the first reports of joint admissions were published in Hebrew in 1974³ (Magal, 1974). Maizel and colleagues described how the practice originated from nursing staff that went against resistance from hospital administrators to admit nine mother and

³ This original article was not sourced as it was published in Hebrew.

baby pairs to a psychiatric unit that was part of a general hospital in Israel. They described how this original report was followed by a report published in 1975 (in English) that eight mothers with their babies had been admitted to an open ward at Eitanim Psychiatric Hospital over a three year period (Mester et al., 1975). Maizel and colleagues described how there continued to be sporadic admissions to the psychiatric hospital until 1984 when a mother attempted to kill her baby in response to hallucinations. The baby apparently was not harmed but the incident resulted in severe resistance from hospital staff and administrators and joint admissions were subsequently stopped. This remained the position until the 1990's when the practice was reintroduced to the same hospital and a dedicated unit with two beds was opened in 1999 (Maizel et al., 2005). This unit was the only facility that provided for joint admissions in Israel.

Australia appeared to have opened its first specialist psychiatric mother and baby unit in 1983 in Melbourne, Victoria (Buist et al., 1989). It was reported that development of the units in Australia was dependent upon political, group, and individual forces and, as in the UK, there was no uniformity in how or where they were developed (Buist et al., 2004). In 2003 there were three mother and baby units in the public sector in Melbourne and one unit in Adelaide. In the private sector the authors reported there were another four units in four of the six remaining States and the authors noted that Melbourne had considerably more mother and baby psychiatric beds per head of population than other Australian and international cities but did not provide any insight as to why this was the case (Buist et al., 2004). One of the units, which had eight beds, only admitted women with anxiety or moderate depressive disorders as the unit was housed within the seventh floor of an obstetric hospital, with no other psychiatric services on site. This model appears to have been unique to Australia and indeed was later revised by the Government and was re-provided as an extension to an acute psychiatric hospital when a new general and obstetric hospital was built. The other units, each with six beds, admitted women with the full range of mental illness including psychosis. It was also reported that a private unit had closed due to financial reasons and concerns about inadequate space (Buist et al., 2004).

I visited the units in Melbourne in 2002 and found that, in addition to those units that were similar to the units developed in the UK and other European countries, the model in Australia included a variation in the private sector which focused on issues in parenting. Mothers and babies were admitted for reasons such as difficulties with infant feeding or sleep disturbance and were able to receive a specific program of intervention and education to address such issues that may interfere with mother infant attachment. Many of these women had mild to moderate postnatal depression but the units also admitted mothers who did not have mental illness and therefore would not be considered to be psychiatric mother and baby units per se.

In Belgium the first unit was opened in 1990. There were three units until 2003 when one unit was closed. Similarly to France, one unit was located in a paediatric unit (Cazas and Glangeaud-Freudenthal, 2004).

It appeared that there was at least one mother and baby unit in Germany as was reported in the article by Cazas and Glangeaud-Freudenthal (2004). However, the two articles they cited in relation to this unit were not published in English and were therefore not accessed for further primary information. The same authors also stated that a unit was soon to be opened in Luxembourg but an internet search in January 2012 did not identify any further references pertaining to the existence of this unit.

It can therefore be seen that although the practice of joint admissions and specialist service provision extends beyond the UK, it predominantly exists only in Australasia and a small number of European countries. Similar to the UK, it is evident that practice and service provision within these countries is not homogenous.

There have been significant differences in service provision of this type across the United Kingdom (UK). Families in some areas of the UK could access specialist service provision, knowledge, skills and expertise, whilst at the same time families with equal needs living in other geographic areas could not access such service provision. Equitable access to health services is commonly described as equal access to treatment for those in equal medical need, irrespective of other characteristics, such as income. This principle is also known as 'horizontal equity' of health care delivery (Wagstaff and Van Doorslaer, 2000). In applying this definition, it indicated a longstanding inequity of service provision for this particular client group across the UK.

The services that have existed have varied in how they operated and in the care and treatment they provided (Nicholls and Cox, 1999; Elkin et al, 2009). In addition, surveys of service provision carried out over several years identified that some services were withdrawn after a period of time (Kumar et al, 1986; Cassell and Coleman, 1990; Oluwatayo and Friedman, 2005). An exploration and analysis of events, processes and influences to service provision is warranted in order to identify and understand possible reasons for the observed inconsistencies in service and practice development. Identification of the reasons underlying service withdrawal could also be important in understanding the influencers to sustainability of existing services.

1.4 Literature review: Part 2

Possible reasons why this apparent inequity of service provision existed across the UK have not previously been studied. The spread or 'diffusion' of joint admissions and in particular, specialist mother and baby units, appeared to start more than 60 years ago. Despite this lengthy period of time since the first development of the practice, many areas still do not provide facilities for joint admissions, yet the model is widely held to be one that benefits mothers with severe mental disorder and their infants (Oates, 2000; NICE, 2007). In order to identify and understand the reasons for this apparently unusually slow spread of service development, it was important to

identify an appropriate theoretical framework that could be used to inform this. This part of the literature review has therefore been structured to provide the reader with an introduction and explanation of the theoretical framework 'diffusion of innovation' (Rogers, 1962; 2003) followed by a review of the literature that focuses on the application of diffusion of innovation theory to health care service development.

1.5 The theoretical framework of diffusion of innovations

The theoretical framework that has been identified to support an understanding of the evidence of joint mother and baby service development is 'diffusion of innovation' (Rogers, 1962. 2003).

Definitions of 'diffusion' and 'innovation' are provided to facilitate the understanding of the basis of the theory:

"An innovation is an idea, practice, or object that is perceived as new by an individual or other unit of adoption"..... "The perceived newness of the idea for the individual determines their reaction to it: if an idea seems new to the individual, it is an innovation" (Rogers, 2003. 12).

'Diffusion' is described as a particular type of communication in which the content of the message is concerned with a new idea. It is a type of social change and is defined as:

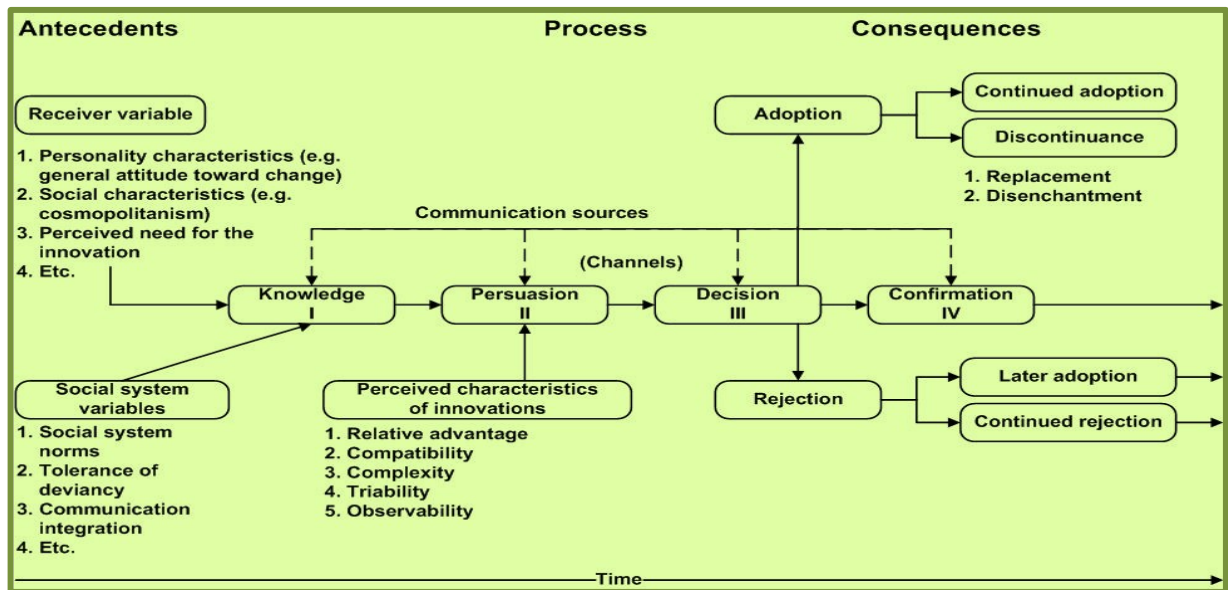
"The process by which an innovation is communicated through certain channels over time among the members of a social system". The four main elements are the innovation; the communication channels; time; and the social system (Rogers, 2003. 35).

Diffusion research offers a particularly useful means of gaining an understanding of change and has the unique quality of giving 'life' to a behavioural change process. Conceptual and analytical strength is gained by incorporating time into the framework as an essential element in the analysis of behaviour change (Rogers, 2003. 104). The diffusion model is a conceptual paradigm with relevance for many disciplines and cuts across various scientific fields (Rogers, 2003. 103). The

theoretical framework of diffusion of innovations provided by Rogers (2003) has been replicated in

Figure 1:

FIGURE 1: Rogers' theory of diffusion of innovations (1962; 2003)



Diffusion research is a particular type of communication process research, but its origins lie outside of the academic field of communication. The origins of the study of diffusion of innovations have a long history in social science, spanning approximately one hundred and ten years. Since it was first developed however, the concept of diffusion of innovations has been adapted or extended to apply it to specific domains of interest. Education, anthropology, marketing, geography, rural sociology, political science and public health have all pursued diffusion research in their own ways. The works of Rogers (1962; 2003) and Van de Ven (Van de Ven et al, 2000) are probably the most well known in the field. Rogers introduced the subject by confirming that getting a new idea adopted, even when it has obvious advantages, is a difficult thing to do (Rogers, 2003. 1).

Numerous variables have been identified as affecting the diffusion and adoption of innovations. Once an innovation has been developed and the decision is taken to communicate the innovation to potential adopters, the next stage in the diffusion of the innovation is the innovation decision

process. Rogers (2003. 168), described this process as having five stages: the process through which an individual (or the decision-making unit) passes from (1) gaining initial knowledge of an innovation, (2) to forming an attitude toward the innovation, (3) to making a decision to adopt or reject the innovation, (4) to implementation of the new idea, and (5) to confirmation of this decision.

Rogers (2003. 403) describes three types of innovation decisions:

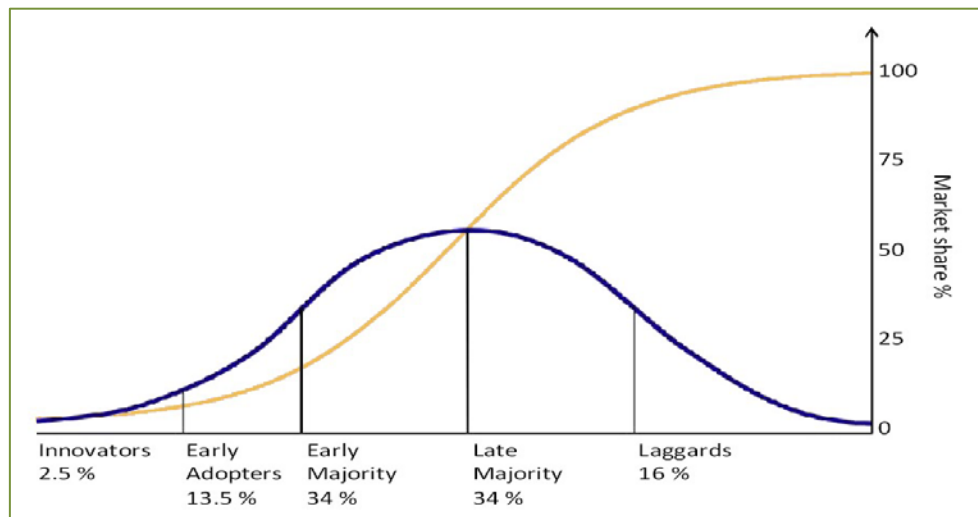
- (1) Optional innovation-decisions: choices to adopt or reject an innovation that are made by an individual independent of the decisions by other members of a system.
- (2) Collective innovation-decisions: choices to adopt or reject an innovation that are made by consensus among the members of a system.
- (3) Authority innovation decisions: choices to adopt or reject an innovation that are made by relatively few individuals in a system who possess power, high social status, or technical expertise.

In their research on diffusion of innovations, Rogers followed by Van de Ven, identified three main groupings of influence that are important factors to the rate of a change being adopted. These findings were the perception of the innovation; the characteristics of the people or organisations who adopt and do not adopt the innovation; and the characteristics of the environment and contextual factors such as leadership, incentives, communication and management (Rogers, 1962; 2003; Van de Ven et al, 2000; Berwick, 2003). Whilst there is a general agreement regarding the relevant variables, there is very little consensus on the relative importance of the different variables, and in some cases disagreements over the direction of relationships (Tidd, 2010. 20).

The rate of adoption is the relative speed with which an innovation is adopted by members of a social system. It tends to be measured as the number of individuals (or other unit of adoption such as number of organisations) who adopt a new idea in a specified period of time. The rate of adoption is therefore a numerical indicator of the steepness of the adoption curve for an innovation

(Rogers, 2003. 221). Rogers' (2003) model of diffusion is based on the classical 'bell shaped' normal distribution curve, where the curve represents the frequency of consumers adopting a product or innovation over time. If the cumulative number of adopters is plotted, the result is an s-shaped (sigmoid) pattern. Adoption can therefore be demonstrated in two ways; by frequency which typically follows a bell shaped curve (dark line in Figure 2); and by cumulative totals of number of units of adoption which typically follows an s-shaped or sigmoid curve (lighter line in Figure 2). In basic terms, the S-curve model demonstrates that in cases when the decisions to adopt are voluntary, there is a mathematically consistent sigmoid pattern cumulative curve of adoption.

FIGURE 2: Diffusion curves (Reproduced from Wikimedia Commons, accessed September 2011)



Rogers (2003) argues that the adoption curve is normally distributed because of a learning effect due to personal interaction within social systems. As the number of adopters in the system increases so does the level of interpersonal influence on non-adopters. The innovation is first adopted by a few individuals or organisations, the more the innovation is then used, the more other people see it in use, and if the innovation is perceived to be better than what was available or what happened before, more people or organisations (as the unit of adoption) begin to use it. Diffusion

studies have repeatedly demonstrated the theory's strength as a theory of social change (Green et al, 1991). Many studies have shown that the predictable pattern of adoption, spread over time, is largely due to opinion leaders telling others about it and modelling the innovation for others to see (Dearing, 2008). Once the diffusion reaches a level of critical mass, the diffusion rate normally proceeds rapidly. Critical mass occurs at the point at which enough individuals in a system have adopted an innovation so that the innovation's further rate of adoption becomes self-sustaining (Rogers, 2003. 344). At some point in time, or in frequency, the innovation reaches a section of the population that is less likely to adopt it, and diffusion slows to a point of saturation (Cain and Mittman, 2002. 11).

Rogers (1962; 2003) identified that there is a hierarchy of people likely to adopt an innovation and divided them into five categories: (1) Innovators (2) Early adopters (3) Early majority (4) Late majority, and (5) Laggards. He defined the various categories statistically, taking the number of standard deviations from the mean adoption time for the population of adopters and categorising them in this way. He acknowledged this was an artificial classification but the categories of adopters he identified have proven over time and in numerous studies to be helpful as a model of variation in adoption behaviours (Berwick, 2003. 1972). Where the categories sit in the adoption curve in terms of frequency over time is demonstrated in Figure 2.

The characteristics of adopter categories are described as follows: innovators are characterized as being technically sophisticated, risk-taking and as a result are atypical. Early adopters, in contrast, are more integrated with and respected by peers, and help to reduce perceived uncertainty for latter adopters. The early majority are well-connected in the social system and include opinion leaders; the late majority are more sceptical, and adoption is more the result of peer pressure and economic necessity. Finally, laggards, despite the label, have the least innovation bias and are the most rational of adopters (Tidd, 2010. 9).

In addition to the characteristics of adopter categories, previous research identified five indicators that are the most important characteristics in explaining the rate at which an innovation is adopted. These characteristics include relative advantage, compatibility, complexity, trialability and observability. The innovations that are perceived by individuals as having greater relative advantage, and greater compatibility, that are able to be tried first, and are less complex and are observable, will be adopted more rapidly than other innovations (Rogers, 2003. 16). If potential users see no relative advantage in the innovation, then they are unlikely to consider it further. Innovations that have a clear unambiguous advantage in terms of effectiveness or cost effectiveness are more easily adopted and implemented (Rogers, 2003; Meyer et al. 1997). Relative advantage alone, however, does not guarantee widespread adoption (Denis, et al. 2002; Fitzgerald, et al. 2002).

The influence of interpersonal communication, including nonverbal observations, is also seen as a key factor accounting for the speed and shape of the diffusion curve (Rogers 2003; Gatignon and Robertson 1985; Mahajan, Muller and Bass 1990). The main focus of diffusion theory is the means by which information about an innovation is disseminated to, or within, the social system. Tidd (2010) suggested that in practice, the precise pattern of the adoption of an innovation will depend on the interaction of 'demand-side' and 'supply-side' factors. He identified that demand-side factors included direct contact with or imitation of prior adopters, and adopters with different perceptions of benefits and risks. Supply-side factors, in comparison, included relative advantage of an innovation, availability of information, barriers to adoption, and feedback between developers and users (Tidd, 2010. 14). Tidd (2010) also indicated that there are many barriers to the widespread adoption of innovations. These include economic barriers such as personal costs versus social benefits, access to information and insufficient incentives. He also includes behavioural barriers such as priorities, motivations, rationality, inertia, propensity for change or risk. The organizational barriers include goals, routines, power and influence, culture and stakeholders, and the structural barriers include infrastructure, sunk costs, and governance. Tidd (2010) concluded that the simple epidemic model

or S-curve model appears to provide a good fit to the diffusion of new processes, techniques and procedures.

Diffusion of innovations theory is not without its critics and research in the field has been acknowledged as having short-comings. Critics of the model conclude that it is an overly simplified representation of a complex reality. Adopters often fall within different categories for different innovations: a current laggard can be an early adopter the next time around (Downs and Mohr, 1976). The model is not predictive. It does not provide insight to how well a new idea or product will do before it has gone through its adoption curve (Rogers, 2003. 106). It has also been recognised that 'pro-innovation bias' exists in the research (Rogers and Shoemaker, 1971; Downs and Mohr, 1976). This is described by Rogers as:

“the implication in the diffusion research that an innovation should be diffused and adopted by all members of a social system, that it should be diffused more rapidly, and that the innovation should be neither reinvented nor rejected” (Rogers, 2003. 106).

Rogers points out that the bias is rarely outwardly acknowledged in published research but is assumed or implied. Referring to 'pro-innovation bias' he explains the potential implications of this as:

“Potentially dangerous in an intellectual sense. The bias leads diffusion researchers to ignore the study of ignorance about innovations, to under emphasise the rejection or discontinuance of innovations, to overlook reinvention.....The result of the pro-innovation bias in diffusion research is a failure to learn about certain very important aspects of diffusion. As a result, what we do know about diffusion is unnecessarily limited”. (Rogers, 2003.107).

The bias has led diffusion researchers to under emphasise the rejection or discontinuance of innovations and to overlook reinvention (Rogers, 2003. 107). The study of the diffusion of joint admissions has not only focussed on the influencers to adoption, but has also considered reasons

why the practice was not adopted, or was later rejected. The decision therefore, to apply this theoretical framework to support the analysis of the findings, was not a weakness in this study as the aim was not biased towards the positive value of the adoption of the innovation.

1.6 Diffusion of innovations and health care services

The literature on the diffusion of innovations is vast as the theory was originally applied more than a century ago to industrial innovations and, as mentioned previously, has been applied across many academic fields of research since. In view of the fact that the focus of this research is the development of a particular service within the national health care system it was decided that a search of the literature on diffusion of innovations theory and its specific application to health care services was most appropriate for the purpose of this study. Rogers (2003) had provided a comprehensive review of the literature. His review of the literature was thought to be reliable as this was the fifth edition of this text and Rogers is renowned as an expert in the study of diffusion of innovation research. Therefore, in order to manage the literature more effectively, the search period selected was from 2002 until 2011 (2002 was selected as the starting point as it was likely that the date of publication of his text was several months after Rogers (2003) had carried out his review of the literature).

This literature review involved a search of online electronic databases that are known to hold healthcare related publications: Ovid Medline 1996 until 2011; Ovid Medline 1988 until 1995; Medline with Full Text; Journals@Ovid Full Text; NHS Scotland Journals@ Ovid; EBM Reviews full text; CINAHL Plus with full text; Embase 1988 until 2011; PsycINFO until 2011; Health Business Elite. Keyword search terms were used: "innovation diffusion"; "diffusion of innovations"; health care"; "health services"; and "service development" and combination searches of the keywords were then conducted. Relevant articles identified through searches of the keywords and combinations were supplemented by identifying the references cited in these articles to provide

further sources of published articles, a snowballing methodology. Only full-text English language articles were sourced to eradicate the need for translation from other languages.

The results of the literature search process identified an extensive systematic review of the literature on research into the diffusion of service innovations commissioned by the Department of Health in England to inform the National Health Service (NHS) modernisation programme (Greenhalgh et al, 2004). This systematic review was the most comprehensive review of the literature within the field of healthcare identified to date. More than 1000 papers on the diffusion, spread and sustainability of innovation in health service organisations were included. The authors noted that the amount of replication of empirical studies when carrying out the review and made recommendations for further empirical research in specific areas. They highlighted areas where further research was not needed (Greenhalgh et al, 2004. 11). The authors did not recommend further descriptive studies on patterns of adoption by individuals. They also identified that there was enough research on intervention trials of the use of opinion leaders to change the behaviours of potential adopters. However the reviewers found that the majority of empirical studies of implementing and maintaining innovations in service organisations had been undertaken from a pragmatic rather than an academic perspective. They also found the data was presented in the form of reports rather than robust studies and that the majority of the research was embedded within the wider literature on change management and was lacking in process information.

A recommendation by the authors was that further research in terms of implementation and maintenance of innovations should focus on two areas. One of the recommended areas for further study was:

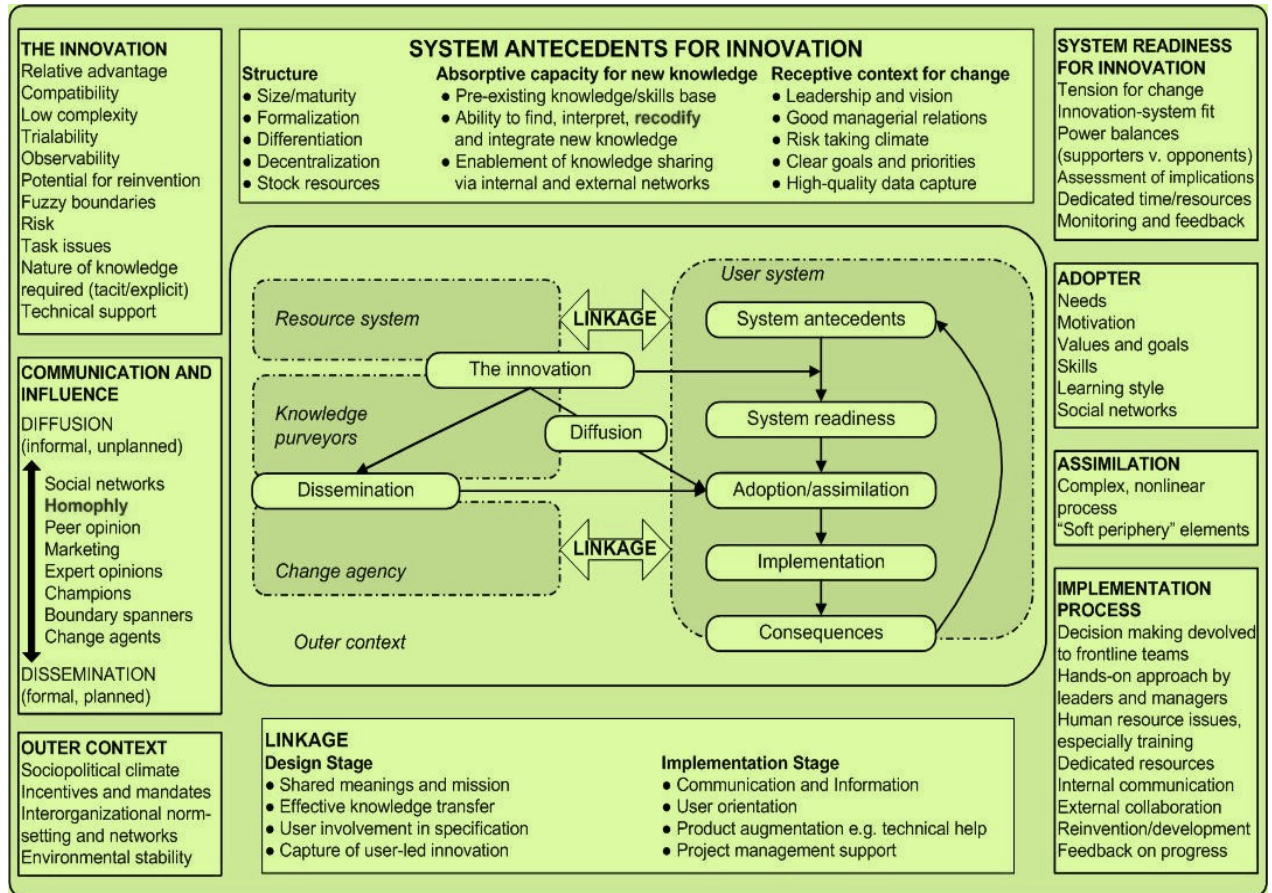
“By what processes are particular innovations in health service delivery and organisation implemented and sustained (or not) in particular contexts and settings, and can these processes be enhanced?” (Greenhalgh et al., 2004).

This recommendation appeared to correlate to the aim of this study on the diffusion of joint admissions and was therefore used as a basis for one of the study questions. Furthermore, from

their synthesis of the theoretical and empirical findings of the systematic review, the authors identified a conceptual model of diffusion and dissemination to aid the identification of different aspects involved within complex organisations such as the health service, which strengthened the decision to take forward their recommendation (Greenhalgh et al., 2004. 6). The reviewers proposed an adaptation to Rogers (2003) model for considering the diffusion of innovations in health service organisations. A more detailed textbook on the findings of this review was published later (Greenhalgh et al., 2005). The model has been reproduced in Figure 3.

It is known that the healthcare industry has a unique structure and that the diffusion of innovations depends on different dynamics. These dynamics are formed from factors that subsequently affect the diffusion process (Daim et al., 2008). Plsek (2003) described how within healthcare there systems are embedded within other systems that co-evolve. Plsek (2003) provided an example: he described how a group of medical professionals in itself comprised a social system which was embedded within a local or regional health care system. This was further embedded within the national healthcare system, which in turn was embedded within a political system. Within these formal systems and hierarchical relationships there also exist various informal systems. The example he gave was colleagues and friends having discussions over lunch, which could be both an aid to the spread of innovation or could work against it (Plsek, 2003). Berwick (2003) noted that even when an evidence-based innovation is implemented successfully in one part of a hospital, it may spread slowly or not at all to other parts of the organisation.

FIGURE 3: Conceptual model for considering the determinants of diffusion, dissemination and implementation of innovations in health service delivery and organisations



Innovation in health care has been recognised as a complex issue and health care organisations are themselves complex systems (Plsek and Greenhalgh, 2001). Van de Ven and colleagues (1999) also noted the complexity of health service organisations and the process of adoption of innovations in such complex environments and systems is not straight forward and does not follow a clear path, with multi factorial influences and barriers (Van de Ven et al., 1999). An organisation such as the NHS is considered to be a complex system by the degree to which the organisation's members possess a relatively high level of knowledge and expertise, usually measured by the

member's range of occupational specialities and their degree of professionalism (Rogers, 2003. 412).

A study to investigate factors influencing the implementation of a model for service delivery and organisation in mental healthcare identified that implementation was influenced by three interrelated factors: the means by which the model was introduced to the workforce, use of the model itself by service providers, and the broader service context. Thus, negative reactions to the way the model was initially presented strongly influenced service providers' subsequent views of it. It is not known if this has implications for sustainability of services (Kaner et al, 2003).

Rogers' classical diffusion model focussed on adopter innovativeness, with individuals as the locus of decision, communication channels, and adoption as the primary outcome measures in post hoc observational study designs. The diffusion systems were centralised and fidelity of implementation was often assumed (Dearing, 2008). There are differences in the innovations individual people adopt and at what rate they spread them to others. Some innovations are never adopted at all whilst others are later abandoned (Greenhalgh et al., 2004; 5). Diffusion in organisations is more complex than diffusion by individuals. Within healthcare organisations diffusion exists alongside dissemination. Government policy informs healthcare delivery in the modern NHS in many fields of practice and the local NHS Boards or healthcare trusts are required to implement the government policies. This shifts the paradigm from a voluntary, informal and unplanned process among peers to one of planned centralised distribution and spread. Greenhalgh and colleagues' conceptual model recognised this added factor (Greenhalgh et al., 2004. 6). Berwick on the recognition that dissemination of innovations in the healthcare system was difficult stated, "*in healthcare, invention is hard, but dissemination is even harder*" (Berwick, 2003. 1970). Rogers suggests that within the research on the diffusion of innovations in organisations there is an assumption that organisational variables are of relevance over and above the variables of individual people within the organisation (Rogers, 2003. 418).

1.7 Summary of literature review part 2

The vast amount of literature on the diffusion of innovations within healthcare organisations that was comprehensively reviewed by Greenhalgh and colleagues (2004) evidenced that the theoretical framework has been used extensively to research diffusion of innovations within the NHS in the UK. The outcome of particular relevance from their review was their suggested conceptual model of diffusion and dissemination of innovations within healthcare organisations (Greenhalgh, et al., 2004). The depths of their findings have not been included in detail as neither the scope of the thesis would allow for this, nor was it necessary for the purpose of the study.

1.8 Aim and objectives of the study

This study has therefore examined the history of the development of practice of joint mother and baby admissions across the UK. The aims were to:

- a) Identify the pattern of service and practice development, the reasons for the pattern history and provide a narrative that accounted for the complex history of service development.
- b) Identify and discuss the processes involved in the diffusion of joint mother and baby admissions in the UK, how they were sustained (or not) and why this was the case.
- c) Contribute new information to the continued development of innovation diffusion theory and research, and its application to health care service development and practice development.

1.9 Research questions

The research questions were:

1. What was the chronology of the diffusion of joint mother and baby psychiatric admissions in the UK?
2. Why did this pattern of service development evolve; what factors and influencers were relevant to the identified pattern of service development?
3. Were there differences in the factors and influencers of relevance to service development across the four areas of the UK and what were the possible reasons for this?
4. Did the factors influencing service development change over time?

In achieving these objectives and answering these questions the data examined was analysed using the theoretical framework of diffusion of innovations (Rogers, 1962; 2003) in the context of the following three areas:

1. UK development of practice as a whole.
2. At the level of the individual areas in the UK: England, Wales, Scotland and Northern Ireland.
3. At the level of local development of practice in Glasgow (a key influence in the decision to undertake this study was personal involvement in the development of a specialist service by NHS Greater Glasgow and Clyde).

1.10 Summary of Chapter 1

Chapter 1 has provided a review of the relevant literature on perinatal mental illness and its wider consequences to give the reader an overview of the seriousness of the clinical conditions and to highlight why the study of joint mother and baby admissions specifically, is an important area of study. The literature on the practice of joint mother and baby admissions has been outlined in Chapter 1 but is considered in more depth and detail in Chapter 3. The second part of the literature review introduces diffusion of innovation (Rogers, 1962; 2003) as a theoretical framework concerned with a particular form of communication about new inventions, ideas or 'innovations'.

The relevant literature pertaining to the theoretical framework used in studies of health care service development has been reviewed and an explanation has been given as to why this framework was selected as an appropriate theoretical framework to guide the analysis of the evidence.

1.11 Structure of the thesis

Chapter 2 describes the methods used in the study. A historical method has been selected with a combination of historical narrative and historical analysis. The rationale for the selection of this method and for the selection of the theoretical framework diffusion of innovation to guide the analysis is explained.

The history of joint mother and baby admissions has been organised across Chapters 3, 4, 5, and 6. Chapter 3 is a detailed narrative of the documented evidence from published papers on the practice of joint admissions and service development across each area of the UK between 1948, the date of the first account of the practice, until the time of reporting in February 2012. Further evidence from particular professional bodies, organisations and events which is of relevance to the history of the practice of joint admissions is included in Chapter 4. Chapter 5 is a detailed narrative of the history of relevant health policy throughout the same time period, arranged in chronological order of year of publication for each area of the UK. This was included because service provision in the National Health Service (NHS) was directly provided on behalf of the respective governments of the UK and the relationships between policy and service provision are closely linked. To complete the chronology of the history of joint admissions Chapter 6 is an account of specialist service development in Scotland from my own perspective of personal involvement in the processes.

The findings are presented in Chapter 7 and analysed in Chapter 8. The themes that emerged in the evidence from the documented history are highlighted and considered in more depth in these two chapters. The thesis is concluded in Chapter 9 with a discussion of the findings and the analysis. Conclusions and recommendations complete the thesis in Chapter 10.

CHAPTER 2: METHODS

2.1 Selected study methodology and rationale

To identify the pattern of development of joint mother and baby psychiatric hospital admissions from 1948 onwards, to answer the research questions and to achieve the aims and objectives of the study it was appropriate to select a historical method. The prolonged timeframe of the implementation of the practice of joint mother infant admissions indicated a historical method was appropriate for this study as the documented and empirical evidence of the diffusion of joint mother infant admissions across the UK could be demonstrated using narrative to organise the sequence of, and analysis of, the relevant events.

The word 'history' has several meanings (Shafer, 1980). History can refer to the actual happenings and events of the past. History can also mean a record or an account of events whereby someone attempts to relate the events of a particular period in time, examples of which include writings on wars or revolutions. The third meaning is history as a discipline, a field of study that has developed a set of methods and concepts by which historians collect evidence of past events, evaluate that evidence, and present a meaningful discussion on the subject (Shafer, 1980. 2). It is this latter meaning of history that is applicable to the methodology used in this study.

The purpose of an historical method is to reconstruct the past objectively and accurately often in relation to the tenability of a hypothesis (Isaac & Michael, 1995). There is tracing of information from the present to the past or from the past to the present (Ekmekçi, 1997. 4). Historical method provides data that can be used to inform decision making in the future. When combined with individual experience historical research and literature provides an understanding of similar problems or events and knowledge of what has happened in the past and how people responded or reacted to the past events or situations can be applicable in solving present problems. The events

or problems will not be identical in detail but will be similar in the demands or challenges they pose to individuals or groups (Shafer, 1980. 2). Historical literature can take the form of narrative or analysis although the two are frequently combined.

Narrative is story, which often includes description which verges on a simple form of analysis or can include more profound analysis. A historical narrative recounts events using chronology as a framework (Rael, 2005) and it is this chronology that differentiates it from a description of events. However it is not just events, the sequence of events or chronology that is important, the strength of historical narrative is causation. An exploration of why something happened or 'what caused what' is an important aspect of historical narrative and has particular relevance to this study. It is difficult to pin point single causes for events and each cause for an event will have antecedent causes. A series of causes is not a mere succession of events in time. Some kind of logical dependence of one upon another must be demonstrated. All the causes of complex events will rarely be identified therefore the explanations of the relationships between historical data are less likely to be causal but can be demonstrated as probable or plausible (Shafer, 1980. 27). A logical connection between the series of events must be established but to attempt this in a meaningful way there has to be some degree of generalisation about the causes that are identified and a distinction made between true and erroneous causes (Shafer, 1980. 29). The narrative includes the complicating action or temporal component, whilst providing an adequate evaluation is crucial for establishing the meaning of the events that have been recounted (Polanyi, 1985). The process of reasoning in making these logical connections is referred to as analysis.

Analysis in historical method is the examination of topics, groups of events or ideas, with only incidental attention to the individual events or occurrences (Shafer, 1980. 11). Analysis is a systematic attempt to learn about a subject or problem by looking at its elements and breaking it into components. Narrative at its extreme contains little analysis and analysis at its limit has little narrative (Shafer, 1980. 11).

A review of the related literature is part of the study procedure. In using a historical method a range of written documents are also introduced and analysed within the data collection and analysis. Written documents may be in the form of published articles, records, reports, minutes of meetings and other relevant documents. Aside from written documents, interviews with people who have participated in the event or process under investigation may be used as a source of data for historical research. As historical research is a retrospective study design the research is usually limited with what is available in terms of data collection. Sources of data should be analysed for the establishment of authenticity (external criticism), and accuracy (internal criticism) (Ekmekçi, 1997. 4). According to Gay (2011) there are four factors that need to be considered when establishing accuracy of the data for analysis. These four factors are: how knowledgeable and competent the author was, whether or not there was a great degree of lapsed time between the occurrence of the event and the recording of the facts, if there was any bias on the part of the author, and if the account of the event is given in the same manner by different sources or if there is disagreement between the authors in reporting the same event (Gay et al., 2011). Once the data is analysed it is organised and synthesised and conclusions and generalisations are formulated (Ekmekçi, 1997. 5).

The awareness of the importance of narrative among qualitative researchers has spread through a wide range of different substantive fields since it emerged as an authentic methodology within sociology in the 1980's. Health care is one such field to which historical research methodology has spread (Elliot, 2005). The historical method of most relevance for this study is the combination of both historical narrative and analysis as the detail of many of the individual events in the history of joint admissions had relevance to the overall diffusion of the practice.

2.2 Selected theoretical framework

In order to facilitate interpretation of meaning from the historical narration, a theoretical framework was identified that could be used to organise the information, identify any corresponding

relationships between sections of information and help identify any patterns which emerged or were clearly evident. As already described in Chapter 1 the theoretical framework that was selected was diffusion of innovation (Rogers, 1962; 2003).

This theoretical framework was selected as it appeared to have a robust empirical evidence base and was applicable to this particular study method. When selecting a suitable theoretical framework to support the analysis of the data, consideration was given to the suitability of a related theory to diffusion of innovations proposed within the field of medical sociology. 'Normalisation process theory' (NPT) provides a conceptual framework for understanding and evaluating the processes by which new health technologies and other complex interventions are routinely operationalised in everyday work and sustained in practice. It is a sociological toolkit that can be used to understand the dynamics of implementing, embedding, and integrating new technologies or complex interventions (May et al., 2010). It has practical value in helping people understand how new ways of thinking, acting and organizing become embedded in healthcare systems and it helps to disassemble the human processes that are at work when a new set of practices are encountered (May et al., 2009. 538; May et al., 2010). It aims to identify why some processes lead to a practice becoming normalised whilst other processes do not.

On assessment it was decided that normalisation process theory was not comprehensive enough to be used to facilitate the analysis of the spread of joint admissions and psychiatric mother and baby units. Key elements considered to be of importance in this study are the influencers to the decisions to adopt the practice in the first place. Implementation (or not) is the process which ensues as a result of this decision making process. Implementation of the innovation is only one stage in the wider process of diffusion. As this alternative theory is mainly concerned with the social processes of operational implementation and sustainability, it was not viewed to be suitable for use in this study to analyse results.

Psychiatric mother and baby units are not fully diffused across the UK or even in one particular area of the UK therefore significant inequity in service provision evidently continues (Elkin et al. 2009). Rogers (2003) suggested that it would be possible to investigate the diffusion of an innovation while the diffusion process was still under way. He also believed that 'in-process diffusion' research design would allow a scholar to investigate less successful cases of innovation diffusion, and therefore avoid the pro-innovation bias (Rogers, 2003. 113).

The diffusion process for psychiatric mother and baby units is still under way so this novel approach to diffusion research can be tested in this study without concerns around the choice of theoretical framework in terms of pro-innovation bias. In addition, it is important that the study should try to contribute additional knowledge to the existing empirical evidence. The study design can therefore be considered as 'in-process diffusion research' which is being used to investigate what may be a less successful case of innovation diffusion. This will therefore help in avoiding the pro-innovation bias and attempt to make contributions to an area of diffusion research that has been highlighted as needing more examination (Rogers, 2003. 113).

Rogers (2003) highlighted that because of pro-innovation bias, there is more written about the diffusion of rapidly spreading innovations than there is known about the diffusion of slowly diffused innovations. There is also more known about adoption than about rejection of innovations, and there has been more research conducted on continued use of innovations rather than discontinuation of them (Rogers, 2003. 111). This study aims to consider not only the rate at which services have developed and the reasons for this, but also to seek answers as to why some areas did not develop services or took many years to do so. A better understanding of how and why innovations are adopted, or not, can help inform the development of more realistic public policies. Organisational innovations are the basis of much potential health, social and educational gain. In practice, however, most innovations fail to be adopted widely, so they have limited social or economic impact (Tidd, 2010. 3). It is also known that the benefits of innovations that are adopted

can take between 10 and 15 years to be fully effected (Jaffe, 1986). It was therefore identified that in studying these areas, it would be appropriate to use this theoretical framework.

This research takes a complex organisation as the unit of adoption (the NHS) but with several sub systems of adoption within it, and the primary outcome measures as not only adoption, but also the lack of adoption, and in some cases discontinuation after a period of time. For these reasons Greenhalgh's (2004) conceptual model presented in Figure 3 is appropriate for use in this study as the study is examining the development of joint admissions practice and services within the NHS systems, and policy was a component part of the evidence examined.

2.3 Research methods

The search strategy for the gathering of data involved two stages: the first stage involved the identification and selection of documentary evidence and information that was potentially relevant to the study and the second stage involved the collection of the evidence. Before identifying the history of events in relation to joint admissions of mothers and babies to psychiatric inpatient services, it was necessary to identify the categories of data that would be included. The initial process was therefore to define the patient group that the study was of relevance to. Women are affected by a range of psychiatric conditions in the postnatal period including exacerbations of pre-existing illness such as bipolar disorder or schizophrenia, and episodes of newly onset illness as a direct response to childbirth such as puerperal psychosis or postnatal depression. It was decided that evidence would be included for joint admissions of women with psychotic and non-psychotic illness, pre-existing and newly onset illness.

A further subject matter considered to be of importance in the process of categorisation was to agree the organisational system that would be included in the study evidence. The study focus had been informed by an earlier review of equity of access to services in the UK. By including private service provision consideration would need to be given to several factors: the influence on the

diffusion pattern of differing costs of services across private and public providers, accessibility by individuals in terms of affordability and personal wealth, differing conditions of insurance cover applied by health care insurance providers, and the issue of stigma and mental illness and how this can influence decisions to access private services.

All of these issues would potentially influence the decision making by private companies to provide services as a business concern and would also influence the use of services by individual patients. These factors would not be comparative to a public funded, free at the point of access, service which is provided through the NHS. It was therefore decided to not include evidence about services provided solely by the private sector. There are a few establishments however that are privately owned but that the NHS purchase services from. Where this NHS purchasing arrangement was evidenced to be in existence then those establishments were included as evidence.

The final category identified was the parameters for what constituted a joint admission. It was decided that all forms of the practice where mental disorder in the mother was the primary reason for the joint admission within the field of mental health care would be included in the time period from 1948 onwards⁴.

Exclusions were identified to ensure this definition of joint admissions was applied. Literature that focussed on the field of child psychiatry where the emphasis of the admission of family members was due to problems being addressed in the child or the wider family unit relationships was excluded⁵. Literature on non-psychiatric mother and baby units such as maternity care facilities or social work facilities was also excluded as the focus of the study was specific to the care and treatment of the women's mental illness and these units did not have this primary remit.

⁴ 1948 had already been identified as the first recorded year of the practice of joint admissions.

⁵ In the UK there is a specific branch of psychiatry that is categorised as 'child and family' psychiatry or 'child and adolescent' psychiatry or in recent years more commonly referred to as child and adolescent mental health services.

Publications written in languages other than English were also excluded unless they had been referenced as secondary evidence by another author.

Having identified the categories of evidence, the next stage was to conduct an in-depth search of the published literature on the subject of joint mother infant admissions. It was appropriate for this study to identify both primary and secondary historical sources of data to elicit different versions of events and interpretations around the subject of joint mother and baby mental health admissions. In adopting a historical method, primary sources of data include evidence gathered, selected, interpreted and arranged in order to produce analysis and argument. A secondary source of data is evidence that has already been written about the subject within the time period where the author has already analysed the information in some way (Gocsik, 2005). For the purpose of the study primary sources of evidence are the sourced original documents or papers published by the original authors of the work being referenced. Secondary sources of evidence are documented historical accounts or information provided by others on the subject matter.

To identify both primary and secondary sources of literature on the subject of joint admissions a literature search was carried out of information published between the years of 1940 and February 2012. This involved a search of online electronic databases that are known to hold healthcare related publications: Ovid Medline (R) 1948 to 2011, Books@Ovid, Journals@Ovid Full Text, NHS Scotland Journals@ Ovid, EBM Reviews Cochrane Database of systematic Reviews 2005 to 2012, EBM Reviews ACP Journal Club 1991 to 2011, EBM Reviews Database of Abstracts of Reviews of Effects 4th Quarter 2011, British Nursing Index and Archive 1985 to 2012, Embase 1980 to 2012, PsycINFO 1806 to 2011, Social Policy and Practice 2011. A combination of keyword search terms was used: (See footnotes regarding the use of the following general terms during the search of the literature) “perinatal”⁶; “baby”⁷, “patients”⁸, “ward”⁹, “psychiatric”¹⁰, combined with keywords:

⁶ “perinatal”, “postnatal”, “postpartum” and “puerperal” terms were used interchangeably

⁷ “baby”, “babies”, “infant(s)”, “child”, and “children” were used interchangeably

⁸ “patients”, “women” and “mothers” were used interchangeably

⁹ “ward(s)” and “hospital(s)” were used interchangeably

“postpartum psychotic patients”, “postpartum depression patients”, “mentally disordered mothers”, “puerperal psychosis”, “mother and baby units”, “mother and baby mental health units”, “psychiatric mother and baby units”, “joint admissions”, “joint mother and baby admissions”, “babies in psychiatric hospital(s)”, “admitting babies of patients with mental illness”, “side room admissions” and “Cassel Hospital”. References cited in articles obtained via the primary search were searched to provide further sources. The aforementioned databases were also searched further using the names of key authors in the field.

Websites of relevant professional organisations and associations were searched for references, publications and reports on the subject using limited keywords: “perinatal mental health”, “mother and baby units”, “joint admissions” and “puerperal psychosis”. The range of search terms could be narrowed from those in the keyword search of the academic healthcare related databases as the websites accessed would generally not hold wider literature on related topics that would have been identified on the previously mentioned electronic data bases and search engines. The websites accessed and searched included the websites of The Royal College of Psychiatrists, The Marcé Society, The Index of Lunatic Asylums and Mental Hospitals, Workhouses, The Association of Therapeutic Communities, The National Institute for Health Research Archives, Mental Health History Timeline, The Scottish Government, The Department of Health, The Cassel Hospital, The Welsh Assembly Government and The Northern Irish Assembly. The search engine Google was also used using the keywords “psychiatric mother and baby unit” and “mother and baby mental health unit”, the search terms being limited to include these phrases and exclude duplicates to maximise the relevant hits.

In addition to the electronic search, a hand search of the full catalogue of thirteen volumes of the journal titled ‘Archives of Women’s Mental Health’ was also carried out. This journal is produced by The Marcé Society, an international organisation specifically concerned with the field of perinatal

¹⁰ “psychiatric” and “mental health” were used interchangeably

mental health care and thus a source of highly relevant data. Personal contact was also made with the archivist of the NHS Lothian Archives and a hand search was conducted of archived hospital records of meetings and annual reports held by NHS Greater Glasgow and Clyde. Specific documents including meeting notes relating to the mother and baby unit development in Glasgow were also accessed.

Secondary historical sources that were already known included a textbook on the subject titled 'Motherhood and Mental Health' (Brockington, 1996). Professor Ian Brockington, a leading psychiatrist in the field of perinatal mental health care in the UK since the 1970s, devoted a chapter in his book to a chronology of service developments which proved to be a good source of information for this study. In the text Brockington provided his own narrative of the history of psychiatric mother and baby units and the practice of joint mother infant admissions from 1948 until 1996 when the third edition of the text was published (Brockington, 1996. 555-572). This was found to be a good source of secondary evidence and many of the articles and publications he referenced were accessed to gain a more direct perspective on the works, rather than solely relying on the interpretations and accounts offered by Brockington (1996). The evidence that fitted the parameters of the study were included as primary historical sources. This process was repeated with these potential sources of further evidence through sourcing any additional references provided. Some of the references provided were not English papers and these potential further sources of primary evidence were therefore excluded, relying instead on the perspective given by the author of the secondary source of evidence.

Primary historical sources that were examined included published research, books, evidence based guidelines, relevant accounts, information and evidence from policy, legislation and strategic frameworks, strategic documents published by any of the UK Governments or Assemblies, reports from professional bodies, evidence from relevant networks, practice standards, media articles, transcripts of meetings and political debates and oral history accounts.

2.4 Reporting of the evidence

External criticism was used where appropriate to authenticate the documented evidence. An example of this was taking Brockington's (1996) summary of joint admissions and mother and baby units and authenticating his account of events by sourcing the primary evidence to determine how authentic it was, taking into consideration the date of publication. Authenticity of the documents was not a particular issue in this study as the sourced documents were largely published in professional peer reviewed journals or were official published reports.

Internal criticism was then used to determine the credibility of the evidence by comparing the sources of evidence for accuracy and where possible further establishing the content and meaning of the evidence with additional information obtained from the primary documents and other secondary sources. It is recognised that historical research may include distortion or error in the evidence or error may arise from the interpretation or use of the evidence by the researcher (Shafer, 1980. 153). Any sources of error in the evidence that has been reported in this study have been inadvertently included and are not intended. It is accepted in historical research that the majority of sources of evidence are in some way inaccurate, incomplete or tainted by prejudice and self-interest (Tosh, 2010. 134).

The orientation of the author of the documentary evidence was a consideration in the reporting of the evidence as it was important to be vigilant for bias, subjectivity and intentional distortion on the part of the author and to report where these arose in the evidence as these factors have relevance to the diffusion pattern. Where there was ambiguity about the credibility or accuracy of the content of the evidence or where contradiction was identified between sources of evidence, attempts were made to source further evidence of the event or information in question. This approach helped to identify strengths and weaknesses of each source of evidence and when considered together and compared against each other there was a greater probability of identifying more accuracy in the data. This has been demonstrated in the thesis by the inclusion of methodological notes explaining

the steps taken to confirm or obtain further information. Particular attention was paid to ensure the evidence was not taken out of context and evidence that has been reported in the thesis in quotes from the original source has been reported in this way to provide a greater understanding of the context when it was thought to be of particular relevance to the diffusion of joint admissions.

The evidence was grouped as set out under the headings in Chapters 3, 4, 5 and 6 and within each grouping of evidence a chronological order was used to help extrapolate relationships between events.

2.5 Analysis

The reporting of the identified evidence involved preliminary analysis throughout the process of the selection and reporting of the evidence in the form of external and internal criticism already described above. Preliminary analysis was particularly necessary where the evidence was contradictory or required further corroboration. Analysis was therefore multi-layered. The process of the overall analysis of the findings is described here.

In analysing the data causation has been explained using statements of probability or probable causal relationships given that causation cannot be attributed to a single factor owing to the manner in which different areas of human experience constantly interpose on one another (Tosh, 2010. 153). It is recognised that historical narrative alone is not a robust methodology to support historical explanation as placing events in their temporal sequence does not mean that one event caused the next event in the sequence (Tosh, 2010. 154). The analysis of the reported data was therefore supported by the structure of the theoretical framework diffusion of innovations (Rogers, 2003). The conceptual model which further developed the diffusion of innovation framework and described in Chapter 1 of the thesis is of particular relevance to this study (Greenhalgh et al., 2004. 6). From their synthesis of the theoretical and empirical findings of their systematic review, Greenhalgh et al (2004) identified the conceptual model to aid the identification of different aspects involved in diffusion within complex organisations such as the NHS (Greenhalgh et al., 2004; 6). As the

conceptual model is specific to the diffusion and dissemination of innovations in health care organisations the framework assisted in identifying and understanding the various processes, influencers and the behaviours of the adopters in the NHS that were relevant to the adoption, or not, of the practice of joint admissions.

The evidence was organised into chronological order by the year that the event took place or the year of the publication of the document. Where applicable, evidence was arranged into the respective area of the UK it was of relevance to. The content of the data was then reflected upon and 'digested' and a conclusion drawn on where there may have been gaps in the evidence across the time line. Shafer (1980) described how in order to attain meaningful synthesis of historical evidence it was necessary to 'digest' the evidence (Shafer, 1980. 187). He described this as sufficient reflection on and manipulation of the evidence by reading, re-reading, making preliminary generalisations, combinations and re-combinations of the evidence (Shafer, 1980. 187). The diffusion of innovation framework and Greenhalgh et al's conceptual model (2004) was used to guide and inform this stage in the analysis.

One of the areas recommended for further research by Greenhalgh et al, (2004) was a study of the characteristics of successful external pushes promoting the assimilation and implementation of innovations by health service organisations. This is relevant to the analysis of the development of services in the context of the NHS in Scotland. As previously mentioned (Greenhalgh et al., 2004), the systematic review identified a considerable gap in the literature in relation to a lack of process information within the studies around diffusion of innovation of health care services and suggested further studies were needed to look at by what processes particular innovations in health service delivery and organisations were implemented and sustained (or not) in particular contexts and settings, and could these processes be enhanced. This has therefore been included as a focus of analysis in this study.

2.6 Additional points on research methods

Some historical research such as oral history uses interviews as a source of evidence. In diffusion studies it is also normal to gather data through the use of questionnaires or interviews, asking respondents for retrospective information over a period of time after an innovation has been diffused widely. The use of interviews and questionnaires were considered as a method for obtaining data in this study. It was felt, however, that it would not be feasible to use this additional method of data collection whilst also sourcing data from documentary evidence due to the limitations of the clinical doctorate thesis. The use of interviews to obtain historical evidence is a source of primary evidence however their effectiveness in obtaining accurate data is reliant on the memory of the research participants. Tosh (2010) stated that the testimony of informants, especially elderly informants, departs from the known record by omission or by the incorporation of extraneous elements. The memories of the informant, however precise and vivid, are filtered through subsequent experience. What is remembered from several decades back is modified by the impact of subsequent experience and the recollections of other people (Tosh, 2010. 313). These findings are of relevance to this study as the timeframe involved in the diffusion of joint admissions is more than 60 years.

In addition it would be extremely difficult to access key respondents as many of the individuals who would have been involved in the events across the timespan would either be dead or would be retired and not contactable. Others would have proved difficult to track down, and if they could be located and contacted, there was no guarantee they would have consented to participate in the study once invited. There may also have been difficulty with data being distorted as an effect of inaccuracy of the recall of events after such a significant time lapse. The data therefore would have been incomplete if either interviews or questionnaires had been the only method of data collection selected. For these reasons it was decided that data collection from documented evidence was a more appropriate method for sourcing the necessary data for this study.

2.7 Historical evidence from personal recollection

In Chapter 6 a more detailed history of the development of services in Scotland is provided. This evidence has been included from a personal perspective of direct involvement in the development of the specialist services in the NHS in Scotland from 2001 onwards within the role of Nurse Consultant in Perinatal Mental Health. The knowledge and information of the events and processes of development gained through personal experience are not fully available as documented evidence but are a source of primary evidence of relevance to the study. The personal account of specialist service development in Scotland has therefore been included as a separate chapter as, in the absence of interviews being used as a method of data collection, this level of detail is not available for any of the other service developments included as evidence. This gives a particular insight into the diffusion of services in the Scottish health care system. The observations I made as the participant in the history are recounted retrospectively and thus it is acknowledged that the accuracy of the evidence may be affected by my recollection of the events from as far back as 11 years ago as research notes were not being taken at the time of the events.

In summary a historical method using a combination of historical narrative and historical analysis was used to evidence the history of joint admissions and the development of psychiatric mother and baby units across the UK. The theoretical framework of diffusion of innovations (Rogers, 2003) and the conceptual framework developed by Greenhalgh et al (2004) were used to support the analysis of the evidence from 1948 until the current time and answer the research questions detailed in Chapter 1.

CHAPTER 3: THE HISTORY OF MOTHER AND BABY JOINT PSYCHIATRIC ADMISSIONS

3.1 Introduction

Chapter 3 details the primary and secondary sources of evidence that I have selected to inform the history of joint mother and baby admissions. This chapter primarily focusses on evidence from papers, research articles, reports, and case studies published in academic or professional journals, or from textbooks. Most publications in this chapter were written by single authors or small groups of authors. I have not included publications produced by professional bodies or organisations in this chapter, but have separated them into subsequent chapters. The history is presented in chronological order, largely by the date of the spread of the practice or where this date was not conclusive, by the date of the publication of the evidence. I have presented the evidence in this way to provide a structure for the reader which details the information on the events themselves and to describe what the sequence of the events was.

This structure facilitates the identification of relationships or connections between events that influenced or deterred adoption of the practice. I have considered the causal relationships between the influencers to the diffusion pattern in more depth in Chapters 7 and 8. I have included methodological notes on how some of the primary evidence was sourced to highlight the methods used to access the range of evidence and to demonstrate internal criticism in the identification, selection and reporting of the evidence. Methodological notes have also been included to provide the reader with a degree of confidence that, despite difficulties in obtaining some of the older documents, they were pursued in order to ensure the history presented is a comprehensive account.

3.2 The origins of psychiatric mother and baby admissions

In identifying evidence it was logical to firstly consider secondary sources of historical evidence: historical information already collated about the subject by other authors and researchers. This was a logical approach as this was an effective way of identifying potential primary evidence from the references that were provided within the secondary account of available evidence. In this study, a good source of secondary evidence was a textbook by Brockington titled "Motherhood and Mental Health" (Brockington, 1996). This text brought together many years of his personal experience as a psychiatrist with an extensive review of the literature, abstraction of case histories and anecdotal data. This was the third volume of this title which was published in 1996. The first and second volumes were published in 1980 and 1988 respectively. The first two volumes were edited jointly by Kumar and Brockington (1982; 1988) and had a focus on the syndrome of postpartum psychosis, and on collections of invited review papers. The third volume used here as the source for secondary evidence gives a more global account of the many facets of motherhood and mental illness, but Brockington outlines further in his preface that an aim of his book was to improve clinical practice and services (Brockington, 1996. ix). He dedicated a full chapter to 'services' which provides his account of an historical narrative on the practice of joint mother infant admissions. He also gave his own view of what an "ideal" service should include (Brockington, 1996; 555-583).

In his 1996 textbook, Brockington provided a chronology of the history of the development of psychiatric mother and baby units in the UK until the mid-1990's and identified Thomas Main as the pioneer of the practice of joint admissions at the Cassel Hospital in Surrey. Brockington recounts how the first documented admission took place in 1948. He suggested the decision to admit the woman with her child was not based on any clinical decision around innovative new practice or scientific research but instead a pragmatic response to the request of a patient who required hospital admission for treatment of mental illness but had no one to care for her infant son (Brockington, 1996; 555). Brockington's secondary evidence was his interpretation of Thomas

Main's original writings as a primary source of information on joint mother infant admissions to psychiatric hospital.

Accessing the primary source provides more detail and context to the narrative provided by Brockington (1996). Thomas Main was a psychiatrist and psychoanalyst who had an article published in *The Lancet* as a 'special article' on his work with women admitted to psychiatric hospital with their children. The content of the article was taken from a paper he had read at a meeting of the Psychotherapy and Social Psychiatry Section of the Royal Medico-Psychological Association (RMPA) on March 27th 1958, a small professional organisation of psychiatrists. The Association was considered by other physicians at the time to be the "medical superintendents' trade union" and was not considered by other physicians to be a scientific body of medicine (Freeman, 1999).

Thomas Main described in his paper how he had agreed to a patient's request to bring her toddler son into hospital with her as she had no one else to care for him. He asserted that his decision to agree to her request was influenced by previous teachings as a student of a paediatrician Sir James Spence. In 1925 Sir James Spence founded the Babies' Hospital at Newcastle upon Tyne with the principle aim that mothers would nurse their own babies. He apparently held the view that there were 'twin dangers' of separating mother and child during hospitalisation; firstly dangers to the child's physical and emotional health and secondly to the mother's confidence in her future capacities as a mother (recounted in Main, 1958). Spence's teachings generated a further interest for Main in the work of psychoanalysts Rene Spitz (1945) and John Bowlby (1951) who reported on their observations of adverse effects on the mental wellbeing of children in cases of prolonged separation from their mothers.

Considering the reference to Spitz's work by Main, I traced the original publication and accessed it as a source of primary evidence (Spitz, 1945). It was identified that earlier publications had

described a condition in infants who spent prolonged periods in hospital separated from their mothers care. 'Anaclitic depression' was the term first used by Spitz (1945) to describe this condition but it had been commonly referred to by physicians in children's hospitals in the previous century as 'hospitalism' (Crandall, 1897). An editorial published by Crandall (1897) discussed the condition that had apparently been described earlier in the nineteenth century by an American paediatrician Abraham Jacobi¹¹. Crandall wrote:

“Hospitalism, a disease more deadly than pneumonia or diphtheria describes a very definite and grave condition. Even in general hospitals the attending staff soon learns that, except for certain incurable diseases, a prolonged stay [in hospital] is usually not advantageous..... The earlier the age, the greater is the susceptibility to hospitalism, and the quicker it ensues. One of the first conditions to be noted is a progressive loss of weight that is not dependent on the original disease, as it often takes place after recovery when the child is not sent out soon enough. This ensuing atrophy bears an inverse ratio to the age, and is especially marked under six months. Older infants are less susceptible, but if kept long enough, they will surely show stationary, and then losing weight. This often takes place while the infant is apparently digesting its food, which may be the best that can be artificially produced. Beginning atrophy, not depending upon a lesion, should be an indication for immediate discharge from the hospital. If it gets beyond a certain point, no change of environment or food will save the infant..... As this condition develops, progressive anaemia appears, and the child frequently dies from marasmus, or simple wasting without organic disease. Not infrequently pneumonia, diarrhoea, or other acute disease supervenes, which the child is totally unable to overcome. Many such children might be saved by timely removal from the hospital, despite the apparent contradiction that their lives had been saved not many weeks before by admission to its wards” (Crandall, 1897).

¹¹ Further searches of the literature could not trace any specific publications by Jacobi on the subject.

Crandall's description clearly highlighted the serious nature of the condition. The hospitalisation of the children was normally funded by rich benefactors and it was a quandary to them that those children whom they were supporting financially to receive hospital care in clean and dry conditions with ample food and nutrition available, had much poorer outcomes than the children being housed with their parents or families in the local poor houses where the living conditions, by contrast, were very poor.

The later studies of hospitalism by Spitz were concerned with the effect of continuous institutional care in 'foundling homes' of infants under one year of age in the 1940s (Spitz, 1945). With this work in mind, Main had the child admitted with its mother to the Cassel mental hospital for adults, with the original intention of facilitating the mother's hospital treatment for neurotic illness. Further admissions of other mother and child pairs followed and what had started as an exceptional occurrence in the hospital became an occasional practice that grew into a more common element of life at the hospital between 1948 and 1954. Up until that point, Thomas Main and his staff had viewed the admissions as something that facilitated treatment of generic neurotic conditions in women and treatment did not particularly centre on the mother child relationship. He recounts how studying disturbances in motherhood were an 'opportunistic realisation' as he and his staff became more experienced at working with mothers and their children. This, however, had not been a deliberate function of the joint admissions originally but the field work developed over several years during joint admissions of the mothers and their children.

It followed that from 1955 onwards it became a condition of admission that mothers should bring their babies and young children into hospital with them. Thomas Main had observed over the preceding years that it seemed important that a mother should be kept in touch with the "*stresses and strains of domestic life to which they would inevitably return*", the children being a central part of that life. This statement was in keeping with the views largely held at that time in relation to the predominant role of women in society but this view would be challenged by today's changed

position of women in society where they are much more likely to have their own careers and the majority would not now remain at home to look after the house and children.

Main (1958) reported that two benefits of joint admissions had been found: they helped maintain and promote positive elements in the mother-infant relationship but they also prevented escape from, and concealment of, the negative elements. Bringing the child into hospital presented the mother's problems with her child in day to day living which according to Main (1958) allowed treatment to be more effective.

All of Main's work up to this point had been with women with non-psychotic mental disorders and he had no special experience of puerperal specific disorders, but his work was influenced by a consultation between himself and Dr Gwenyth Douglas. Main acknowledged her advice in his paper but did not give any more detail of the work she had been involved with.

Taking Main's reference to Gwenyth Douglas as a further potential source of primary evidence, I searched the Ovid databases under her name as author but this search returned no results. I conducted a further search using the search term 'psychotic mothers' and identified an article written by her under the name Gwen Douglas whilst she was a senior registrar at the Portman Clinic in London (Douglas, 1956). She described her involvement in work with women with puerperal psychosis who had difficulty caring for their infants and required support from nurses to care in part for their babies in the early postnatal period. Her case presentations described a joint approach taken across maternity, psychiatric and paediatric departments of the West Middlesex Hospital with a psychiatrist called Haldane. They evidenced good outcomes where women had successfully recovered from episodes of puerperal psychosis and were able to leave hospital and continue to care for their child without relapse over a two year period of follow up (Douglas, 1956).

The basis for the work she described appeared to be the observation that women with acute psychotic episodes would often recover fairly rapidly from the initial episode, only to relapse with a much longer duration of illness. Their view was that the consequential separation of the mother from the child in the child's first year of life may impair the child's ability to form good relationships later in life (Douglas, 1956). The theory presented for the presence of puerperal psychosis was that the patient had an *"inability to bear the hostility she felt towards the baby"* and this hostility coupled with a predisposition for mental disorder resulted in psychosis developing (Douglas, 1956. 124). Hostility was believed to be present in all cases of puerperal psychosis. The opinion was that by separating mother and child, with the child cared for by a nurse or relative, the mother was more likely to recover. The following excerpt is taken from the paper:

"The mother relieved of the unbearable hostility was more likely to recover. Mothers admitted to an observation ward or a mental hospital for treatment, although she usually recovers in hospital, commonly relapses when she is again required to care for her baby" (Douglas, 1956. 124).

Prevention of the lengthy period of relapse from the initial episode appeared to have been the aim of the approach taken by the team at West Middlesex Hospital, enabling the women to return home and resume full care of the child during the first year of their life.

The actual intervention involving joint admission of the mother and child was described by Douglas below:

"This difficulty has been overcome in a small series of cases by admitting the baby along with its mother. The husband's cooperation was sought, and the methods and aims of the treatment explained to him. While the nurses undertook the physical care of the child, the mother was encouraged to do as much for the child as she felt able; and she was enabled to discuss her sentiments about this with a psychotherapist, who tried to gain the mother's confidence."

Under this arrangement psychotherapy proceeded surprisingly quickly, probably because after childbirth primitive drives are strong, and thought processes which at other times are unconscious are more readily accessible. Thus the patient would consider and discuss fairly readily her past relationships and attitudes to herself and others, and would accept interpretations which at another time would have been strongly resisted, and make good use of those interpretations to resolve her difficulties. Once this stage was reached, the patient gradually withdrew her interest from the psychotherapeutic sessions and transferred it to her baby.

Thus the mother got to know the baby at her own pace, and had daily reassurance that, despite all her own strange mixed feelings towards her infant, it still survived with the detached physical attention given by the nurses. As her fear of her own negative feelings to the child lessened she gained more confidence to undertake its physical care; but she was not detached, for she felt that she could give her baby more than anybody else” (Douglas, 1956. 124).

This excerpt from the article gives an insight into the thinking behind the hypothesis at the time and that psychotherapy was an evident feature of treatment. Douglas provided four case examples in the paper. Two cases demonstrated relapse in women who were not admitted with their baby. The other two cases demonstrated that the approach had been effective in preventing relapse. Those women who did not relapse were able to parent their child during its first year of life. Although no specific longitudinal outcomes of this nature were presented in the paper, the evidence of the negative effects of separation of the mother from the child had already been documented by the time the practice was being tested (Crandall, 1897; Spitz 1945; Bowlby, 1951). Physical treatment such as Electroconvulsive Therapy (ECT) was used in some cases. Douglas reported that the six cases involved in the joint admission approach had no relapse in a two year period of follow-up and

recommended that women with puerperal psychosis should be treated in a unit with their baby (Douglas, 1956).

Although Main is afforded the recognition as the innovator of joint mother and baby admissions for psychiatric care and treatment, it is of interest that the work of Douglas and Haldane focused on those women with psychotic disorders whilst Main's focus was on the joint admissions and treatment of women with what he referred to as neurosis, which included anxiety disorders and depressive illness. Main's work with women and children during joint admissions, based on theories about mother-child relationship, was born out of practical means to facilitate treatment in the absence of alternative child care, and opportunities arose thereafter for observation of mother-infant dyads. In comparison, Douglas and Haldane's work had a theoretical basis for its origins involving the causes, nature and management of puerperal psychosis. Up until this point women with psychosis were regarded as a risk to their children influenced by the view that hostility towards the baby was the underpinning core feature of the disorder. It was routine practice for mothers and babies to be separated in cases of psychosis (Brockington, 1996; Howard, 2000).

Main's work seems to have paved the way for the idea of joint admissions to be pursued in cases of women with psychosis, although this is an assumption and there is no confirmed evidence that this was the case. Douglas made reference to "*the old fashioned remedy in such cases was to separate mother and baby*" (Douglas, 1956). This statement suggests that at the time of publication in 1956 the practice of joint mother and baby admissions was a recognised and common practice yet Douglas's 1956 article was the earliest published account of the practice. Main's paper was not presented and published in the *Lancet* until two years later (Main, 1958). This suggests that despite a lack of publication on the subject, the practice was perhaps being discussed in professional circles between 1948 and 1956. At the time of publication Douglas had left the West Middlesex Hospital and was working in the position of senior registrar at the Portman Clinic in London. This clinic specialised in the treatment of young people with delinquency but was closely linked to the

Tavistock Clinic that specialised in family psychotherapy. It was at the Tavistock Clinic that Bowlby worked during his studies of attachment theory that were later directly linked to the vast evidence on the importance of the mother-infant relationship to future outcomes for both mother and child (Cohn et al, 1990; Murray and Cooper, 1997; Gerhardt, 2005). No evidence was found to confirm that Douglas and Bowlby worked together but clearly the themes of each of their studies were related, with the psychotherapeutic relationship between the mother and the baby being a key feature of each of their works¹.

Brockington's (1996) secondary evidence and Main's (1958) and Douglas' (1956) primary evidence provide the origins and description of the practice or 'innovation' of joint mother and baby admissions to psychiatric care that form the basis of the study. The remainder of this chapter documents the history of how this practice or innovation was spread or 'diffused' across the UK from these early reports until the current day. The evidence has been organised into each decade merely to provide some structure to the material to make it easier to read through in chronological order.

3.3 Chronology from published evidence of the practice and service development of joint mother and baby psychiatric admissions in the UK

As described previously, the first recorded practice of joint mother-infant admission for psychiatric treatment of the mother was in 1948 at the Cassel Hospital in Surrey (Main, 1958). In 1956, Douglas's published case series described the work with mothers with puerperal psychosis and their babies in the West Middlesex Hospital where there was a collaborative approach by the maternity, psychiatry and paediatric services. This work appears to have further influenced Main's work at the Cassel Hospital to progress to not only admit women with neurotic disorders, but to

¹² I carried out an internet search to try to identify further publications by Douglas but none were found. ~~She may of course have changed~~ She may of course have changed her name through marriage at a later point in her career and this may account for no further publications being identified.

start to admit women with more severe puerperal conditions, but he still excluded women who had “*gross confusional insanity or schizophrenia of certifiable extent*” (Main, 1958. 845), whereas Douglas and colleagues did not exclude these women from admission to their unit.

3.4 The 1950's

Returning to Brockington's book chapter (1996) as a reliable source of secondary evidence and following the chronology from Main's and Douglas' work, he described how in Banstead in Surrey in the late 1950's Baker and colleagues started admitting mothers with schizophrenia with their children (Baker et al., 1961). Although Brockington provided a good summary of the study and outcomes reported by Baker and colleagues the primary evidence was sourced to gain a direct impression of the work of the authors.

The article described how the work of Baker and colleagues centred on women with psychotic illness, in particular those with 'puerperal schizophrenia' (now referred to as puerperal psychosis). They had observed that prognosis of these women seemed to be made worse by the practice of separating mother and baby and hypothesised that joint admissions might be therapeutic. They undertook to study young mothers admitted without their babies and after three years concluded that separation increased the women's difficulties. They also made some other observations that presumably informed the decision to progress their research. They observed that schizophrenic mothers rarely made any active attempts to harm their children. They also identified that their affect for their babies could be normal, but that they may neglect their children, and only half of the children were cared for by the mother on their return home. The authors described having extreme difficulty in assessing the mothers' ability to care for their children on their return home due to complex social problems and for these reasons they recommended that a unit should be established for mothers to be admitted together with their babies for treatment, assessment and observation (Baker, et al., 1961).

An eight bed unit was subsequently opened in 1959. Baker and colleagues describe the unit as having side rooms for the mothers and a large dormitory that was used as a nursery, and was staffed with trained mental nurses and nursery nurses. The infants ranged in age from one week to one year. The authors made reference to consideration of the issue of risk for the babies, patients and staff, in view of the fact they were treating severely disturbed patients in the environment, but reported that they experienced no serious difficulties in this respect. Admissions were accepted from outside the normal geographical catchment area for the hospital as there were fewer local admissions than expected. They studied what were described as comparable groups of women and initially compared twenty women who were admitted to the unit with their baby to twenty women who had previously been admitted to the psychiatric admission ward without their baby but who received treatment from the same consultant psychiatrist. Treatment consisted of randomisation to either Electroconvulsive Therapy (ECT) or chlorpromazine antipsychotic medication but results showed that to maintain remission a combination of both ECT and Chlorpromazine had been most effective (Baker et al., 1961).

The authors presented results which suggested the effectiveness of the unit and treatment programs with perhaps the most striking outcome being the report that one hundred per cent of women admitted were discharged home with their infant in comparison to the group of women admitted without their baby where only thirty five per cent were discharged home to care for their baby (Baker et al., 1961). Treatment was similar to that described by Douglas (1956) with a combination of ECT and Chlorpromazine medication but, in contrast to Douglas' description of treatment offered in her case examples, the authors make the point that they "*avoid interpretive psychotherapy as likely to harm a schizophrenic patient, but provide an atmosphere of emotional warmth and support*". The results for the first forty admissions to the unit were very similar and the authors concluded that women admitted jointly with their babies recovered from their episode of illness better, they had a lower relapse rate, and were more able to look after their babies on return home (Baker et al., 1961).

Baker was deputy physician superintendent at the hospital, and his three colleagues were a psychiatrist (M. Morison), a research psychiatric social worker (J.A. Game) and a principal psychologist (J.G. Thorpe). Their work was underpinned by the 'generally accepted' theoretical view taken from the paediatric field that sick children admitted to hospital should not be separated from their mothers, to reduce the risks of 'emotional trauma' (this evidence from paediatrics was also used by Main (1958) referenced previously). They also make the point that "*there is agreement that mother and baby should not be separated when the baby is ill but the position is less clear when it is the mother who is ill, particularly if her illness is psychiatric*" (Baker et al 1961; 237). This implies that Spence's work in 1925, and Spitz findings (Spitz, 1945) around child development and hospitalisation, had been translated into policy but no definitive position had been reached in policy in relation to best practice when it was the mother who required hospitalisation. The points made by Baker and colleagues are likely to be referring to the recommendations that were produced by the Ministry of Health (1959a) around visiting and accommodation facilities to be provided for parents by hospitals in the case of children being admitted to hospital.

Baker and colleagues (1961) described how they set out to study the problems of young mothers with schizophrenia admitted to Banstead hospital with a view to examining their theory that prognosis for these women was made worse by the practice of separating mother and baby (Baker et al., 1961). As in the case of Douglas (1956), their research is based on theory and hypothesis, unlike that of Main (1958) who, as previously mentioned, did not seem to have deliberately introduced the practice of joint admissions to test out any initial theoretical views or unproven hypothesis. Baker et al (1961) made reference to the work reported by Main (1958) but pointed out that this involved women with neurotic illness, as opposed to those with psychotic illness, which was the focus of their own work. Baker and colleagues (1961) commented that they had presented a preliminary report on their studies of women diagnosed with schizophrenia at The Second International Congress of Psychiatry in Zurich in 1957 but a search of the literature could not trace this preliminary report or abstract. This preliminary work was notably before Main's publication in

1958, and around the same time as Douglas was reporting on the work underway at West Middlesex Hospital (Douglas, 1956), although no reference was made to either of these works.

The case series presented by Baker and colleagues (1961) demonstrated there was a strong hereditary element in the development of puerperal schizophrenia (puerperal psychosis) and challenged the previously held view that feelings of hatred towards the baby was the primary emotional factor leading to a mother's mental breakdown. They also suggested that previous personality was not as indicative as previously thought and finally they challenged the view of Hemphill (1952) that puerperal schizophrenia held a bad prognosis (Baker et al., 1961).

The 1950s therefore, was a time when the innovators of joint admissions of mothers and babies took the decision to communicate the details of their work with colleagues through various media including, presentations at conferences and meetings, during consultations with each other, and by publication in the professional press. Communication took place in the local geographic locality, in the national press, and internationally at the congress of psychiatry in Zurich. Other clinicians were obviously influenced sufficiently by the work of Douglas (1956) and Main (1958) for them to take the knowledge of the innovation, implement it in their own areas, and conduct further research involving the practice. It is worth highlighting that Gwen Douglas, Thomas Main, and Baker and colleagues all worked in close geographic proximity in the Surrey and London areas.

3.5 The 1960s

Moving on from 1961, the next publication of relevance to the study cited by Brockington (1996) is that of Glaser (1962) who reported on the development of a unit with ten beds that was opened at Shenley Hospital near St. Albans. In reference to this unit Brockington states "*Barton² first admitted a mother with her baby in 1956*" (Brockington, 1996; 559). The paper by Glaser (1962)

13. Barton is not to be confused with the later reference to 'Bardon' (Bardon et al., 1968; Bardon, 1977). They both worked at Shenley Hospital.

was originally read at the meeting of the South East Division of the Royal Medico-Psychological Association in October 1960. The unit at Shenley Hospital had ten single rooms and a separate nursery room and play room. Later evidence identified that the unit was reduced to five beds in 1965 and then increased again to eight beds in 1973 (Bardon, 1977). The babies slept with the mothers in the single rooms except in cases where the mother was acutely disturbed and the child slept in the nursery for the first few days of admission.

The theoretical basis for the practice was cited by Glaser (1962) as the work of Spitz (1945) and Bowlby (1951), on the psychological risks that arose if the baby was separated from the mother at an early age. The clinical model described was one of a combination of physical and psychotherapeutic treatment i.e. ECT, individual and group psychotherapy, and an occupational focus whereby the patients had a roster to cook, clean and maintain the ward environment themselves (Glaser, 1962). It was believed that having patients maintain this level of domestic activity discouraged them from using hospital admission as an escape from these responsibilities and it was also thought to enable the patients to overcome some of their feelings of inadequacy in relation to their mothering role. The ward was staffed by mental nurses³¹⁴ and patients were followed up in the community after discharge by psychiatric social workers. Women with both neurotic conditions and psychotic admissions were admitted for treatment and Glaser (1962) reported that, of the 20 women who had been admitted and discharged from hospital at the time of the publication only two women required readmission to hospital due to relapse. Glaser (1962) proposed that there was a need for psychiatric maternity units and recommended that research should be conducted on the possibility of a combined maternity unit and psychiatric mother and baby unit where women who had a previous puerperal episode of illness and “*women whose mental health is precarious*”, could be admitted for delivery of the baby and be provided with

¹⁴ 'Mental nurses' was the terminology used at the time. In more recent years nurses who work in psychiatric services have commonly been referred to as 'psychiatric nurses' and more recently, as 'mental health nurses'. The registered title with the Nursing and Midwifery Council is 'registered mental nurse'.

immediate psychiatric treatment. Glaser suggested this type of unit should be staffed by nurses who had experience of both maternity and mental nursing (Glaser, 1962). Glaser and colleagues later published statistics on the treatment of approximately one hundred and fifteen women admitted to the unit with their babies by 1968. This is referenced further on in this narrative (Bardon et al., 1968).

Using the primary evidence of a paper published by Bardon and colleagues (1968) as a secondary source of evidence, the authors made reference in the text to a correspondence with C. Protheroe in which they stated Protheroe reported that he had admitted sixty seven mothers and babies between 1964 and 1968 to St Nicholas Hospital in Newcastle upon Tyne. This prompted a further searching of electronic data bases under the name of the author which identified an article published in 1977 by Colin Protheroe, a Consultant Psychiatrist, recounting the work of the mother and baby unit at Newcastle upon Tyne and referred to by Bardon et al (1968).

The article by Protheroe (1977) is included here as, although it was published in 1977, the unit it described was developed in 1963. Protheroe described how in 1963 a 38 bed acute female admission ward was modified at one end to provide a small suite of rooms that were converted into a central nursery which had five cots and three smaller interconnecting rooms, which provided for a milk kitchen, a utility room for bathing and weighing babies and a small bedroom which accommodated two adult beds. Today this would be referred to as an annex but Protheroe called it a 'mother-baby unit'. The criterion for admission was generally women whose psychiatric illness merited hospital admission, whether it was psychotic or not. The clinical model of the unit is described below:

"Mothers are admitted like any other women to the acute unit, and apart from baby-caring take part in the ward activities. They are treated by the particular consultant who admits them, but the unit itself is administered by the writer [Protheroe] and a member of his team, a general practitioner clinical assistant, who supervises the medical needs of the babies and

advises the mothers on contraception, etc. Usually there is a nursery trained nurse available.....we only allow the mothers into the nursery when a nurse is present. We encourage mother-baby contact as early as practicable.....As mothers improve, they may sleep in the small adjoining bedroom and take the babies out walking, and home at weekends” (Protheroe 1977.13).

Protheroe did not statistically evidence the value of the work of the unit but outlined his view on the perceived benefits. The benefits he described included the informal admission for those women who would otherwise have objected to be separated from their baby and may have ended up being admitted under the mental health legislation. A further benefit was the provision of a more therapeutic environment facilitating stimulation of and training in child care for the mothers. The fostering of better mother-child relationships and in some cases preventing ill treatment of babies was also identified as benefits and the admissions allowed for ‘rational therapy’. Protheroe pointed out that there were opportunities to study the process of mother-baby interactions and the *“often dramatic beneficial influences which our treatments can have upon it”* (Protheroe, 1977).

The next point of reference in the secondary evidence provided by Brockington (1996. 560), and subsequently traced as primary evidence, was a publication by Fowler and Brandon (1965). They were senior assistant psychiatrists who published an article in The Lancet that described how they opened a twenty bed unit for the admission of women with acute mental illness at the Pastures Hospital in Derby in 1963. This had two side rooms set aside for joint admissions of mothers and babies. This enabled them to compare progress of women with puerperal mental disorder admitted with their babies to those who were admitted to the same unit without them. The authors described the clinical model as follows:

“Before the unit was opened, the two sisters in charge of the villa were sent to the local maternity unit for a course of instruction in general infant management... We have used all the usual forms of treatment, including electroconvulsion therapy (ECT), phenothiazines

(medication), *thymoleptics* [now known as antidepressant medication], *abreactive techniques and supportive psychotherapy*. *The only difference from what is customary has been the continued presence of the baby and the patient's graded responsibility for it, together with the need to adjust to the social and domestic requirements of a self-contained and self-supporting unit*" (Fowler and Brandon, 1965. 161).

Fowler and Brandon (1965) also made an observation that the patients admitted with their babies had a similar length of stay to non-puerperal patients but had a significantly shorter length of stay than those puerperal patients admitted without their babies. They reported that joint admissions reduced the average length of stay from seventy five to forty eight days. On this outcome they made the comment:

"The more rapid response which the patients have generally shown has, we think, been principally due to the two last factors" (referring to the preceding paragraph in italics above) (Fowler and Brandon, 1965. 161).

The authors Fowler and Brandon (1965) make the point that the unit had been relatively inexpensive to equip and had not placed unmanageable added pressure on the nursing staff (Fowler and Brandon, 1965). As Brockington (1996) pointed out, this was perhaps the first record of a specifically agreed model. Small numbers of admissions would be facilitated within side room accommodation of a general acute adult admission ward rather than in a specialist unit or annex. The early reported joint admissions were obviously initially facilitated within adult wards but this example appears to have been developed with a particular model in mind, that small numbers of joint admissions would routinely be equipped for and facilitated within an acute female admission ward.

A further reference provided by Brockington (1996; 559) as the secondary source of evidence led to an article published by Mitchell and Turton (1966) which was traced to gain more information than

that referenced by Brockington. This article described another unit that was opened for the admission of older children with their mothers to what was described as a short stay adult psychiatric ward at Park Prewett Hospital in Hampshire. The unit had twenty five beds and admitted women both without their children and those women admitted with their children, up to thirteen children being admitted to the unit at any one time. This also included admissions of mothers accompanied by more than one child, which differed considerably from the other units already evidenced above. The paper described the admission of 50 mothers with a total of 67 children and they suggested that the practice should be adopted more widely (Mitchell and Turton, 1966). Similarities are drawn by Brockington (1996) with the first reported unit at Cassel hospital insofar as the unit at Park Prewett Hospital also admitted children older than twelve months; they reported that they admitted children up to five years of age, with no reported adverse events and indeed some improvements were noted in previously 'emotionally disturbed' children (Mitchell and Turton, 1966). Up until this point in the chronology, units which provided for joint admissions generally only accepted one child, occasionally two with each mother and usually only within the first postnatal year (with the exception of the early experiences at the Cassel Hospital of admission of toddler age children).

The next evidence in the chronology of evidence relevant to the study was published by Bardon and Glaser et al (1968), which referenced the published UK papers already considered as primary evidence above, and an American publication by Grunebaum and Weiss (1963), referenced by Brockington (1996. 561). Bardon and his psychiatrist colleagues, reported further on the mother and baby unit opened at Shenley Hospital where women had been admitted with their infants to the hospital from 1956 onwards and described earlier (Glaser, 1962). By the time of publication in 1968, they reported that they had opened a new unit in 1965. It was located in a former staff house in the hospital grounds which had five beds and cots. The earlier publication on the work of the hospital (Glaser, 1962) made reference to ten beds so it is not known why there was a reduction in the number of beds. Reasons why could not be identified from the published evidence but a later

publication confirmed the beds were later increased again to eight, perhaps because they identified more capacity was required to meet demands for the service. Prior to their move to the new unit in 1965 they:

“Offered admission to any mother whose illness required treatment in hospital and in whose case separation from her child appeared likely to be harmful to either or both” (Bardon and Glaser et al., 1968. 755).

After the move to the new unit they devised admission criteria as demand exceeded capacity, prioritising those women who had:

“Unequivocal puerperal psychosis, preferably occurring within a stable marriage and without material obstacles to discharge on recovery” (Bardon and Glaser et al., 1968. 757).

Clearly they were being very selective as to who should be offered the service to evidence optimum outcomes. The clinical model continued to be a combination of physical and psychological treatment with medication (antidepressants and / or antipsychotics), ECT for a small number of patients, weekly group therapy sessions, and some patients who also received individual supportive or ‘interpretative’ psychotherapy. As in the 1962 paper (Glaser, 1962), the patients were expected to attend to their own activities of living such as cooking and cleaning. Bardon and colleagues pointed out that an essential part of the treatment regimen was the encouragement of the mother to assume complete responsibility for the care of their infant as quickly as possible, with the staff providing a supportive role as opposed to taking over the care of the babies (Bardon et al., 1968). The unit at this point was staffed by qualified nurses, student nurses and assistant nurses but there was no mention of specifically trained nursery nurses.

The clinical model described previously appeared to have combined the approaches of therapeutic community in the form of group psychotherapy advocated by Main (1958), physical treatments of ECT and antipsychotic medication, psychological treatment in the form of interpretative psychotherapy advocated by Douglas (1956), but in addition they introduced occupational

approaches. The women cooked their own meals and undertook the cleaning routines of the unit. The notion that the mothers should gradually take full responsibility for the care for their child within a supportive environment mirrored that of earlier models. Despite Glaser being one of the researchers in the publication by Bardon et al (1968), there was no mention in their paper of the model that had been an earlier suggestion by Glaser (1962). Glaser had suggested that a combined maternity and psychiatric mother and baby unit should be considered as a research project (Glaser, 1962).

The only issue of operational policy that was referred to was that initially there had been agreement that no mother who was 'actively infanticidal' should be admitted. The offence of infanticide applied only in England and Wales and does not extend to Scotland or Northern Ireland. It is defined in The Infanticide Act 1938 as:

"Where a woman by any wilful act or omission causes the death of her child being a child under the age of twelve months, but at the time of the act or omission the balance of her mind was disturbed by reason of her not having fully recovered from the effect of giving birth to the child or by reason of the effect of lactation consequent upon the birth of the child, then, notwithstanding that the circumstances were such that but for this Act the offence would have amounted to murder, she shall be guilty of felony, to wit of infanticide, and may for such offence be dealt with and punished as if she had been guilty of the offence of manslaughter of the child" (The Law Commission, 2006. 157).

Bardon and Glaser (1968) pointed out that no such women presented for admission during the period of study and that by the time of publication it was felt this exclusion criterion would not be necessary. This suggests, that the staff had gained more experience and skills of working with severely disturbed women in the unit which had eased initial staff anxieties about infanticide when the unit opened, referred to by the authors (Bardon and Glaser et al. 1968). Bardon et al (1968) reported that eighty nine per cent of the one hundred and fifteen cases returned home to care for

their child upon discharge from the unit. The cases studied had been admitted to the unit before the admission criteria were put in place in 1965. They noted that women with long standing neurotic disorder or personality disorders and coexisting social problems did less well and had longer lengths of stay than those women with psychosis. They did, however, not elaborate on the nature of these social problems. They concluded that:

“it is possible to admit with their children mothers suffering from any type and degree of puerperal mental illness.....As a result of our experience we believe that the procedures described constitute an advance in the treatment of puerperal mental illness, though the present study does not make a statistically validated case for the positive value of such procedures”. (Bardon and Glaser et al., 1968. 757).

Bardon and Glaser (1968) noted the lack of quantitative research evidencing positive outcomes of the value of mother and baby units. They noted, however, that there were non-measurable and therefore non-controllable variables in the treatment situation which made it difficult to assess the effect of the presence or absence of the infant. They suggested that reports of further experiences and collaborations between psychiatric hospitals were needed to allow comparisons of different patterns of management but acknowledged it would be difficult to control variables to compare treatment settings (Bardon et al., 1968. 758). They suggested that comparison of the psychological and physical development of the children over a prolonged period may have been useful (Bardon et al., 1968). An interesting point was made by the Bardon and colleagues in relation to their focus of joint admissions: they introduced the article with reference to the previous work of Spitz (1945), Bowlby (1951), Bowlby et al (1952), and Robertson, (1952a, 1952b), making the point that the practice of joint admissions was considered to be of benefits to the child. They presented these theoretical perspectives along with their views that the infant was the receptacle for projections by the mother of her own *“repressed infantile feelings”*, leading to rejection and hostility towards the baby, and joint admission gave opportunity to help with these difficulties. They finished the article by clearly stating their position in relation to the priority focus of their work:

“As a result of our experience we, whose orientation is towards immediate benefits to the mother rather than the child, believe that these units constitute an advance in the treatment of puerperal mental illness” (Bardon et al., 1968; 758).

It is not known if Bardon and Glaser et al (1968) started out with this theoretical position or if it developed over time with their experience of joint admissions. Their first admission is reported as being in 1956 which was the same year that Douglas and colleagues reported on joint mother infant admissions for women with psychosis at the West Middlesex Hospital (Douglas, 1956) but the article was written some twelve years later. As previously mentioned, the work of Douglas and her team was focussed on the prevention of lengthy periods of relapse subsequent to the initial puerperal psychotic episodes, enabling the women to return home and resume full care of the child during the first year of its life. This is where similarities in thinking can be drawn with the later work of Bardon and Glaser et al (1968) in relation to benefits to the mother. Douglas (1956) seems to have seen the bigger picture in so far as she considered that prevention of relapse in the mothers, and subsequently being able to continue to care for the child, had significant potential benefits in the longer term for the child's own mental health and wellbeing.

In concluding the evidence from the 1960s, there was reference made to the existence of a mother and baby unit at the Eastern District Hospital in Glasgow in the late 1960's in a further article written by Bardon (1977). The primary source of this evidence proved to be extremely difficult to obtain. An internet search did not identify the source of this information from any published materials. The Glasgow Eastern District Hospital no longer exists so a hand search of archived hospital records of minutes of meetings and annual reports for NHS Greater Glasgow and Clyde to try to trace information on the existence of this unit was therefore conducted. The search identified a reference in the annual nursing report of 1969-1970. The chief nursing officer Miss L.G. Brown wrote:

“Miss M. Cochrane, ward sister, psychiatric unit, Eastern District Hospital contributed to an

excellent article on psychiatric nursing to the Nursing Mirror. This article illustrated the work carried out in the psychiatric unit” (Glasgow Royal Infirmary and Associated Hospitals, 1970).

The report provided a reference for the published article. Interestingly the article had not been identified during the original literature search or the specific internet search following up Bardon’s (1977) mention of the unit. An internet search of the article title identified that the journal title of the paper had been wrongly referenced in the archived report. The paper was not available electronically either as an abstract or in full text and was therefore requested from the British Library who could not provide a copy of it. A hard copy of the paper was eventually traced at a local university archive who allowed access to it.

The paper was authored by three clinicians. Hamilton was a consultant psychiatrist, Cochrane was the ward sister, and Ure, was a health visitor, all of whom worked at the psychiatric unit of the Eastern District Hospital in Glasgow, Scotland. The paper described the practice of side room admissions that had been first implemented in 1966 and reported on their experience of ten cases during the three year period (Hamilton et al., 1969). The paper was written from the perspectives of each of the disciplines, the consultant psychiatrist, the ward nursing sister, and the health visitor. Based on their findings and outcomes, Hamilton et al (1969) were advocating that mothers with mental illness should have their babies in hospital with them and that it was feasible to do this within an acute admission ward without additional staffing resources.

Hamilton et al (1969) went so far as to state that if a woman was not admitted with her baby then there must be a very good reason for this (Hamilton et al., 1969. 28). This primary evidence gives an interesting insight into their respective perceptions of the complexities of the practice that was not previously reported in earlier publications, none of which were authored by nurses. The ward had eighteen beds and admitted patients with *“psychosis, neurosis, adolescent crisis, drug*

addiction, alcoholism, psycho-geriatrics and patients who also had physical illness" (Hamilton et al., 1969. 28). The ten women studied had diagnoses of schizophrenia, manic-depressive psychosis⁴⁵, reactive depression, personality disorder and one patient was diagnosed with hysteria. The unit was run as a therapeutic community, similar to the previous example provided by Main (1958) and group psychotherapy was a component part of treatment for all patients. All ten women had apparently 'completely rejected' their babies at the point of admission but all ten recovered from their episode of illness and continued to parent their children at home after discharge from hospital and at follow-up over the three year period (Hamilton et al., 1969. 28).

The issue of risk to the babies was considered in detail from the perspective of the nursing sister M. Cochrane. This is the first account in the history identified up to this point that the issue of risk of harm to the babies features in any detail:

"In five cases there was a danger of the mother harming the child, and this can take many forms – actual physical violence, where the mother expresses a wish to suffocate the child or slap the baby, 'nipping' or 'patting' too heartily. Four of the mothers tended to show their aggression in more devious forms, i.e. neglect of the baby by not changing or feeding, attempting to give feeds too hot or too cold, giving too much or too little, 'forgetting' to 'burp' the baby or, worse still, giving a heavy thump to assist breaking wind; dressing the baby in too much or too little clothing, damp clothing, or leaving safety pins open; neglect of hygiene, not washing hands or bottle teats, and leaving bottles etc. lying around uncovered. The greatest danger is that the patient may lull the nurse into a false sense of security by pretending affection for the baby" (Hamilton et al., 1969. 28).

Cochrane who wrote this section of the paper refers to the poor parenting practice that she described as *"showing their aggression in more devious forms"*. This is a strong value judgement and does not account for the possibility that some of the examples given may not have been

15 "Manic-depressive psychosis" is now known as bipolar disorder.

deliberate but consequential acts of harm, alternatively explained by the nature of the effect of the women's illness on their level of functioning and cognition.

The other issues that Cochrane identified (Hamilton et al., 1969) were the attitudes of other patients towards the women when in group psychotherapy they openly expressed their negative feelings that led to their rejection of their babies. There were both positive and negative aspects to group psychotherapy in these situations. For some patients they felt anger towards the women and openly criticised them for rejecting their babies and made the women reflect on their feelings, but for some other patients it allowed them to highlight their own relationships with their children or the relationships they had with their own parents. They found over time most of the other patients were sympathetic towards the women although some patients felt neglected due to the amount of time the nurses spent with the patients with the babies (Hamilton et al., 1968. 29). Cochrane also described risks in terms of the baby "*becoming the pet of the ward*" with other patients wanting to spend time with the baby. In reference to this Cochrane commented, "*This is just what the mother would like – someone else taking over her role*" (Hamilton et al., 1969. 28). The final risk that was identified from the joint admissions in Glasgow was the direct risk of harm to the babies from other patients. One incident was described where a psychotic patient threatened to throw a baby out of the window.

The final section of the paper by Hamilton et al (1969) was written by the health visitor Miss I.C. Ure who was one of three part time health visitors who worked half time in the psychiatric unit after completing a six month university course on the care and after-care of the psychiatrically ill patient in the community. This in itself was an innovative model of care and service provision and combined the health visitor's knowledge of child welfare with psychiatric after-care. The health visitor built up a relationship with the women whilst they were in the unit, supporting and advising them in their care of their babies and ensured the welfare of the babies therein. As the women recovered they encouraged them to attend the local child welfare clinics in the community Preparing them for their eventual discharge home. The psychiatric unit health visitors liaised

between the hospital and the health visitors in the community who would be visiting the family after discharge. They also met with the fathers of the babies to try to ensure they were supportive of the women although Ure commented on the immaturity of most of the fathers in terms of what support they could offer and that in all ten cases, the relationships within the family were poor.

The team conducted a survey of the ten women after their discharge from hospital. Of the ten women admitted with their babies, eight of them agreed it had been beneficial to their recovery whilst two women, one woman with reactive depression and one woman diagnosed with hysteria, felt having the baby in hospital with them was an added burden (Hamilton et al., 1969. 30).

The work in the Eastern District Hospital in Glasgow evidenced that word of the practice of joint admissions had spread from England to Scotland and the team in Glasgow had further developed the model of care to include the health visiting service for the mothers and babies. This, coupled with continuity of care after discharge from hospital, ensured the continued welfare of the babies was given priority.

The evidence from the 1960s appears to have added to the evidence base for the practice of joint admissions, but also described how the practice was modified and accommodated within general acute psychiatric admission wards, rather than specialist mother and baby units. The work in Glasgow clearly gave equal consideration to the direct welfare and health of the babies, whereas it could be argued the earlier evidence was dominated by the direct benefits to the women and the benefits to the babies were perhaps secondary from the reduced incidence of relapse of illness in the women. The next decade in the history continues with evidence from clinicians in the field who published papers on the subject of joint admissions.

3.6 The 1970s

Moving on in the chronology to the 1970s, and continuing to use relevant information from Brockington's (1996) account as a source of secondary evidence, he stated that "*throughout the 1970's and 1980s there was a proliferation of joint admission throughout Britain, mainly to side room facilities*" of the type described in Fowler and Brandon (1965) cited above (Brockington, 1996: 560). Brockington did not provide secondary sources of evidence that pertained to the 1970s, however he did provide primary evidence from his personal experience of working in a purpose built unit that was opened in 1972 at Withington Hospital in South Manchester. He recounted that the unit could accommodate nine mothers with their babies but occupancy was relatively low although he did not give any possible reasons for why this may have been the case. The unit was a regional facility providing inpatient admissions for the population of Lancashire (Brockington, 1996: 564).

A specialist mother and baby unit with six beds opened in Nottingham in 1974. An account of the service was published in a chapter by Oates (1988) in Kumar and Brockington's second edition of their text 'Motherhood and Mental Illness' (Kumar and Brockington, 1988). The unit had six beds and was later expanded to include liaison services to the maternity hospital and community services.

The previously cited article written by Protheroe (1977), in which he described his experience of working in a mother and baby unit at St Nicholas Hospital, Newcastle upon Tyne, made reference to a facility for joint mother and baby admissions at Middlewood Psychiatric Hospital in Sheffield that had opened around the time of him writing the article. He commented that "*the venture was sufficiently novel and noteworthy to receive mention in national newspapers*" (Protheroe, 1977:12). Running a search of the term 'Middlewood psychiatric hospital mother and baby unit' on the search engine Google did not return any newspaper results but led to the website of Wadsley Park Village. On this website there was a summary of the history of the hospital found. Within the chronology

summarising the history of the hospital there was reference made to the opening of the mother and baby unit:

“At last in 1977 Middlewood developed a mother and baby unit to allow postnatal depressed mothers to be admitted with their babies” (wpvonline, accessed Feb 2011).

A search of the literature did not identify any early papers specifically written about the mother and baby unit at Middlewood Hospital. The first published information on the work of this unit appeared as a letter of correspondence published in 1980 on the topic of puerperal psychosis, and referred to work the authors had been engaged in with thirty two patients admitted to their mother and baby unit during the preceding three years. The address given at the end of the correspondence was Middlewood Hospital, Sheffield (Sneddon and Kerry, 1980). Later publications provided more detailed accounts of the work undertaken in the Middlewood mother and baby unit (Sneddon et al., 1981; Sneddon and Kerry, 1985; Sneddon, 1990). Although these articles were published in the 1980s, they are included here in the chronology as they gave accounts of the work of the unit opened in 1977. The unit had three beds and was an annex to an acute female admission ward. The majority of women had been admitted due to a diagnosis of psychotic illness.

The clinical model described particular regard for the health and welfare of the infants with a midwife visiting women and babies daily in the early postnatal period. After the twelfth postnatal day the family's own health visitor would visit the mother and baby on the ward to build relationships before her discharge home and to ensure early identification by the health visitor, of the need for readmission should it be necessary in cases of relapse. The model also involved input from a social worker, usually in cases where older siblings were on the local authority child at risk register. Treatment included ECT and medication, with active encouragement of close family members to visit regularly. Interestingly, there is no mention of psychotherapy being part of the clinical model of treatment, as was the case in the units previously. This possibly reflects the fact that psychotherapy in the 1970s was less prevalent with the modality of treatment having moved closer to a bio-

psychiatry model. One could question if this had any relevance to outcomes for the women as it was reported that relapses were common, therefore women were nominally discharged when felt to be well enough but were followed up on the ward at regular intervals until the baby was six months old (Sneddon et al., 1981).

Sneddon et al (1981) acknowledged a risk of physical injury to the babies on the unit, claiming that the greatest risk to the baby was from the acutely disturbed mother as opposed to injury from other disturbed mothers. They reported that five mothers tried to injure their child whilst in the mother and baby unit but that this risk was greater from women with depressive disorders than it was from women with psychosis (Sneddon, et al., 1981. 1299). From the articles reviewed up to this point in the history, this is the second reference to actual risk of direct harm encountered by infants subject to the practice of joint admission in the UK. The earlier paper by Hamilton et al (1969) also described evidence of risk of physical harm to the babies during joint admissions.

Bardon (1977) wrote another descriptive paper on the continued work of the mother and baby unit at Shenley Hospital which had first been established twenty years earlier (Bardon et al., 1968). He described how they originally opened a unit with ten beds, reduced the number to five beds in 1965 and increased the bed numbers again in 1973 to eight beds but, again, no information was provided on the reasons for the change in the bed numbers. Bardon gave a helpful chronology of secondary evidence of his knowledge of mother and baby units. He listed units at St Luke's Hospital in Muswell Hill which was opened in 1960, St John's Hospital, Lincoln which was opened in 1963, St Nicholas Hospital, Gosforth, which he stated was opened in 1964 but Protheroe reported this unit opened in 1963. Bardon also listed the Eastern District Hospital in Glasgow which he claimed had been established in 1969 but the evidence identified that joint admissions were in fact introduced in 1966. From the 1970s he listed Basingstoke Hospital which opened in 1974, and Middlewood Hospital, Sheffield that opened in 1977. He reported that these units continued to flourish at the time of his publication but that the Cassel Hospital, West Middlesex Hospitals and the

unit at Banstead had stopped admitting puerperal mothers and their babies but that a new unit at Springfield had been developed (Bardon, 1977). However, he provided no insight as to why these units had stopped the practice of joint admissions.

Bardon (1977) acknowledged that no statistical demonstration of the value of psychiatric mother and baby units existed and research in the area was problematic. His view was that:

“The main thing to be measured is the quality of the mother-child relationship and the quality and degree of the child’s socialisation. This constitutes a formidable research problem. No such objective measuring takes place in our unit and we should not find it easy to devise objective measures for such important things. We should find it even more difficult to allow for all the variables” (Bardon, 1977. 32).

The clinical model described the use of medication and ECT with the principle aim of *“abolishing psychotic symptoms as quickly as possible”* (Bardon, 1977). The article presents an interesting shift in the theoretical basis for the work of the unit at Shenley Hospital from that reported in the earlier publication by Bardon and colleagues who had clearly stated the priority of their work was weighted towards immediate benefits to the mother rather than the child (Bardon and Glaser et al., 1968).

The article published in 1977 put a much stronger emphasis on the outcomes for the infants being the predominant focus, which was the original theoretical basis for the work of the unit when it was first opened in 1956 (Glaser, 1962). Bardon also reported on adverse events specific to the infants within the unit, one case of infanticide and ten cases of the mother being physically violent to their children *“to the degree that caused concern”* (Bardon, 1977. 31).

In completing the history of joint admissions up until the end of the 1970s it appears from the evidence that the theme of physical risk and harm to the infants is emerging as an area of particular consideration in the provision of such services. Although this study is focussed on the history of

service developments in the UK, this issue of risk and harm to infants was also evident in the international press during the 1970s (Lindsay and Pollard, 1978).

3.7 The 1980's

During the 1980s there appears to have been an increased interest in the service provision for joint admissions and several surveys were published on the subject. A regional survey conducted in the South East Thames Health Region in 1979 and repeated in 1981 was published in 1986. This evidence has been included at this point in the chronology as it pertained to service provision in 1979 and 1981 (Kumar et al. 1986). The survey involved the use of a questionnaire in 1979 and in a follow-up enquiry two years later sent to 75 hospitals and units where it was likely mothers with mental illness might receive some form of care with their babies. All 75 facilities responded and it was identified that there were twelve hospitals in the region which admitted mothers and babies. One of these was a paediatric ward and one unit had closed during the period of the survey, apparently due to nursing staff shortage. The facilities ranged in size from one side room on adult wards to separate units with up to six beds and cots, the largest being in Hellingly Hospital. The researchers visited all twelve facilities between 1982 and 1983 to see for themselves the facilities provided. They concluded that:

“Services in the South East Thames Health Region had evolved piecemeal to meet a particular clinical need without incurring substantial capital costs and virtually no demands on recurring revenue. This has been achieved because the load has been spread across a number of psychiatric hospitals and units. An obvious advantage of a decentralised service is the relative proximity of the hospital to the patient's home. One disadvantage of a thinly spread service is an inevitable limitation of the types of specialised in-patient care and treatments that can be offered to mothers and their families. Although large units are costly, they do also provide an essential platform for research into puerperal mental illness and its consequences” (Kumar et al., 1986. 172).

The next evidence identified in the chronology of evidence from the 1980s was the first edition of the text 'Motherhood and Mental illness' that was published in 1982 and included a chapter on psychiatric mother and baby units (Margison and Brockington, 1982). In the evidence from published literature, it is possible to see consideration of risks to infants involved in joint admissions continuing to emerge as a theme. The majority of publications thus far in the history have either reported that there had been no issues of risk of harm to the babies or that risk had not specifically been explored within the published reports and articles. Three UK publications (Hamilton et al., 1969; Bardon, 1977; Sneddon, 1981) did however specifically report on incidents of attempted or actual harm. The chapter by Margison and Brockington (1982) specifically posed the question as to how safe the units were, referencing the fatality which was reported by Bardon (1977) and a second fatality by a woman who murdered another patient's baby, reported from a unit in New Zealand (Lindsay and Pollard, 1978).

Margison and Brockington (1982) gave an account of their examination of risks within a mother and baby unit with nine beds at Withington Hospital in Manchester. They identified cross-infection, in the main, gastrointestinal infection as one of the main risks to the infants and provided data on the incidence and nature of infection encountered by the infants admitted. They also provided details of incidents of physical risk or harm that occurred to infants in the unit over a five year period taken from a retrospective study of documentary evidence conducted by Margison for an MSc dissertation (Margison, 1981). The account of the results of the study provided in the book chapter have been used as the source of secondary evidence as they have not been found to have been published elsewhere in the professional press (Margison and Brockington, 1982. 229-232). Margison reported that 37 incidents of possible non accidental injury involving 21 babies were identified in the study of 245 patients (Margison, 1981). Margison and Brockington suggested that the incidents should be considered in terms of severity and described how they categorised the various incidents below:

“the risk to the baby was minimal in ten cases (e.g. slapping or shaking, rough handling, throwing him into the cot without violence); it was judged moderate in eight cases (throwing him into the cot violently, shaking or slapping violently, or attempting to smother him in the presence of nurses), and it was judged severe in three instances. In one incident a baby was thrown at least six feet across the room.....in another, an attempt was made to kill a baby by suffocating him with a plastic bag. The third was the most serious: the mother had already made several attacks on members of staff and three on the baby and then suddenly managed to push him off her lap onto the floor in the presence of nurses.... He sustained a skull fracture” (Margison and Brockington, 1982. 231-232).

Margison and Brockington (1982) identified that there was significantly less risk of non-accidental injury to the infants by women with puerperal psychosis than there was by women with depression, personality disorder or ‘bonding failure’ (which was described by Sluckin (1998) as an extreme and persistent lack of emotional connection between a mother and her infant) (Margison and Brockington,1982). A commentary on the results of the study is provided below:

“The results confirm that the babies are at risk, but that real injury is remarkably uncommon on these wards full of disturbed women. No doubt this is largely due to the vigilance of the nursing staff on this unit, maintained over a period of years at a high level. Rarely however, does a major incident occur. Bearing in mind the skull fracture sustained by one of our babies and the two babies who have been killed on these units in the past 30 years, is the risk acceptable? Unfortunately there are no data to make informed judgement on this point. It is possible that other serious injuries have not been reported and more extensive survey of serious injuries sustained on mother and baby units should be made” (Margison and Brockington, 1982. 232).

“At the present stage of uncertainty and unease about the safety of these units following the recent reports of two non-accidental deaths, there must be a period when admission of

potentially dangerous mothers is viewed conservatively. Ideally the unit should care for all types of mental disturbance within its field of interest, and it may eventually be able to do so, but not until further research has been carried out on the diagnosis and management of mothers at high risk” (Margison and Brockington, 1982. 235).

The same chapter by Margison and Brockington (1982) also touched on the question of economics and the need for the units to have a high ratio of staff due to the needs of not just the patients themselves, but also the needs of the infants admitted with them. Having taken into consideration the bed occupancy, length of stay and number of admissions per year to the nine bed regional unit in Manchester, coupled with the high staff ratios, Margison and Brockington estimated that costs of running the unit were three times the cost per patient than those on a general adult psychiatric ward, but emphasise this did not take into consideration the cost of providing alternative care for infants who were not admitted in the case of admission of patients alone to general adult wards (Margison and Brockington, 1982. 234).

Margison and Brockington (1982) also considered the positive value of the units, acknowledging this was a complicated area to try to explain and evidence as there was more than one category of patient treated in the units. They highlighted both the positive and negative aspects of such admissions and categorised patients into three groups:

“hospital admission is a treatment with its own side effects, one of the most important being the atrophy of skills and the loss of confidence in one’s ability to carry out the job and the tasks of daily living. A mother needs to remain, so far as possible, in touch with her normal role. If her mental distress is particularly associated with that role,... avoidance of the difficulties may make it even more difficult for her to cope when she returns home. The mother and baby unit provides an ideal opportunity for focussing treatment on a disordered relationship. The nature of the difficulties can be directly observed and accurately diagnosed. Caring for mothers with difficulties in their relationship with their babies is the

most obvious function of such a unit. It is also appropriate to admit mothers with psychiatric illness (usually depression) associated with other environmental difficulties such as unhappy marriage or the lack of support from a husband or family, but no obvious problem in their feelings for the baby” (Margison and Brockington, 1982. 234-235).

The second large group of women they identified who were treated on the units were those with puerperal psychosis. Margison's and Brockington's view was that the useful purpose of joint admissions for this group of patients was less obvious:

“The risks to the baby appear to be less in these patients because the main risk comes from the mother rather than other patients and these mothers are not (as a rule) hostile to their babies. The babies are younger and more vulnerable to infection.....our own non-systematic observations seem to show that psychotic mothers often relate well to their babies during the illness and have no difficulty in establishing a normal bond when they recover. The most obvious advantage of joint admission in these women is the convenience to the families....The case for admitting babies with puerperal psychotic mothers, therefore, is less obvious than for mothers with late onset depressions, though later research may show that it has important benefits” (Margison and Brockington, 1982. 235-236).

This does not reflect the findings of the very first study of this group of women by Douglas (1956) who demonstrated that these patients had better outcomes in terms of reduced relapse of psychosis after discharge from hospital and return to parental responsibilities and improved outcomes in terms of continued care of their child. Margison and Brockington (1982) identified however that a small group of non-puerperal psychotic patients may have benefitted from joint admission:

“A typical example would be a long-stay schizophrenic patient who became pregnant. The unit is an ideal solution to the management of such a patient who would otherwise have to

be discharged from hospital [long stay institution], or deprived of her baby without even a trial of caring for him” (Margison and Brockington, 1982. 236).

The third group of patients identified within the Manchester psychiatric mother and baby unit were those who required an assessment of maternal competence and attitudes. Margison and Brockington (1982) described how requests were made by social services to admit mothers in whom there was uncertainty whether they could or should be given custody of their babies. They commented that the staff did not enjoy this aspect of work as their orientation was towards treatment rather than assessment and they were only willing to undertake such an assessment if there was a definite possibility that the mother was mentally ill (Margison and Brockington, 1982. 236).

Categorisation of patients would signify that it may have been possible for clinicians and researchers in the field to consider what the outcomes of admission for each of the respective groups might have been but, from the evidence, it does not appear that this was progressed robustly. At the time of writing of this chapter, the practice of joint admissions had been happening for more than 30 years but by this account it appeared that the empirical evidence surrounding the value of the practice was still not available, despite the call for further research in the field being a common feature of papers published up to this point. Margison and Brockington (1982) made this observation themselves and concluded:

“There is a need for more research on the therapeutic effectiveness and the risks of both kinds of units [general adult wards that provided for joint admissions and specific dedicated mother and baby units].....The present writers take the view that psychiatric mother and baby units are an innovation of considerable promise, but that their full potential has not yet been realised.....As psychiatry becomes more differentiated and specialised, such units could serve a valuable function, but we need more empirical investigation and experience

before we can recommend a general deployment of scarce resources in this way”

(Margison and Brockington, 1982. 237).

The issue of the lack of research on effectiveness emerged again from the authors of the article on the outcomes of the survey conducted by Kumar and colleagues in 1979 and 1981. In their publication of the results of the survey they too noted the lack of networking between services and lack of research in the area:

“The circumstances in which the benefits of joint admissions of mothers and babies outweigh the possible disadvantages need to be clarified. The lack of research into these kinds of questions is striking.....Most facilities are working in isolation from each other and there are no accurate registers of the services that are available....At present there are few opportunities for comparing notes, discussing operational policies at local or regional level, or for carrying out research, e.g. into outcome, following differing treatments and methods of clinical management” (Kumar et al., 1986. 172).

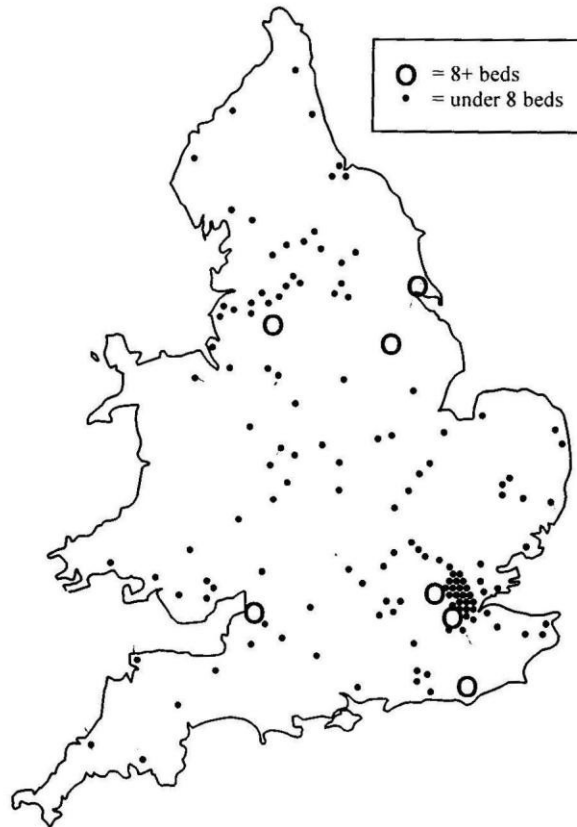
Kumar and colleagues presented an alternative formula for calculating need in relation to the required numbers of beds for joint admissions. Instead of using per head of population as had been the case earlier the same year by Shawcross and McCrae (1986), Kumar and colleagues calculated the estimated number of required admissions based on birth rates for the district and information on incidence of mental illness in the postnatal period, which they estimated as between one and two women in every 1000 mothers. They concluded their paper by making four recommendations:

1. *Compilation of regional and national registers of in-patient facilities for mentally ill mothers with young infants;*
2. *Clarification of the status of babies who are in hospital with their mothers;*

3. *Planning and coordination of services at a regional level to link day and community care with local in-patient facilities, and where possible, with large, specialist mother and baby units;*
4. *Studies of the clinical efficacy and cost-effectiveness of different forms of services for mothers and babies and the promotion of research into prevention and treatment of severe postnatal mental illness (Kumar et al., 1986. 172).*

The survey referenced above was carried out in 1979 and 1981 but the results were not published until 1986. Again, using Brockington's history of mother and baby units as a reliable source of secondary evidence, he described the results of a much larger unpublished survey that he had referenced in his chapter on the subject of mother and baby units (Brockington, 1986. 560-561). This survey was not available in the public domain so Brockington's account of the survey has been included in this chronology as secondary evidence. The survey was conducted by Aston and Thomas between 1985 and 1986 across 305 psychiatric and district hospitals in the whole of England and Wales (this is the first reference to service provision in Wales). They wrote directly to the hospitals and received a very high return of 293 responses from the 305 surveyed. Brockington plotted the results of the survey on an outline of a map of England and Wales to illustrate where the facilities were geographically located (this map has been reproduced in Figure 4 below).

FIGURE 4: Mother and baby facilities in England and Wales in 1985-86, as surveyed by Aston and Thomas (1986) and provided by Brockington (1996).



The survey identified that 141 of the 293 hospitals that responded provided inpatient joint mother and baby care, totalling 294 beds across England and Wales (Brockington, 1996: 560). The breakdown of the data provided by Brockington on the number of beds in the number of hospitals is provided in Table 1, however the information he has provided in his account of the survey data appears to be incomplete.

The survey apparently identified 294 beds across England and Wales but the number detailed by Brockington totals 284 beds. He only provided the breakdown of the number of beds for 97 of the identified 141 facilities. In addition, the actual geographic locations of all the facilities was not provided in his narrative, however he did provide a visual map outline with the 141 facilities plotted

on it (Brockington, 1996. 561). Based on the secondary evidence provided by Brockington, it is not possible to accurately compare the data already collated within the chronology against the results of Aston and Thomas's survey. Brockington did not provide the complete data set in his narrative so it has not been possible to extrapolate which of the mother and baby units already referenced were still in existence in 1985-86.

Table 1: Number of hospitals with number of beds referenced by Brockington (1996) from Aston and Thomas (1986)^{*16}

No. of beds	1	2	3	4	5	6	7	8	9	10	Total
No. of hospitals	18	44	10	8	3	7	0	5	1	1	97
Total beds	18	88	30	32	15	42	0	40	9	10	284

As previously referenced Brockington (1996. 561) provided an illustration of where the facilities were geographically across England and Wales which has been replicated in Figure 4. Shawcross and McRae (1986) conducted their own enquiries on facilities for joint mother and baby admissions through the use of a questionnaire sent to 42 district medical officers in England. Shawcross was a consultant psychiatrist and McRae was a nursing officer at Knowle Hospital in Fareham, Hampshire.

In their article published in March 1986 Shawcross and McRae referred to the practice of joint admissions as being 'common practice' but highlighted that the development of mother and baby facilities was 'piecemeal' (Shawcross and McRae, 1986. 50). Their view was that psychiatric mother and baby service developments usually happened as the result of local interest, motivated by the

¹⁶ *N.B. The data outlined in Table 1 includes the information provided in Brockington's (1996) secondary evidence. It does not include data for all one hundred and forty one facilities identified through the survey conducted by Aston and Thomas (1986) as Brockington provided an incomplete breakdown of this data and a copy of the original survey could not be sourced.

belief that such services added to the quality of care for mother and baby, and were not the subject to more formalised central planning. The driver for Shawcross and McRae conducting the survey was to inform their own planning decisions as to whether or not a service of that type was needed in their own geographical area. They received 29 responses to their questionnaire which was a 69 per cent response rate and identified considerable variety in the services offered. They divided the types of service into two groups: specialised units; and mother and baby beds on acute psychiatric units. Their survey identified six hospitals that had specialised units which ranged in size from two to 14 beds and 17 hospitals that provided joint admissions to beds in the acute psychiatric unit. Their survey asked questions about the size of the district by head of population to enable them to calculate the number of beds required for their own population.

Shawcross and McRae noted that there was an enormous variety of services available and great variation in bed availability and usage per head of population depending upon the district, with some districts with large populations not providing any facilities for joint admissions, and others with less population providing fairly large numbers of beds by proportion. However, they concluded that in order to justify a specialised unit, it was probably necessary to have a catchment population of approximately 500,000 people; one bed per 112,437 people. They suggested that differing admission criteria accounted for variation in admission rates and length of patient stay and therefore differences in bed usage between districts (Shawcross and McRae, 1986).

Shawcross' and McRae's conclusions that a satisfactory facility could not be provided in a general adult psychiatric ward were challenged in a letter published in July of the same year (Pandita-Gunawardena, 1986). Pandita-Gunawardena (1986) detailed the provision of a three bed mother and baby facility within a general adult ward at Netherne Hospital in Coulsdon, East Surrey which had provided for joint admissions for a period of ten years. There was provision for adjacent single rooms, a nursery downstairs and a nursery upstairs where the babies slept at night. Pandita-Gunawardena claimed it was not difficult to provide such a facility, with a need for extra staffing

only rarely. If the beds were not in use, they were used by the general adult ward if necessary.

Pandita-Gunawardena concluded:

“though the mother and baby facility is not in use all the time it serves a very important client group and should be available in all health districts in the country” (Pandita-Gunawardena, 1986).

The second edition of *Motherhood and Mental Illness* was published in 1988 (Kumar and Brockington, 1988) and in addition to a strengthening of the original chapter on mother and baby units, a chapter was included on the pioneering work of psychiatrist Margaret Oates who in 1982 had piloted a domiciliary service as part of the service offered by the Nottingham mother and baby unit that had opened in 1974. The pilot involved two patients with psychotic illness who were treated at home in the postnatal period, through intensive home visiting by the primary care team and staff from the mother and baby unit. The pilot which was developed into a multidisciplinary community team in 1984 had positive outcomes in reducing admissions to hospital of mothers and babies, and also in reducing length of stay of those women admitted (Oates, 1988).

The service described by Oates (1988) was resource intensive but it had the added advantage of women and their babies not facing prolonged separation from their families. This community service development may have had some influence on the slowing of the diffusion of specialist inpatient services because, for the first time since the introduction of asylums in the nineteenth century, very ill mothers could be treated at home thus placing less of an emphasis on the absolute need for admission to hospital.

The knowledge of the practice of joint admissions had clearly spread widely by the end of the 1980s but curiosity and interest as to how the practice was being implemented was growing. Clinicians in the field of practice were making attempts to identify just how wide spread the practice was and they were also keen that research on the effectiveness of the practice was progressed.

This was linked to questions being raised about the high cost of specialist units in comparison to side room admissions. The evidence from the surveys identified that side room admissions had become more wide spread than specialist units. The literature also suggests that up to this point in time there is evidently a theme about the risk of harm to the babies in the history of joint admissions to the extent that it warrants more detailed consideration. This theme is addressed later in the thesis in the analysis in Chapter 8.

3.8 The 1990's

In 1990 the results of a further survey of resources for mother and baby admissions in the six regions in the South of England and Wales were published (Cassell and Coleman, 1990). Cassell was a lecturer in child psychiatry at Westminster Children's Hospital in London and Coleman was a psychiatrist at Gordon Hospital in London but no information was included on what the author's involvement was, if any, in the provision of joint admissions. A questionnaire was sent to the senior nurse manager of the psychiatric units of 120 hospitals with requests for information on the existence of mother and baby units, local resources to treat mothers and babies, problems, and plans for future developments. Requests were also made for policy documents specific to the mother and baby units.

They received 103 responses (86 per cent) that enabled them to identify 38 hospitals that had mother and baby units, five of which had five beds or more. Hospitals that provided single beds for admissions within adult psychiatric wards totalled 25 hospitals and hospitals that facilitated the mother's admission whilst the infant was accommodated in the local paediatric unit were 11 in total. One hospital provided for admission of the whole family into the child psychiatric unit and one hospital also facilitated admissions by having the child cared for in the staff crèche. The five units that had at least five beds had specifically designated staff. One unit had four beds, two units had three beds, and 17 units had two beds. Some of the larger units were regional facilities and some

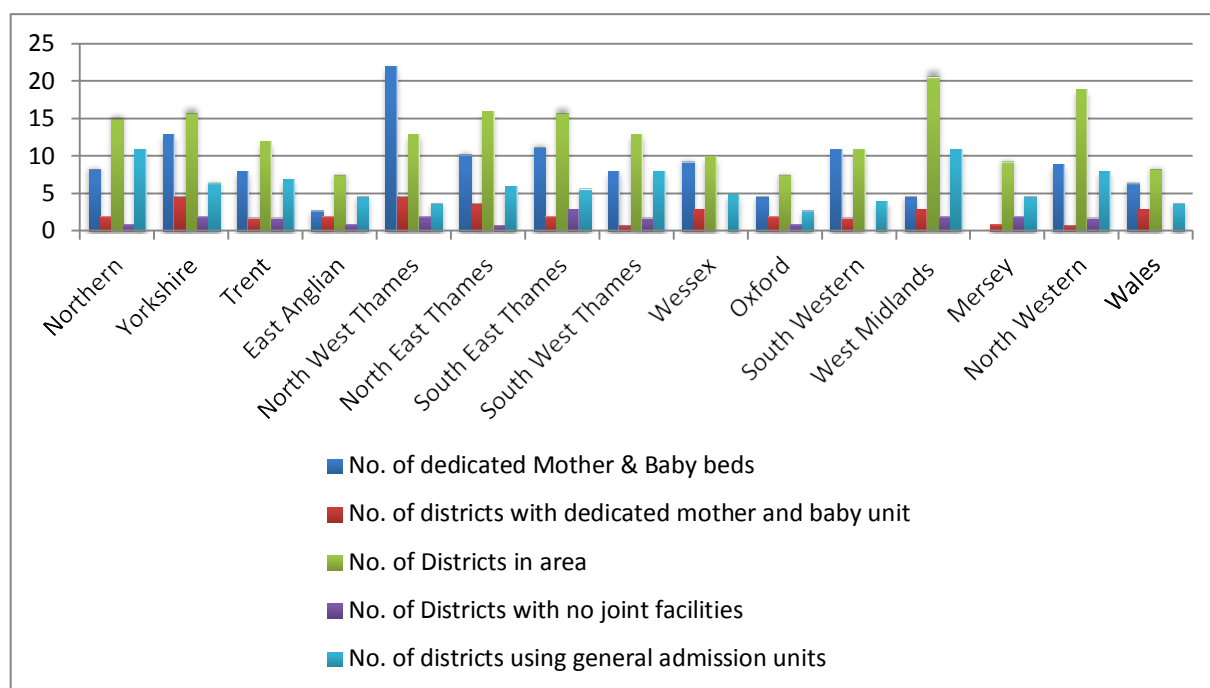
districts had more than one facility. Only two units provided copies of operational policies (Cassell and Coleman, 1990).

There was no commentary provided on the location or names of the units so it is not known whether the facilities reported in this survey include those previously referenced and it is not possible to know how many of the units mentioned earlier in the historical narrative were no longer functioning at this stage. Cassell and Coleman (1990) commented that it was of concern that so many units were strained for resources, particularly dedicated staff or staff trained in the field of practice. Cassell and Coleman (1990) reported that two units were closed due to lack of staff but they did not state this was due to the funding of staff or due to inability to recruit staff to work in the areas, or what discipline of staff they were having difficulty with. They suggested their results indicated a need for research aimed at clarifying the level and type of staff required by the various types of units and the outcome of patients cared for in each, to identify whether provision should be in the form of smaller local units or larger more specialised ones. They finished their article by endorsing the need for a national register of mother and baby facilities as had been earlier recommended by Kumar and colleagues (Kumar et al., 1986), and suggested the register would have helped provide an information base from which standards of practice could have been developed (Cassell and Coleman, 1990). This appears to be the first reference made to a call for specific standards of practice for mother and baby units within the published literature reviewed to this point in the historical narrative.

Prettyman and Friedman (1991) conducted a further survey of psychiatric mother and baby units in England and Wales. Prettyman was a senior house officer training as a general practitioner and Friedman was a consultant liaison psychiatrist at Leicester General Hospital. They sent a questionnaire to 201 health authorities across England and Wales and received an exceptional return of 194 (97 per cent) completed questionnaires in response. Results identified 38 districts reported having dedicated facilities; 94 districts reported that mothers and babies were admitted to

acute general adult wards, 50 districts reported they used facilities in another district, and 21 districts reported there was no provision at all for joint admissions. In total they identified 173 facilities that provided joint admissions. It should be noted that none of the categories were mutually exclusive so some districts used more than one option to provide for joint admissions. Interestingly, 30 districts indicated they planned to set up a dedicated inpatient facility and 63 districts indicated their existing facilities were under review. Nine districts had no facilities and no plans to provide them either. 140 districts indicated provision of specialised mother and baby facilities were a resource priority. The reported results have been converted into Table 2.

Table 2: Results of a survey demonstrating provision of facilities for joint mother and baby psychiatric admissions in England and Wales identified by Prettyman and Friedman, 1991.



In 1991 the survey by Prettyman and Friedman (1991) was the most comprehensive in detailing service provision in the 40 year history of the practice of joint admissions. As can be seen in Table 2, Wales had three dedicated mother and baby units with a total of seven beds, which is the first specific report of service provision in Wales. The authors commented that:

“There seems to have been a general move towards providing joint admission for mothers and their babies, partly because of the opportunities presented by the opening of new psychiatric units as older hospitals close” (Prettyman and Friedman, 1991.1246).

Prettyman and Friedman (1991) also commented on the lack of research in this field of service provision:

“Little research has been done into the best way of organising the service for this group of patients....More research is needed into the different patterns of care and organisation of postnatal mental illness services” (Prettyman and Friedman, 1991.1246).

A few years after the publication of this survey, Brockington published his text, 'Motherhood and Mental Health' (1996), which has been referenced throughout this thesis as a source of secondary evidence included in the presented history. This was a comprehensive text and was a third edition but, as previously mentioned, this edition had a chapter dedicated to services which included what Brockington regarded as the 'ideal service' which included inpatient facilities (Brockington, 1996. 582). For this reason it is considered here as part of the chronology of possible influencers on the diffusion of joint admissions.

Brockington recounted that in the 1980s he worked in Birmingham providing outpatient perinatal mental health services but in cases where hospital admission were required he would access inpatient beds in general adult psychiatric wards. It is likely that these were the earlier referred to 'side room admissions' (Fowler and Brandon, 1965). Brockington stated that he gained experience of the problems of admitting mothers to general psychiatric wards but he did not elaborate on what these problems were. In June 1992 a purpose built dedicated mother and baby unit with eight beds was opened in Birmingham. There was also an adjoining flat which essentially meant nine women could be accommodated. Brockington gave a view on what influenced the investment, stating:

“The unit opened after the profound reorganisation of the NHS, which introduced the

'internal market' and the 'purchaser/provider split'. I have little doubt that, given the financial difficulties of the South Birmingham District Health Authority, it would never have been opened, except in the rigorous climate of market-controlled health provision" (Brockington, 1996. 565).

Based on the rates of admission and demand for the Birmingham service Brockington reported that within two years of opening demand exceeded capacity and the revenue the unit was generating exceeded the running costs of the unit. Brockington estimated that the need in the UK for specialist mother and baby unit beds was 500 beds across the population of the UK. This was based on the average lengths of stay, bed occupancy levels, and a calculation that the demand for admission was five admissions per 1000 births (Brockington, 1996. 566). According to Prettyman and Friedman's survey of 1991, England and Wales provided 133 beds, which, taking into account Birmingham's additional nine beds, this still left a considerable shortfall if his estimated need was anywhere near accurate. Brockington went as far as to state the areas in the UK where he thought the units should be:

"In Britain there should be four units in London, and one each in Birmingham, Manchester, Liverpool, the West Riding of Yorkshire and Glasgow. Units in smaller towns e.g. Bristol and Nottingham can be viable if they recruit patients from the hinterland. Although the distance may make visiting difficult, this is not a disadvantage for isolated mothers. Specialised units can receive national or even international referrals" (Brockington, 1996. 572).

Brockington's text again referenced the community service model provided by Oates (1988) in Nottingham but Brockington was cautious not to recommend that this same model of service should be replicated in all geographic areas (Brockington, 1988. 574).

Brockington also discussed the issue of safety of the infants. He referenced several cases where infants were subject to death or harm and also stated that he knew anecdotally that there had been

deaths that had not been publicised (Brockington, 1996. 566). He suggested that the risks differed depending on whether the joint admission was to a specialist unit or to a side room within a general adult admission ward, believing the risk was greater in side room admissions. He posed the question as to whether or not the risk was acceptable and provided several perspectives to answer this, concluding that in his view:

“the risk is small, provided that danger is pre-empted by strict rules of observation. It is acceptable provided that we also take on the responsibility of researching the level of risk”
(Brockington, 1996. 568).

Brockington also gave consideration to the cost of the practice of joint admissions, acknowledging that it was significantly more expensive than admitting the mother alone. His calculations suggested joint admissions were approximately 50 per cent more expensive. He argued that economy of scale with regional provision should be considered as a more economical option. However he claimed that the survival of the specialist units in Britain was under threat due to the focus within the NHS at the time being increasingly orientated towards cost control, which may be interpreted as a reference to the internal market arrangements that were then introduced by the Government White Paper ‘Working for Patients’ (Department of Health, 1989).

A publication in the same year by Oates (1996) continued with the theme of service provision and referenced the survey published in 1991 (Prettyman and Friedman, 1991). She highlighted the difficulty in understanding the pattern of service provision across the UK, largely due to the considerable variation in the services that were provided (Oates, 1996. 88). She made reference to the practice of joint admissions and the thinking of the time:

“This wide spread belief in the need for joint admission is largely based on humane reasons and the early work of Bowlby rather than on the evidence of controlled clinical trials, of the superiority of this type of management over traditional psychiatric admission of the mother alone” (Oates, 1996. 88).

This clearly sets out that the practice of joint admissions at this point in time was not being driven by an evidence base of effectiveness identified through empirical research, but more by the notion of its connection to the mother-infant relationship and expert opinion that it was a 'good' thing to do.

The complexities of providing services for relatively few patients was discussed in the context of regional service provision but also by the challenges posed by the purchaser-provider health policy at the time. This aspect of policy is considered in Chapter 5 of the thesis. Unlike Brockington (1996), Oates suggested that it was not possible to prescribe one standard model for service provision. She did however attempt to set out a set of principles that should guide service provision. She also provided a formula for calculating local and regional need based on local birth rates and her estimate of the staffing resource needed for the provision of specialist services (Oates, 1996). Oates advised on how to go about developing a service:

“The first step is to convince colleagues, planners and potential purchasers that there is a substantial group of patients who need (i.e. will experience significant benefits from) a postnatal mental illness service. Knowledge derived from research findings and the best contemporary clinical practice combined with local statistics and socio-demographic factors to present the case of need, the case for specialisation and an estimation of local morbidity and service usage” (Oates, 1996).

This publication by Oates (1996) was a clear example of an expert in the field trying to influence colleagues to develop services and offered very practical advice and guidance on how they might do this.

In 1999 Nicholls and Cox published a paper on UK service provision for women with postnatal mental disorder (Nicholls and Cox, 1999). They stated their specialised view and that designated services were justified in terms of the specific needs of this particular client group and their infants and that dedicated units could provide 'critical mass' care in terms of sufficient numbers of patients

warranting a multidisciplinary approach to care and treatment. They also claimed that:

Such units are viable in terms of facilitating a research and teaching base to assist others in academic work and service development” (Nicholls and Cox, 1999).

They reconfirmed that services provided in the UK were not uniform and that:

“The variation reflected to a large extent the individual qualities and flair of the senior clinicians of each service, and their diversity should be viewed as a strength that enables comparisons to be made between different models of care” (Nicholls and Cox, 1999, 45).

This paper went on to challenge the established assumptions that joint admission practice was best in view of the fact that research on the subject was lacking. They pointed out that there was no empirical evidence to say that mother only admissions were detrimental to bonding and attachment when intensive infant contact was arranged during the period of admission (Nicholls and Cox, 1999, 46). They also cited research that Nicholls had published the previous year in which she identified that there were not substantial differences between admission to an acute psychiatric ward and a designated mother and baby unit (Nicholls, 1998). The paper did not provide further details of the study and it is not clear if the study included admission of babies to the acute psychiatric ward or if it was mothers alone.

Nicholls and Cox (1999) stated that there had been an increase in provision of joint admissions since the survey conducted by Prettyman and Friedman (1991) but did not substantiate this with any additional information on provision, except to surmise that it was probably due to an increase in beds allocated for joint admissions in general adult acute wards. They questioned the value of such arrangements and recounted their own experience of joint admissions to general adult wards causing considerable anxiety among ward nurses (Nicholls and Cox, 1999, 47).

They do point out that substantive mother and baby units and ‘mother and baby beds’ in acute psychiatric wards should be distinguished between as often the dedicated units were tertiary

treatment services dealing with more complex cases. They concluded that the value of joint admission was poorly defined and there was clearly an identified need to divert increased effort into providing services in the area but that further research was needed (Nicholls and Cox, 1999).

By the end of the 1990s it was 50 years since the practice was first introduced. Further surveys had been conducted which evidenced a continued interest in the spread and design of the practice of joint admissions. The practice had spread further over the preceding decade but there were still significant gaps in provision and services were not homogenous. The issue of risk of harm to the babies continued to be evidenced in the literature. The evidence that is available through published papers informs the history of services in England and Wales but there is an absence of evidence that further informs the history of the practice in Scotland. Up to this point in the history there is also no evidence of the practice having spread to Northern Ireland.

3.9 The 2000's

In 2006 the mental health charity MIND published a report, 'Out of the blue? Motherhood and Depression' (MIND 2006). The report focussed on the results of research conducted in England around the experiences of women with antenatal or postnatal mental distress. They identified that 63 per cent of women admitted to hospital had been admitted to general adult psychiatric wards. They were concerned about shortcomings in specialist service provision that they had demonstrated with 75 per cent of England's mental health trusts neither having a mother and baby unit or providing access to one. They reported that at the time of their study in 2006 there were 16 mother and baby units in England, one in Wales, two in Scotland and none in Northern Ireland. They also noted there was a lack of standards for mother and baby units and the number of beds in each ranged from two to ten (MIND, 2006).

A further survey conducted as part of the development process of the National Institute for Health and Clinical Excellence (NICE) Guideline for antenatal and postnatal mental health identified that

fifteen per cent of Primary Care Trusts in England and 20 per cent of Health Boards in Wales did not provide access to mother and baby unit care (National Institute for Health and Clinical Excellence, 2007).

The most recently published survey was undertaken in 2005 and published in 2009 (Elkin et al., 2009). The aim was to identify the availability and function of psychiatric mother and baby units in England. Thirty one per cent of respondents reported that they were direct providers of either a specialist mother and baby unit or had designated beds specifically for women in pregnancy or postnatal period. A further 40 per cent made use of mother and baby beds outside their own Trust area and 52 per cent reported using general adult beds with no facility for admitting infants. Total responses amounted to a greater number than the total number of Trusts that responded (123 per cent of the 91). This appeared to indicate that a number of Trusts used several different services, which it was thought could imply a limited capacity to best make use of any one particular service (Elkin et al., 2009). The survey identified 26 facilities that had adopted the practice of joint admissions, which included 13 specialist units of four beds or more across England that met the inclusion criteria for the survey.

Elkin et al (2009) concluded that the provision of psychiatric mother and baby units in England was inequitable, and the clinical and operating characteristics of these services were highly variable. The survey also showed that psychiatric mother and baby units were serving women with the most severe mental illness. Elkin et al (2009) suggested that if services were to expand and develop in the future, more qualitative and quantitative studies were required to identify the most effective components of the services and examine for whom the units were most helpful (Elkin et al., 2009).

3.10 Chronology of service provision in Scotland and Northern Ireland

The majority of information in the historical narrative pertains to services in England and Wales. With the exception of the paper published by Hamilton et al (1969) service provision in Scotland is

not well documented. This paper is the only one identified prior to 2000 that is specific to the service provision in Scotland. Personally, I can recall oral information from earlier in my career that there had been a mother and baby unit in the Royal Edinburgh Psychiatric Hospital in the 1980's. Contact was therefore made with the historian at the NHS Lothian archives. The librarian at the archives made enquiries and confirmed there had been an eight bedded professorial psychiatric unit at the Royal Edinburgh Hospital and two beds within this unit had been used for joint mother infant admissions. The unit had closed around 1993 but the historian could not locate any information on its closure. She had made contact with a former nursing sister of the unit but she too could not recollect much about her time there or the reason for the unit's closure, which was rather unusual, but does evidence the difficulty with the accuracy and reliability of data from personal recall.

The practice of joint admissions to side rooms of general adult psychiatric admission wards was common practice in many hospitals in Scotland in the 1980's, 1990's and in early 2000's. This is known anecdotally and also from personal experience from earlier in my own career. The practice was also further confirmed in a survey conducted between 2003 and 2004 as part of a Chief Scientist Office funded audit of policy implementation in the field of perinatal mental illness in Scotland (NHS Quality Improvement Scotland, 2006). Fourteen NHS Boards reported the presence of eight facilities across Scotland that provided for joint admissions, none of which at that time were specialist units, but instead admissions were to side rooms of general adult psychiatric wards (NHS Quality Improvement Scotland, 2006). Side room admissions to general adult wards were largely phased out in Scotland in 2004-2006 and the pattern of events surrounding their withdrawal are discussed later in the thesis in Chapter 8. The practice of side room admissions was replaced with the development of specialist regional units, the first one opening in 2004 in Glasgow. This unit had six beds and provided admissions to the west region of Scotland. A detailed account on how this service was developed is provided in Chapter 6 later in the thesis. The opening of this unit was followed by the opening of a second similar unit in 2006 in West Lothian, providing admissions to

the east area of Scotland. This service was modelled on the service that had been developed in Glasgow.

In summer 2007 NHS Grampian developed two single bed facilities annexed to psychiatric admission units in Aberdeen and Elgin, one bed in each area. These facilities had a dedicated sitting area and provision for making baby feeds and although they are referred to as 'units' by the NHS Board they would not meet the specification for specialist psychiatric mother and baby units set out in the Scottish Executive service framework (Scottish Executive Health Department, 2004). The Board quoted that the services were developed in response to the changes in the mental health act (NHS Grampian, 2007).

A two bed annexed facility was also developed by Forth Valley NHS Board in the Stirlingshire area following a public consultation in 2004 that asked if women were to require inpatient care following childbirth for treatment of mental disorder, whether they wished this to be in their home area or at a regional unit approximately twenty miles away (at the time NHS Forth Valley were considering whether or not to enter in to a service level agreement with NHS Great Glasgow and Clyde who were developing a specialist unit in Glasgow). Somewhat predictably, the preference was for joint admissions locally. The annex was factored into the plans for the new psychiatric hospital that was being planned at the time, but was not to be opened until 2009. When the psychiatric services were transferred to the new hospital in 2010 it is known that the facility that had been planned for joint admissions did not have its own staffing resource and was dependent on staff from the general adult admission ward whenever an admission was to take place. A clinical decision was therefore made that joint admissions to the accommodation should not take place due to the lack of permanent staffing and the difficulty with rotational staff developing and retaining the necessary specialist skills, knowledge and practice to support the needs of the infants for joint admission to be facilitated safely. When joint admissions have been necessary the NHS Board has had to enter into agreement on a case by case basis with the Regional Planning Consortium for East Scotland to

purchase an admission to the specialist mother and baby unit at West Lothian or the mother is admitted locally to a general adult ward without her baby.

There are 14 NHS Boards in Scotland which provide psychiatric hospital services. At January 2012 there are two NHS Board areas in Scotland who do not have access to an inpatient provision. These are the rural Island Board areas, Orkney and Shetland. These NHS Boards serve extremely small populations and it would not be financially or clinically viable for them to develop provisions on the islands. NHS Western Isles is also a remote Islands health board but it has entered into an agreement with NHS Greater Glasgow and Clyde to purchase admissions on a case by case basis to the specialist unit at Glasgow. For many families in the other NHS Board areas who have access to the regional services, a considerable geographic travel distance can be involved which creates additional difficulties of being separated from other family members including partners and older children.

The remaining area of the UK is Northern Ireland where, to date, there has been no mother and baby units developed. There is some oral history information that side room admissions were facilitated in general adult wards in the 1980's and 1990's but no documentary evidence has been identified which can substantiate this. There have been some recommendations made in policy in recent years which are outlined later in the history of published policy documents in Chapter 4 with a move to discussions around the provision of a national mother and baby unit for Northern Ireland.

3.11 Current UK Position

Data from the Perinatal Quality Network at April 2012 indicates that there are 20 specialist mother and baby units across the National Health Service systems of the UK (see Table 3) and it is thought that side room admissions per se to general adult psychiatric units are no longer practised in any area of the UK (Royal College of Psychiatrists Centre for Quality Improvement, 2012).

TABLE 3: Specialist Mother and Baby Units of three beds or more provided within the NHS systems at January 2012 (Perinatal Quality Network, Royal College of Psychiatrists Centre for Quality Improvement, 2012).

England	Wales	Scotland	Northern Ireland
Birmingham	Cardiff	Glasgow	
Bournemouth		West Lothian	
Bracknell (Ascot)			
Chelmsford			
Derby			
Eastbourne			
Leeds			
Leicester			
London – Bethlem Royal			
London- Coombe Wood			
London - Homerton			
Manchester			
Newcastle			
Nottingham			
Staffordshire			
Welwyn Garden City			
Winchester			
17	1	2	0

As noted above there are three additional areas in Scotland who have annexed facilities for joint admission that are not included in the Royal College of Psychiatrists' data presented in Table 3. Presumably this is because these facilities are not fully operational or because they are not recognised by the Perinatal Quality Network as meeting recently developed expert opinion standards for what constitutes a mother and baby unit in modern times (Scottish Executive Health Department, 2004; NICE, 2007; Royal College of Psychiatrists Centre for Quality Improvement, 2008). Because the last published survey on service provision was in 2006 (MIND, 2006) it is not known whether there continues to be other similar facilities across the NHS in England, Wales and Northern Ireland providing for joint admissions in 2012 that would also not meet the identified criteria. The Quality Network has set criteria for specialist units constituting three beds or more and therefore do not include or seek data from any facilities with fewer beds. Any such facilities therefore do not appear in the Network's records of current facilities.

I contacted the Network by phone and email to try to identify if they had any knowledge of facilities of fewer than three beds but they could not supply this information. From oral history, psychiatrists in the field of perinatal mental illness are of the view that it is unlikely they still exist. The unit at Bristol is also missing from this data so the total number of facilities should be 24. This is significantly fewer psychiatric mother and baby units providing for joint admissions in 2012 than the 173 facilities identified at the peak of the adoption of the practice described in earlier surveys (Prettyman and Friedman, 1991), however 21 of these facilities are of three beds or more. If the total bed numbers are taken into consideration in terms of estimated need based on total birth numbers, the total number of beds falls short of the estimated need across the UK.

The evidence from the turn of the century until the present day has moved away from published papers in the professional press by clinicians describing their work or their research into particular aspects of care and treatment and has largely focussed on survey data of service provision. The last decade has also seen a much stronger discourse on standards of service provision, suggesting that attempts are being made nationally to facilitate more homogeneity around the practice of joint admissions and the facilities in which joint admissions are accommodated. The absence of any form of governance that was noted earlier in the history of the practice of joint admissions has clearly been addressed in the last ten years. On the theme of governance relevant policy, standards and legislation are discussed in detail in the thesis in Chapter 5.

The next chapter contributes further evidence to the history of the practice of joint admissions. The evidence from the published papers included here in Chapter 3 is a good source of both primary and secondary evidence as the majority of it is written by the clinicians directly involved in the practice of joint admissions. Using evidence from clinical staff contributes both professional and practical perspectives of the practice from their respective experiences and findings. In addition however, collective viewpoints have been identified as being of relevance to the history of joint

admissions. Chapter 4 therefore describes the evidence from a range of reports and enquiries involving key bodies and organisations that have had relevance to the practice of joint admissions.

CHAPTER 4: THE HISTORY OF MOTHER AND BABY JOINT ADMISSIONS TO PSYCHIATRIC INPATIENT CARE - PART 2

4.1 Introduction to the evidence from relevant bodies on the history of mother and baby joint admissions

The evidence from the published research and reports written mainly by clinicians in the field of practice and referenced in the first part of the history of joint admissions in Chapter 3 is further added to with evidence identified from particular bodies or organisations. The chronology of the evidence from the relevant bodies and reports or publications produced by them is therefore detailed here in Chapter 4.

4.2 Confidential enquiries into maternal deaths

The enquiries into maternal deaths were introduced in 1952. Originally they were carried out separately for England and Wales, Scotland and Northern Ireland but came together to report as UK enquiries from 1985 onwards. In 1997 the government commissioned the enquiries to be undertaken by a body that is now called the Centre for Maternal and Child Enquiries (CMACE) which is an independent charity dedicated to improving the health of mothers, babies and children. The most recent Confidential Enquiries published in March 2011 includes cases from England, Wales, Scotland, Northern Ireland, Isle of Man, States of Jersey and Guernsey, and also for the first time the Republic of Ireland (CMACE, 2011).

Many of the reports focused mainly on clinical issues but more recent reports, as with the very earliest ones in the 1950s, have also focused on the wider public health issues that contribute to poorer health and social outcomes including deaths from psychiatric causes. As a result, their findings and recommendations have played a major part in helping in the development of broader

policies designed to help reduce health inequalities for the poorest of families and for the most vulnerable and socially disadvantaged women (CMACE, 2011).

It is a requirement that all maternal deaths should be subject to this confidential enquiry, and all health professionals have a duty to provide the information required. At a local commissioning level maternity healthcare commissioners, such as Primary Care Trusts and local Health Boards, should commission services which meet the recommendations set out in the reports. The overall aim is to save the lives of as many mothers and babies as possible through the expert anonymous review of the circumstances surrounding and contributing to each maternal death in the UK. Apart from the specific issues and learning points that may emerge from certain cases or causes of death, the findings from individual cases are also aggregated together to learn wider lessons and to formulate and disseminate more general recommendations. The Confidential Enquiries lists one of its objectives as:

“to make recommendations concerning the improvement of clinical care and service provision, including local audit, to commissioners of obstetric services and to providers and professionals involved in caring for pregnant women” (CMACE, April 2011).

At a national level the findings and recommendations of successive reports have been used to develop national maternal and public health-policies and are used in developing government policy. They are also used to inform guideline or audit development undertaken by the National Institute for Health and Clinical Excellence (NICE), the Scottish Intercollegiate Guidelines Network (SIGN), the Northern Ireland Guidelines and Audit Implementation Network (GAIN) and by the relevant Royal Colleges and other bodies. In England, Scotland, Wales and Northern Ireland the findings of the Enquiry inform the work of equivalent bodies responsible for national quality initiatives (CMACE, accessed online April 2011).

The chronology of the reports of the enquiry demonstrates that from the fourth report published in 1998 onwards, deaths from psychiatric causes warranted their own chapter (Department of Health et al., 1998). The recommendations of relevance to joint admissions and mother and baby units are outlined below:

4th Report recommendation - Commissioners and providers of primary care, maternity and psychiatric services should consider the identification in each district of a clinician who would be responsible on a sessional basis for managing a perinatal mental health service (Department of Health et al., 1998. Chapter 12).

5th Report recommendation - Protocols for the management of women who are at risk of a relapse or recurrence of a serious mental illness following delivery should be in place in every Trust providing maternity services. Women who have a past history of serious psychiatric disorder, postpartum or non-postpartum, should be assessed by a psychiatrist in the antenatal period and a management plan instituted with regard to the high risk of recurrence following delivery (National Institute for Clinical Excellence et al., 2001).

6th Report recommendation - Women who require psychiatric admission following childbirth should be admitted to a specialist mother and baby unit, together with their infant. In areas where this service is not available then admission to the nearest unit should take place. Sufficient regional psychiatric mother-and-baby units should be developed to meet the needs of the population (Lewis, 2004).

7th Report recommendation - Women who require to be admitted to psychiatric hospital following delivery should be admitted to a specialist psychiatric mother and baby unit. (Lewis, 2007. 153).

8th report recommendation - All mental health trusts should have specialised community perinatal mental teams to care for pregnant and postpartum women. These should be closely integrated with regional mother and baby units so that all women requiring

psychiatric admission in late pregnancy and the postpartum period can be admitted together with their infants (CMACE, 2011. 132).

Deaths due to psychiatric causes have been reported on since 1994. It is clear to see that in the excerpts from the reports of the Confidential Enquiries there is an increasing emphasis on the specialist nature of the care and service recommendations with each triennial report. By the time of the 6th report in 2004 (Lewis, 2004), and the reports thereafter, there is very clear and specific recommendations about mother and baby unit provision. The author of the chapter in the 4th report was Professor (Ramesh) Channi Kumar who was professor of perinatal psychiatry at the Bethlem Royal Hospital and Institute of Psychiatry in London. He was one of the founder members of the Marcé Society whose function and relevance to the field of perinatal mental health is described below. The author of the psychiatric chapters in the subsequent reports was Dr Margaret Oates, already referenced previously in the history, a perinatal psychiatrist at the psychiatric mother and baby unit in Nottingham and was also one of the early members of the Marcé Society. The relevance of the Marcé Society to the history and spread of the practice of joint admissions and mother and bay units has therefore been considered in more detail in this Chapter.

4.3 The Marcé Society

The Marcé society is an international society that aims to promote, facilitate and communicate about research into all aspects of the mental health of women, their infants and partners around the time of childbirth (Marcé Society, 2011). The society has multidisciplinary membership across mental health, psychological, maternity and child health specialities. It also has regional sections, namely the UK and Ireland, Australasia, and has regional language sections - the Francophone section which largely covers France, Belgium and Luxembourg, the German section and North America. There are also emerging sections in the Spanish language, Scandinavia and South Africa.

The history of the society has been described by Henshaw (2010). She details how the idea for the society came from several clinicians from different disciplines in the field who would consult with each other on clinical issues but who realised they had no way of sharing their knowledge and ideas wider. Henshaw described how the idea for an international society that was aimed at improving the understanding, prevention and treatment of psychiatric disorders related to child-bearing, arose from correspondence in 1977 between Jim Hamilton in America and Ian Brockington in England. A later discussion took place between Ian Brockington and Channi Kumar (Henshaw, 2010).

Henshaw recalled an account given by Brockington in response to the question about the origins of the idea for the society:

“There was a small meeting at Queen Charlotte’s organised by Merton Sandler, and I think I discussed the matter with Channi Kumar there. He and I discussed many things related to mother and baby units etc. In June 1980, I took the initiative of arranging an international conference, to which Jim Hamilton and Ralph Paffenbarger were invited. Although we advertised it only seven or eight months ahead, we had 150 delegates. After the conference, my wife hosted a dinner for six individuals – Jim and myself, Channi, Ralph Paffenbarger, Bob Kendell and George Winokur....it was decided to found the society there and then” (Ian Brockington quoted by Henshaw, 2010).

An internet search identified that Merton Sandler was a pathologist by profession who worked at Queen Charlotte’s Maternity Hospital in London, Jim Hamilton was an American psychiatrist, Ralph Paffenbarger was an American epidemiologist who later specialised in physical exercise and died in 2007. Bob (Robert) Kendell was a leading psychiatrist in Edinburgh who died in 2002, and George Winokur was an American academic psychiatrist who was a leader in psychiatric genetics research and died in 1996.

There is a slightly different recollection of the origins of the society provided by Margaret Oates. Her recollection to Carol Henshaw, was:

“The Marcé Society was ‘conceived’ in Frank Margison’s house in Manchester in early 1980. Physically present at the meeting were Frank, Ian Brockington, Channi Kumar, John Cox and myself. I think Bill Deakin may also have been there. Paffenbarger, James Hamilton and George Winokur were contacted on the telephone. This group, together with Bob Kendell were the original ‘founding fathers’ or ‘steering committee’“(Margaret Oates quoted by Henshaw, 2010).

Frank Margison was a consultant psychiatrist who specialised in psychotherapy in Manchester. Bill Deakin was a psychiatrist and at the time the Marcé society was set up he was senior lecturer and researcher at the University of Manchester, where he continues to be a neuro-scientific researcher and professor of psychiatry. John Cox is a general adult psychiatrist who has a special interest in perinatal psychiatry and is currently professor of mental health at Keele University.

Henshaw also recalled how Channi Kumar had suggested the name of the society should be the ‘Marcé Society’ after the French physician Louis Victor Marcé. His early works in 1858 had apparently been the first to describe specifically puerperal mental disorders (Henshaw, 2010). The Marcé Society was officially launched during the first academic meeting on Puerperal Mental Disorders held in Manchester in July 1980. The first Biennial General Meeting was held in London 1982, organised by Channi Kumar at the Institute of Psychiatry. The Society established a data base to collate demographic and outcome data on patients of mother and baby units in England and later it was used by units in France, Belgium and the UK. In 1996 when they started the audit there were twelve units registered with the Society (Abel et al, 2005). Unfortunately the data base has not been kept up to date as services have developed or closed.

The Marcé Society jointly edits and publishes an academic peer reviewed journal in collaboration with the International Association for Women's Mental Health and the North American Society for Psychosocial Obstetrics and Gynaecology, 'The Archives of Women's Mental Health'. The focus of the journal includes psychodynamics, social and biological aspects of all psychiatric and psychosomatic disorders in women and a key aim of the editors is to support the exchange of knowledge between psychiatrists and obstetrician-gynaecologists. This journal was a source of several relevant articles that were identified during the literature review for this study. The International Scientific meetings and Biennial General Meetings continue to be held until the present day. The society has a strong membership of perinatal mental health clinicians and researchers from the countries who provide joint admissions and also has wider membership from those countries who do not have mother and baby units, but who have an interest in maternal mental health. The society is respected within the field as the key international body for sharing and disseminating knowledge, practice, ideas and research findings and for networking with likeminded colleagues from across the world. Communication is therefore at the centre of what the society contributes to the diffusion of practice in the field of perinatal mental health at local, national and international levels.

4.4 The Royal College of Psychiatrists

The Royal College of Psychiatrists (RCPsych) is the professional and educational body for psychiatrists. It also sets the examinations for psychiatrists, organises continuing professional development programmes, promotes study and research work in psychiatry, aims to improve standards of education and care and has an extensive range of public education initiatives. The RCPsych was formed in 1971 when the Royal Medico-Psychological Association (RMPA), the professional body for psychiatrists since 1926, was granted Royal College status.

The College faculties (previously called specialist sections) developed from 1928 onwards from Research Committee sub committees, and became specialist sections when the RMPA became

the College. A 'Section' represents a specialty and is normally of more recent development of a field that is an accepted area of practice. A Section is normally only established where a specific branch of psychiatry can be identified with a cadre of practising specialists who have acquired higher training in that sub-specialty or branch and where, in the Central Executive's opinion, there exists a substantial body of experience which the College needs to consult (Royal College of Psychiatrists, April 2011).

Specialism within medicine and within psychiatry is not a new trend. Brown (1928) noted that specialisms within the psychiatric field were evident in the early twentieth century. Since the inception of the NHS in 1948 there has been a growing emergence of specialism and sub-specialism and increasing progression from generalist to specialist within psychiatry (Burns, 2001). It may be argued that specialisation is a necessary response to the increased knowledge base and sophistication of interventions; however there is also a view that specialism is driven by professional ambition and enthusiasm. It has been suggested that increasing specialisation can have merits for individuals in the form of promotion, status and power (Burns, 2001). There are recognised benefits for service delivery which include ring-fenced resourcing to prevent neglect and recognition that the distinct skills necessary to deliver the care and treatment require specific training and constant application (Burns, 2001).

In the UK perinatal psychiatry is a newly proposed Royal College of Psychiatrists sub specialism of general adult psychiatry. The Perinatal Section of the RCPsych was inaugurated as recently as 1996, approximately 40 years after the first joint admission took place. The inaugural meeting was held in 2002 and the Section continues to hold an annual scientific meeting. In terms of relevance to the practice of joint admissions, the Section lists one of its aims as the promotion of the provision of services for childbearing women with mental health problems. The Section also lists three priorities, the second one being 'Clinical Service Development and Policy', under which it lists priorities to:

“Promote the development of perinatal Managed Care Networks in all areas, as per NICE (2007) guidance, to support efficient service delivery along clear care pathways.....and closely monitor developments on commissioning” (Royal College of Psychiatrists, April 2011).

Prior to the Section being formed, the Royal College of Psychiatrists established a working group on postnatal mental illness and thereafter published the first of two Council Reports (Royal College of Psychiatrists, 1992; 2000). The first report on postnatal mental illness recommended:

“All women requiring secondary psychiatric services following childbirth should be treated by a consultant psychiatrist with a special interest in their condition, supported by a multi-disciplinary team. This treatment should take place wherever possible in the women's own locality. In the event of them requiring in-patient care, they should be admitted together with their infant wherever possible, to a specialist facility” (Royal College of Psychiatrists, 1992).

Following the publication of this report the RCPsych, in collaboration with the Department of Health, set up a joint advisory group in 1995. The task of the joint advisory group was to take forward the 1992 Council Report (CR28) and to provide advice for the provision of psychiatric services for childbearing women with mental illness. Psychiatrists in the group included John Cox, Channi Kumar and Margaret Oates who have been emerging in the history as key leaders in the field of perinatal mental health care and, in particular, mother and baby units from the late 1980s onwards. The document was approved by Council of the Royal College in October 1996, but a decision was taken to delay publication as it was likely there would be a change of government and health policy in the very near future.

Thereafter there were a number of changes and developments in national health policy and strategies and the publication of several reports that were of relevance to the report of the group (Royal College of Psychiatrists, 2000. 4). The general content of the original report remained the

same but was reviewed and brought up to date to reflect the changing policy direction, evidence base and recommendations that had been published since the original document was compiled and approved by Council of the College in 1996 (Oates, 2000). When the report was finally published in 2000 it made the case for specialist perinatal psychiatric services. The report referenced the terms of reference of the Regional Specialist Services Commissioning Groups as the benchmark for their conclusion that perinatal psychiatry should be a recognised specialist service and, as such, should attract regional planning. The report made the following recommendations:

“Every health authority should identify a consultant with a special interest in perinatal psychiatry. This consultant should take a lead role in establishing a specialist multi-disciplinary team”..... and “Mother and baby units to serve the needs of a number of health authorities should be established” (Royal College of Psychiatrists, 2000. 5).

The report also goes as far as to state:

“All women who require admission to a psychiatric unit following childbirth should be admitted to a specialist mother and baby unit” (Royal College of Psychiatrists, 2000. 20).

At the time of the report in 2000 it stated:

“There are about 10 specialist mother and baby units with six or more beds in the UK.....in addition, a number of trusts provide either the facility for an occasional admission of a mother and infant pair to a general psychiatric ward or a small two-bedded annexe to such a ward. Concerns about the infants’ safety and security and financial difficulties have led to the recent closure of some of these facilities” (Royal College of Psychiatrists, 2000. 16).

The report referenced guidance published by the NHS Executive (NHS Executive, 2000) in respect of this last statement relating to concerns about safety of the child and the practice of joint admissions to general adult facilities. The guidance, ‘Safety, Privacy and Dignity in Mental Health Units’ (NHS Executive, 2000) is referenced later in the thesis in Chapter 5.

The Royal College report also made reference to the uncoordinated and patchy provision of services claiming:

“Although Great Britain is a world leader in this field and has many centres of excellence, the provision of mother and baby units and of perinatal psychiatric services is very patchy”
(Royal College of Psychiatrists, 2000. 16).

It is notable that the report makes the claim that the UK had many ‘centres of excellence’ when, at this point in the history of the services, there were no agreed standards to measure outcomes for the performance of the units or the practice delivered within them against. Indeed the report itself has as a recommendation that all health authorities should have a perinatal mental health strategy and the strategy should include general principles and core standards of care informed by research and best clinical practice (Royal College of Psychiatrists, 2000. 18). It stated that quality standards, performance and activity criteria, monitoring tools and outcome measures should be developed from the core standards and functions (Royal College of Psychiatrists, 2000. 24). There was also acknowledgement in the published academic literature before this report was published that clinical research on effectiveness of mother and baby units was not available. The claim to ‘centres of excellence’ is therefore taken as the report author’s perception as opposed to there being empirical evidence or data to support this statement.

A systematic review on effectiveness of psychiatric mother and baby units carried out in 2007 did not find any relevant studies to include in the review and the authors concluded:

“There does not appear to be any trial-based evidence for the effectiveness of these units. This lack of data is of concern as descriptive studies have found poor outcomes such as anxious attachment and poor development for children of mothers with schizophrenia and a greater risk of the children being placed under supervised or foster care. Effective care of both mothers and babies during this critical time may be crucial to prevent poor clinical and parenting outcomes..... Anecdotal results from a 1961 trial did suggest a beneficial effect,

but non-randomised data from over 40 years ago is difficult to apply to today's care. Such lack of data is of concern as MBUs (Mother and Baby Units) are expensive to set up and run. If they are to be the 'gold standard' of care for mothers and their babies, their effectiveness needs to be validated. Good quality, relevant research is urgently needed" (Irving and Saylan, 2007).

The Council Report highlighted the expensive nature of providing specialist mother and baby units in terms of the cost per patient and how larger units would be more cost effective to run than smaller units. It made the argument that *"economy of scale and critical mass needed to develop and maintain knowledge and skills"* was the best way to provide such services and that joint purchasing consortium arrangements on a regional basis would be the most appropriate and cost effective way to commission them (Royal College of Psychiatrists, 2000. 27).

The most recent activity of the Perinatal Section of the RCPsych in May 2011 has been to apply for subspecialty recognition for Perinatal Psychiatry within General Adult Psychiatry. This would enable the Section to progress the development of a new subspecialty curriculum to formalise training for psychiatrists and ensure appropriate competencies for practicing in the field of perinatal psychiatry, which do not exist under current training arrangements. The application suggests there will be an increased demand for subspecialist perinatal training in coming years based on the establishment or planning of a range of new services within the last five years across the UK. This does not just include mother and baby units, but also community based services. In the application it stated at May 2011 there were 21 specialist mother and baby units across the UK and it is noted in their application that the NICE Guideline published in 2007 has been the main driver for developments in recent years. The application acknowledges that there continues to be a significant number of gaps in specialist service provision (Cantwell, 2011).

The RCPsych and a small number of key psychiatrists therein has clearly been an influential driver for perinatal mental illness and healthcare to be recognised as a specialist area of practice both

within the discipline of psychiatry and among other disciplines such as GPs, obstetricians, nurses and midwives. However given the fact that it was as recent as 1996 that the Perinatal Section was set up and there is currently no higher level training for psychiatrists working in this specific field it would indicate that the lack of strong research evidence to support the practice of joint admissions and the development of specialist mother and baby units is likely to be a factor in the RCPsych not having progressed this sooner. This may also have a bearing on the slow recognition by psychiatrist colleagues that particular knowledge, skills and expertise are required in working with this patient group and their families thus influencing the slow diffusion of specialist mother and baby units across the UK. This lack of recognition and the consequences of inadequate service provision for maternal mental illness can be serious and tragic. The next evidence of relevance to the history of joint admissions and specialist mother and baby units demonstrate the possible consequences.

4.5 Public inquiry of Daksha and Freya Emson

In 2003 the North East London Strategic Health Authority published their report into the independent inquiry into the suicide of Daksha Emson and the death of her three month old daughter Freya in 2000. Daksha was a psychiatrist who had suffered a relapse of bipolar disorder after the birth of her daughter. During a psychotic episode she had stabbed her daughter, stabbed herself, poured accelerant over both of them and set it alight. Freya died from smoke inhalation but it was a further three weeks before Daksha died in a hospital burns unit without ever regaining consciousness.

The inquiry made the following recommendations:

“The Department of Health and all Strategic Health Authorities should insist that:

- 1. Existing guidance from the Royal College of Psychiatrists is followed to ensure comprehensive provision of perinatal mental health services (in many areas costed plans already exist which are not expensive – but the will and the commitment are*

lacking). This is thought to be referencing Council Report 88 detailed above (Royal College of Psychiatrists, 2000)

2. *The National Specialist Commissioning Group at the Department of Health rapidly produces guidance on the commissioning of perinatal mental health services*
3. *Work on the maternal mental health section of the National Service Framework for Children's Services is not further delayed by the internal reorganisation of the Department of Health*
4. *The National Institute for Mental Health in England and the National Institute for Clinical Excellence take responsibility for ensuring all disciplines involved in the post-natal care of mothers with a history of mental illness are up to date with advice on good practice" (North East London Strategic Health Authority, 2003. iv).*

Daksha had herself been a psychiatrist and yet her mental health care and treatment was found to have been far from adequate. It is known through discussion with psychiatrist colleagues that the report on the inquiry into the deaths had a significant impact on clinicians in the field and triggered a wave of energy and enthusiasm from psychiatrists to improve services and identify standards. An annual conference on perinatal mental health was also set up in memory of Daksha and Freya and was run by the Anglia Ruskin University in partnership with North Essex Mental Health Partnership Trust and South East Essex Primary Care Trust. A later outcome from the public inquiry was the establishment of the Quality Network for Perinatal Mental Health Services. The relevance of this to the history of joint admissions is described next in this Chapter.

4.6 The Quality Network for Perinatal Mental Health Services

The Quality Network for Perinatal Mental Health Services was established in 2007 and was an initiative of the Royal College of Psychiatrist's Centre for Quality Improvement. The network was set up in response to the Royal College of Psychiatrists making a commitment to promote perinatal

mental health following the publication of the report of the public inquiry into the deaths of Daksha Emson and her daughter Freya (North East London Strategic Health Authority, 2003). The publication of the Confidential Enquiries into Maternal Deaths in 2001 and 2004 where mental health had featured considerably had also prompted the Royal College of Psychiatrists to be more proactive to improve the quality of mental health care for new mothers (Royal College of Psychiatrists' Centre for Quality Improvement Quality Network for Perinatal Mental Health Services, April 2011).

The Quality Network works with specialist perinatal mental health teams, in particular in psychiatric mother and baby units, to evaluate their performance across a range of expert opinion standards, reflect on their findings through a peer review process and share best practice and approaches to service improvement. The mother and baby units that become members of the network are able to benchmark their practice against similar services and demonstrate the quality of care they provide. These standards take forward the recommendations made in the Council Report CR88 for the development of quality standards, agreement of core functions, and the development of monitoring tools for mother and baby units (Royal College of Psychiatrists, 2000. 24).

Initial funding was provided to enable the College Centre for Quality Improvement (CCQI) to complete a national survey of specialist perinatal mental health services and to set up the network. Participating services are required to pay an annual fee to be members of the network. Because membership is by application and is dependent upon individual units securing funding for the membership, the standards cannot be enforced within all units. A peer review process by other member units is used to measure the service and mother and baby unit against the standards. At April 2011 the Network had completed the third cycle of peer review and had 14 mother and baby units in its membership from across England, Wales and Scotland, two thirds of the total number of specialist mother and baby units known to be in operation. At January 2012 membership entering the fifth cycle had risen to 17 units.

This concludes the documentary evidence from the various bodies that have had influence on the diffusion pattern of joint admissions and specialist mother and baby units. Psychiatrists have clearly played a significant role in the spread of the practice of joint admissions. The public enquiry into the tragic deaths of Daksha and Freya Emson was a key focussing event in the last decade that does appear to have had influence on the subsequent development of a system of governance in the form of expert opinion quality standards however compliance with the quality standards for mother and baby units is optional (RCPsych, 2008). The series of publications of the Confidential Enquiries into Maternal Deaths where psychiatric causes were reported on specifically are believed however to have been the strongest influencing driver and collective focussing event for service change.

The final area of documentary evidence that is of relevance to the history of joint admissions is policy and legislation. Chapter 5 details the relevant policy and legislation that firstly contextualises health policy development across the UK and, secondly, details specific policy and legislation that has had particular influence to the diffusion of joint admissions across the UK.

CHAPTER 5: HEALTH POLICY HISTORY AND MOTHER AND BABY JOINT ADMISSIONS

5.1 Introduction to relevant health policy chronology

An important area to consider in terms of health service influence is health policy and relevant legislation. As previously stated in the literature review in Chapter 1 no specific mention of joint admissions or specialist mother and baby units could be found within any policy documents produced by any areas of the UK prior to the 1990s. In order to understand the reasons behind each area of the UK having different health policy and legislation, an explanation of the systems and arrangements for legislation and health care policy development and monitoring in each of the four areas of the UK is provided in Appendix 1. The health policy and legislation relevant to the history of joint admissions is included as primary evidence in this Chapter.

5.2 Chronology of relevant health policy to contextualise the practice of joint admissions.

Both the National Health Service Act 1946 (Ministry of Health, 1946) and the National Health Service (Scotland) Act 1947 (Ministry of Health, 1946a) provided a uniform national structure for services which were funded from central taxation and did not generally involve a financial charge at the point of use for people accessing services. At the time of the first joint admission, mental health hospitals in England (where the admission took place), were governed by the Lunacy and Mental Treatment Acts 1930 (Ministry of Health, 1930). The introduction of this Act followed the first Royal Commission on Mental Illness in 1924 (Royal Commission, 1926) which proposed reforms to the mental health services and for the first time allowed voluntary admissions to mental hospitals and the provision of out-patient clinics.

In contrast to other areas of medicine at the time of the launch of the NHS, there was no higher qualification in psychiatry. Other branches of medicine were influential in medical policy making whilst the Royal Medico-Psychological Association (RMPA), the professional organisation for psychiatrists, had very little influence over medical policy (Freeman, 1999). Mental hospitals were staffed by a medical superintendent, a deputy and assistant medical officers. During the Second World War the army had trained up a number of psychiatrists and with the war ending a few years before the NHS was introduced in 1948, these psychiatrists were starting to take up positions in the mental hospitals. The consultants leaving the army positions were not receptive to the previous authoritarian routines of the mental hospitals and brought new ideas and more relaxed approaches to care and treatment, with many of the patients being there for treatment on a voluntary basis (Freeman, 1999).

In the early days of the NHS, consultants had a great deal of autonomy. Where one or more doctors had what was perceived to be a good idea in terms of clinical practice, they had the authority and freedom within the hospital to develop the idea locally, as long as it did not have a great deal of cost implications (Freeman, 1999). Dr Thomas Main was one of the army psychiatrists who also held the senior position of medical director. He was a psychoanalyst and was best known worldwide later in his career as the creator of the therapeutic community at the Cassel Hospital in Surrey. His introduction of the practice of joint mother and baby admissions had been associated with his early thinking around therapeutic community within the mental health hospital.

As previously stated, Main had later been influenced by the reported observations and theories of Spitz (1945) and Bowlby (1951) of the possible effects of parental deprivation on the mental welfare of young children. In the 1950s Spitz's studies of emotional deprivation in infants (Spitz, 1952) and Robertson's very powerful film footage of a two year old separated from her mother during admission to hospital (Robertson, 1952a; 1952b) led to a change in practice within children's hospitals. Mothers were encouraged to stay with their children in hospital during their period of

admission with the aim of improving outcomes for the children and their mothers by reducing the incidence of hospitalism or anaclitic depression. Referenced by Bardon and colleagues (1968), the findings demonstrated in the film "A Two Year Old Goes to Hospital" (Bowlby et al., 1952; Robertson, 1952a; 1952b) and "Going to Hospital with Mother" (Robertson, 1958a; 1958b) gained political interest and influenced the production of a report by the Ministry of Health (1959a). This report (Ministry of Health, 1959a) recommended the provision by hospitals of visiting and accommodation facilities which would lessen the incidence of separation of children and their parents and its apparent adverse effects when children were admitted to hospital (Bardon et al., 1968). The recommendations did not however attempt to address the circumstances of a mother's required admission to hospital and the consequential separation from the child who was left at home.

In 1954 a second Royal Commission (Royal Commission, Cmnd. 169, 1957) was set up to review the mental health legislation as there was widespread feeling that the Lunacy and Mental Treatment Acts (Ministry of Health, 1930) were by then obsolete and had become a barrier to progress in mental health care (Freeman, 1999). The Royal Commission, known as The Percy Commission (1954-57), resulted in the 1959 Mental Health Act in England and Wales which put more emphasis on the strengthening of relationships between the NHS and local authorities and a reorientation from institutional care to an expansion of community based care (Ministry of Health, 1959b; Freeman, 1999). The Act established the role of Responsible Medical Officer (RMO) which still exists today. The RMO role was seen to be in conflict with the role of the Medical Superintendent and the latter role gradually disappeared by the 1970s except in Scotland, where it continued until the late 1980s. Scotland had its own mental health legislation. The Mental Health (Scotland) Act 1960 was itself a consolidating Act meaning it re-enacted or consolidated the Lunacy (Scotland) Acts 1857 to 1913, and the Mental Deficiency (Scotland) Acts 1913 and 1940. The 1960 Act dealt primarily with detention (Scottish Office, 1960). It followed a major reform of mental health law and it was in its day a 'liberalising measure' brought about by the Dunlop Committee in

Scotland, which tried to ensure that those with mental disorders would not automatically be detained and to protect the rights of those with mental disorders (Scottish Parliament, 2002).

It was not until the 1960s that the 1962 Hospital Plan for England and Wales led to an expansion of the hospital sector with proposals for the creation of large district general hospitals over the next ten to fifteen years. The Plan saw NHS services separated into three parts: hospitals, general practices and domiciliary services, and local health authorities. During the 1960s, services for the mentally ill came to be recognised as neglected or 'Cinderella' services, where low standards of care for patients were common. But it proved difficult to shift priorities and spending towards this group. Medical advocates such as consultant psychiatrists were less influential than doctors in the acute specialties. The Hospital Plan (1962) demonstrated a growing emphasis upon the need to plan services within the NHS (Bristol Royal Infirmary Inquiry, 2001). For psychiatry, the essential principle was that it became one of the core specialties of the District General Hospital, and the plan predicted that the mental hospitals would subsequently shrink to half their size (Freeman, 1999: 8). This had been informed by an earlier study of the mental hospital populations between 1954 and 1959 which identified a steady downward trend and the prediction that the long stay mental hospital population would have disappeared during the next 15 years (Tooth and Brooke, 1961).

In 1967 a report commonly known as The Cogwheel Report (a reference to the wheels on the cover design of the report) considered the organisation of doctors in hospitals and proposed that specialities should be grouped together (Ministry of Health, 1967). This was probably one of the earlier indicators within health policy of what has become an ever increasing divergence towards specialisms within the medical profession. This was around the same time that the nursing profession had been reviewed and a new structure within nursing was set out. The Salmon Report (Ministry of Health and Scottish Home and Health Departments, 1966) also set out

recommendations for a stronger status for nursing within the hospital management structure. This was a major power shift in terms of authority across the two disciplines.

By the 1970s there had been several changes in mental health care practice since the establishment of the NHS in 1948. These included the therapeutic community, day hospitals, domiciliary visiting by mental health professionals, psychiatric units in district general hospitals, and new treatment methods such as ECT, psychosurgery, neuroleptics and antidepressants. Specific government policy on mental health services was published in 1971 (Department of Health and Social Security, 1971), the same year the Royal College of Psychiatrists was formed. It set out that there should be comprehensive services for defined areas including a full psychiatric service in district general hospitals, adequate community provision by social service departments and joint therapeutic teams. In the 1970s the growth of community psychiatric nursing was heralded as one of the most important developments in the care of the mentally ill in the UK (Freeman, 1999). This move allowed for patients to be discharged home from hospital whilst still in need of care and treatment, thus reducing lengths of stay and reliance on inpatient hospital beds. The 1971 policy was followed by the White Paper, Better Services for the Mentally Ill (DHSS, 1975). The general objectives of the White Paper were the expansion of social services, relocation from large mental health hospitals of hospital beds and facilities to local areas, local community based services and increased staffing on a multidisciplinary basis (DHSS, 1975). This remains the general thrust of modern day services. The White Paper did not make mention of provisions for joint mother and baby admissions.

In 1988 the report 'Community Care: Agenda for Action', also known as the Griffiths Report, was published (Department of Health and Social Security, 1988). An aim of the reorganisation was:

“to provide structure and resources to support the initiatives, the innovations and the commitment at local level and to allow them to flourish; to encourage the success stories in one area to become the commonplace of achievement everywhere else” (DHSS, 1988).

This was followed by the Government announcing a fundamental review of the NHS and subsequently the publication of a White Paper, 'Working for Patients' which proposed major reforms (Department of Health, 1989). A separate White Paper was published for Northern Ireland, People First: Community Care in Northern Ireland (DHSSPS, 1990). The programme of action set out in the White Paper aimed to secure two objectives: *'to give patients, wherever they live, better health care and greater choice amongst the services available;* and *'greater satisfaction and rewards for those working in the NHS who successfully respond to local needs and preferences.'* Health Authorities were to manage their own budgets and buy healthcare from hospitals and other health organisations. In order to be a provider of healthcare, organisations had to become NHS Trusts (i.e. independent organisations with their own management teams and structures). The NHS reforms moved forward rapidly and were legislated as The NHS and Community Care Act 1990.

The 1990s seen the most rapid shift from hospital to community based mental health care in the history of the NHS. The large psychiatric hospitals which had survived from the days of the asylums were subject to widespread closure with inpatient admissions facilitated at much smaller psychiatric units at district general hospitals. At the same time community based mental health services were developed to support the shift from inpatient to community based care and treatment and the numbers of available hospital beds were significantly reduced. This was the policy across the UK however different areas of the UK implemented the changes over different timescales, with England the most rapid to implement these changes and Scotland taking a slower incremental approach. The rapid closure of beds and hospitals in England may have had some bearing on the diffusion pattern and rate of joint admissions and will be considered in Chapter 8 of the thesis.

The next major reform came with a new Government in 1997. The White Paper, The New NHS: Modern and Dependable was published in 1997 and set out how the internal market was to be replaced by a system they called 'integrated care', based on partnership working across health and social care and driven by performance. It formed the basis for a ten year programme to renew and

improve the NHS through evolutionary change rather than organisational upheaval. It also set out new arrangements for commissioning services through the introduction of more effective arrangements for commissioning specialist services, which were to come into force by 1999 (Department Of Health, 1997). 'Designed to Care' was the equivalent Scottish White Paper (Scottish Office, 1997a) and 'Putting Patients First', the Welsh equivalent (Welsh Office, 1998). The Health Act (1999) which received Royal Assent on 30 June 1999, made the necessary changes to the primary legislation across England, Scotland and Wales to provide for the proposals included in the White Papers. The Health Act 1999 amended the National Health Service Act 1977 and made changes to the provisions in the National Health Service and Community Care Act 1990 concerning the establishment of NHS trusts. It made provision for the establishment of new statutory bodies in England and Wales to be known as Primary Care Trusts, and provided for NHS Trusts in Scotland to take on additional functions. This heralded the end of the NHS internal market and GP fund holding in England, Scotland and Wales in September 1999. It also introduced a new statutory duty of quality requiring NHS Trusts, Primary Care Trusts and Health Authorities to put arrangements in place to assure and improve the quality of care they provide, in the interests of patients and the public.

A change of UK Government in May 2010 and in July 2010 the new Government produced a White Paper (Department of Health, 2010) which set out plans for radical reforms of the NHS in England. This document formed the basis of the Health and Social Care Bill (Department of Health, 2012). The reforms have proven controversial and, despite opposition from several Royal Colleges and major unions which represent doctors, nurses and midwives, the Bill received Royal Assent in March 2012. The main controversial aspect of the legislation is the removal of the duty of the Secretary of State to 'provide' a national health service, replacing this with a duty on the Health Secretary to 'promote' a health service. The reforms aim to encourage greater involvement in service provision by the private sector and charitable organisations. Many see this as a political move towards privatisation of the NHS in England. The existing 10 Strategic Health Authorities and

151 Primary Care Trusts will be abolished and replaced by a National Commissioning Board (NCB), four Regional Hubs, 50 local Offices of the NCB and 240 Clinical Commissioning Groups. The NCB will authorise Clinical Commissioning Groups, allocate resources and commission certain services such as Primary Care. It will also host clinical networks to advise on single areas of care and clinical senates providing clinical advice on commissioning plans. The Clinical Commissioning Groups led by GPs, will be empowered to commission for services directly from hospitals, mental health units and community services. Specialist services such as specialist neurology services will be funded directly from the National Board. This legislation is particular to the NHS in England only.

In view of the fact each of the four UK areas has their own devolved decision making powers for healthcare policy and for certain legislation, the chronology of the relevant evidence from this point onwards is separated into the four respective areas of the UK.

5.3 Chronology of relevant health policy specific to joint admissions and the NHS in Scotland

As previously mentioned, Scotland has its own powers to set health policy and legislation. Outlined below are details of the relevant policy documents, reports and legislation that are of particular relevance to service provision for joint admissions in Scotland.

The first report that had a particular focus on the clinical field of perinatal mental illness was produced by a group called the Clinical Resource and Audit Group (CRAG). The White Paper 'Working for Patients' published in 1989 saw the first move in the UK to standardise clinical audit as part of professional healthcare (Department Of Health, 1989). It recognised that medical audit could provide an ideal mechanism to secure change and it led to the decision by the health department in Scotland to set up the Clinical Resource and Audit Group (CRAG). This group was the lead body within the Health Department in Scotland tasked with shaping clinical effectiveness policies in

Scotland. The publication of 'Framework for Action' (Scottish Office, 1991) resulted in short-life working groups being established under the auspices of CRAG to examine four care areas.

Maternity services and mental illness were two of the four areas identified. The objectives of each group were to identify and promote good practice, develop strategies for raising standards and identify means by which improved patient care could be implemented. CRAG's remit included a wide range of issues concerned with the quality of clinical care, including the setting of clinical standards and developing clinical guidelines (CRAG, 2011).

The CRAG working group on maternity services published a report in 1996 on early detection and intervention for women with postnatal depression but it did not go as far as to make any recommendation in relation to hospital admission (CRAG, 1996). To the contrary, the view promoted across Scotland was that the needs of women with mental illness in the postnatal period could be met through early detection and intervention at primary care service level. Earlier research conducted in Edinburgh on the development of a screening tool for postnatal depression (Cox et al., 1987) was used as the evidence base for Scottish health policy to recommend that population screening for postnatal depression by Health visitors should be introduced, despite the screening tool not having robust sensitivity or reliability. For those women thought to be symptomatic of depression, a counselling approach delivered by health visitors was the recommended intervention (CRAG, 1996). The term 'postnatal depression' was used as a catch-all for all postnatal mental illness with no differentiation between psychotic illness, severe anxiety states or depressive illness. The term was also used to describe the full range of illness severity. Upon reflection, this policy decision may in fact have been a barrier in Scotland to specialist inpatient service provision for those women with severe mental illness whose needs could not be met in primary care but whose needs were largely grouped together with those of women with less severe illness presentations.

Shortly after this report was published, the Framework for Mental Health Services in Scotland was published by the Scottish Office of the Westminster Government in 1997. The Framework stated

that its purpose was not to introduce any new policy directives, but sought to consolidate and re-articulate the policy already in existence and underpin the operation of this policy via a set of principles and 'priorities for action' (Scottish Office, 1997). The emphasis of the Framework was on the needs to be met and the process and service elements that were required to meet those needs. The aim was that the Framework should be used by service commissioners to compare local service delivery to that set out in the framework and establish to what extent local services were able to meet identified needs. It was intended it should be used as a performance monitoring tool to guide the commissioning activity of Health Boards, GPs and local authorities and also help in the identification of opportunities for joint commissioning (Scottish Office 1997).

The Framework had 'Service Profiles' as a component part. It is thought that the CRAG report (CRAG, 1996) had some influence over the publication of an NHS Management Executive Letter (MEL) published by the Scottish Office on 18th March 1999 (Scottish Office, 1999) introducing an additional service profile to the Framework. The profile provided guidance on best approaches to the organisation of Services for Women with Postnatal Depression. It set out a collaborative approach in the development of a care pathway aimed at improving prevention, detection and management of postnatal depression and it highlighted the potential damage caused to mother, child and other family members by the impact of Post Natal Depression. It also promoted the argument for effective care and treatment to be provided at a point as close to home as possible (Scottish Office, 1999).

In terms of secondary care provision, the Framework identified that specialist perinatal mental health services were required and appropriate facilities were required to support joint admissions. This appears to be the first time that there is specific consideration in Scottish health policy of joint admissions and specialist service provision:

Secondary care: Description of Needs

The specialist perinatal service will contain key staff, the contribution of each being essential to maintain an integrated service. The main tasks are: Support for mothers and families; Primary Care liaison; In Patients service; Out Patients service; Obstetric service liaison; Liaison with Child and Family Psychiatry; Training, audit and service development.

Secondary Care: Ways in Which Services may respond:

In-patient care: Adequate Community Services will keep admissions to a minimum.

Some services consider that:

It is essential that mothers and babies are admitted together, into a safe environment; a special facility is required; a pool of nursing staff with specific skills is necessary; 4 beds (and associated cots) is the minimum size for viability; a total population of 650,000 would generate sufficient admissions to occupy it; for smaller Health Boards, a Managed Clinical Network (MCN) making joint use of a specialist In-patient facility out-of-area could be considered (Scottish Office, 1999).

In Scotland steps were taken immediately after devolution in order to ensure movement and change on mental health in Scotland (Smith et al., 2007). There have been major policy initiatives and legislative reforms since 1999 which have had influence on service provision in Scotland for joint mother and baby admissions. These are now outlined in turn.

The National Programme for Improving Mental Health and Wellbeing was launched in 2001 by the Scottish Executive Health Department. It adopted a population based approach to mental health policy in Scotland and had four key aims: raising awareness and promoting mental health and well-being, eliminating stigma and discrimination around mental ill-health, preventing suicide and supporting people bereaved by suicide, and promoting and supporting recovery from mental health

problems (Scottish Executive, 2003). One of its key priority areas was 'Improving Infant Mental Health'. The action plan stated:

"The ability to improve mental health and well-being in the 'early years' is a vital area for action. Ensuring the best possible start for children in their early years, promoting their mental health and that of their parents, and working to prevent and reduce the impact of mental health problems are key priorities. Key areas for action include:

- *Ante-natal care*
- *Parenting programmes – educational and community-based parenting support*
- *Identification of and early interventions for Post-Natal Depression"*

(Scottish Executive, 2003. 7).

This, coupled with the 1999 MEL and additional service profile to the Framework for Mental Health Services referenced above (Scottish Office, 1999), put a focus on improved detection and intervention for women affected by mental health problems in the postnatal period. The relationship between maternal mental illness and the priority for improving infant mental health was an added driver for improved service provision.

One of the developments announced in the themed programme of visits by the Mental Health and Well Being Support Group for 2001 and 2002 was the plan to publish a series of 'current practice summaries' (formerly known as thematic reviews). The summaries were to be compiled from information provided by the agencies on the first round of visits carried out by the Support Group. The first area of focus for the group to produce a current practice summary was postnatal depression (Scottish Executive Health Department, 2001b). The planned visits to each NHS Board area in Scotland facilitated the collation of information on current practice and service provision in the treatment of postnatal depression and this information was then used to benchmark each Board's progress against the NHS MEL (1999) 27 referenced previously.

The Framework for Maternity Services in Scotland was published in February 2001 (Scottish Executive Health Department, 2001a) and recommended:

“There should be a comprehensive, multi-professional, multi-agency service for women who have, or are at risk of, postnatal depression and other mental illness..... NHS Boards should consider reviewing current services for women with postnatal depression and other illness with a view to developing regional mother and baby units” (Scottish Executive Health Department, 2001a).

The following year the Scottish Intercollegiate Guideline Network (SIGN) published clinical practice guidelines for postnatal depression and puerperal psychosis (SIGN, 2002). SIGN was set up and funded by CRAG to progress the work of clinical guideline development. Clinical guidelines are systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances. The evidence based guidelines developed by SIGN are developed by multidisciplinary groups, derived from a systematic review of the scientific evidence and are designed as a vehicle for accelerating the translation of new knowledge into action to meet the aim of reducing variations in practice and improving patient-important outcomes (SIGN, 2011). At this point in time, no other area of the UK had published clinical guidelines on the subject.

Implementation of the guidelines is the responsibility of each individual NHS Board and local ownership of the implementation process is crucial to success in changing practice. All SIGN guidelines can be downloaded free from the SIGN website so they are openly available to practitioners and the public via the internet at no financial cost. The guideline included recommendations on service provision and on the issue of mother and baby units but rated the quality of the evidence as ‘D’ which according to the criteria used by SIGN meant the evidence was expert opinion and non-analytic studies, e.g. case reports, case series (SIGN, 2002). The guideline

endorsed the recommendation that had earlier been made by the Royal College of Psychiatrists in their Council Report (Royal College of Psychiatrists, 2000):

“The guideline endorses the Royal College of Psychiatrists recommendation that dedicated mother and baby units be provided and that the current ad hoc arrangements for admitting mothers with their babies to general psychiatric wards should stop. The Royal College of Psychiatrists recommends provision of six to nine beds per 1 to 1.5 million population. This recommendation has significant resource implications for Scotland, with additional resources required across all unified Health Board areas. With the current population of 5.12 million, there would be a requirement for 30 to 45 beds for mothers with their babies in appropriate specialist units with a minimum of four beds per unit. Larger units, which span several Health Board areas are recommended by the Royal College of Psychiatrists report, and may provide greater cost effectiveness. Given the current ad hoc arrangements, there are unlikely to be cost savings associated with rationalising existing service provision”
(SIGN, 2002. 10).

The guideline also suggested that further research was required into what the specific benefits were of mother and baby units to the mother and family (SIGN, 2002. 19).

Keeping a focus on postnatal depression as an important area within Scottish policy for improved care, treatment and service provision, a national audit of postnatal depression in Scotland was funded by the Chief Scientists Office in 2003 (NHS Quality Improvement Scotland, 2006). The key aims of the project were to establish the minimum standard for integrated care pathways in identifying and managing postnatal depression based on the SIGN guideline for postnatal depression and puerperal psychosis (SIGN, 2002). NHS Boards had been tasked with developing and implementing Integrated Care Pathways in the NHS MEL (1999) 27. A second aim was to carry out a survey of practice at the time of the study and audit it against the minimum standards identified in the SIGN Guideline (SIGN, 2002) and thirdly to report on best practice (Alder et al., 2008).

The study was to investigate the implementation of policy and practice in postnatal depression in Scotland and to consider how effectively the SIGN guideline for postnatal depression and puerperal psychosis (SIGN, 2002) had been in changing practice in individual NHS Board and GP practice areas. It is worthy of note that the focus again was on postnatal depression rather than the wider diagnostic groupings of perinatal mental illness. A questionnaire survey of all NHS Boards in Scotland was undertaken between September 2003 and February 2004 to determine what written policies for postnatal depression were in place as at September 2003. This was followed by a questionnaire survey of a representative sample of general practices in Scotland to determine the routine procedures in use for managing postnatal depression in general practice primary care teams, NHS Boards and general practices in Scotland.

Results identified that 47 per cent of Health Boards had developed policies and 68 per cent of General Practices had implemented the majority of the SIGN Guideline evidence based recommendations. GP Practices were more likely than NHS Boards to have addressed a higher percentage of the recommendations ($p < 0.05$). Half of the responses from the NHS Boards reported that they offered in-patient facilities for mothers diagnosed with postnatal mental health problems to be admitted with their child, although the eight facilities were not in specialised mother and baby units. Despite the Guideline recommending that joint admissions should not be facilitated in general adult psychiatric wards, 40 per cent of the NHS Boards in Scotland were still actively providing this practice in 2004, two years after the publication of the guideline (Alder et al., 2008).

5.4 Legislative reform in Scotland relevant to joint admissions

In addition to devolved decision making powers in terms of health policy, Scotland has also had its own mental health legislation since 1960. The Mental Health (Scotland) Act 1984 replaced an earlier 1960 Act of the same name. Until devolution, there had been no systematic reform of mental health legislation in Scotland since 1960 (Smith et al., 2007).

In December 1998, the then Minister for Health at the Scottish Office invited the Right Hon Bruce Millan to chair a review of Scottish mental health law. The Millan Committee was subsequently convened just prior to devolution. The role of the Committee was to review the Mental Health (Scotland) Act 1984. The majority of the work of the Committee was carried out after devolution and reported on its findings in January 2001 in the document, 'New Directions: Report of the Review of the Mental Health (Scotland) Act 1984' which contained over four hundred recommendations, and was the most thorough review of mental health law in Scotland for over forty years (Scottish Executive, 2001). In response to the review in October 2001, the Scottish Executive published 'Renewing Mental Health Law - Policy Statement' (Scottish Executive, 2001a) which set out proposals for a Mental Health Bill and built on the recommendations of the Millan Committee. The following year the Mental Health (Scotland) Bill was introduced (Scottish Parliament, 2002). This led to the development of the Mental Health (Care and Treatment) (Scotland) Act 2003 (Scottish Executive, 2003a), which replaced the 1984 Act and came into force in April 2005.

The Mental Health (Care and Treatment) (Scotland) Act 2003 majorly transformed the previous Act of 1984 and the way in which mental health services are delivered. The human rights of individuals and carers became central to the way in which the legislation is enacted. The 2003 Act is underpinned by ten principles which have come to be known as the Millan Principles and define the roles and responsibilities of all those involved in the care and treatment of those with a mental disorder. The principle that has particular relevance to joint admissions is that of reciprocity (safe and appropriate services for those in care and after discharge).

The Act uniquely made special provision in the Functions of Health Boards and made it their duty to provide specialist services and appropriate facilities for joint admissions:

Provision of services and accommodation for certain mothers with post-natal depression

(1) A Health Board shall provide for any woman who

(a) is the mother or adoptive mother of a child less than one year old

(b) cares for the child;
(c) is not likely to endanger the health or welfare of the child; and
(d) has been admitted to hospital, whether voluntarily or not, for the purposes of receiving treatment for post-natal depression, such services and accommodation as are necessary to ensure that the woman is able, if she wishes, to care for the child in hospital.

(2) Each Health Board shall collaborate with other Health Boards to whatever extent is necessary to fulfil its duty under subsection (1) above (Scottish Executive, 2003b. 14).

This provision was not included in the original Bill that went before Parliament (Scottish Parliament, 2002) and was added as an amendment. The details of the sequence of events that led to this provision being included in the Act are described later in the thesis as the events surrounding this are of interest in terms of influence. This was the first time that it actually had become a legal requirement for specialist services to be provided by Health Boards and legally Health Boards could be held to account if they did not provide appropriate services for joint admission. There is no similar legislation anywhere else in the world. The principle of reciprocity is of particular relevance here. If a woman is detained in hospital then she legally must be provided with safe and appropriate services to meet her needs. To date the absence of specialist provision by certain NHS Boards in Scotland has never been tested in the legal courts and there is therefore no case law established.

In response to this legislation, the Scottish Executive Health Department recognised that there was a requirement for guidance for Health Boards if they were to provide such services, as there were no specialist services in Scotland at the time when this provision was written into the Act. The Act would come into force in April 2005. They therefore appointed a Short Life Working Group in May 2003 which I was appointed to chair. The group's task was to consider, prepare and publish appropriate guidance to inform the planning processes across Scotland. Though the legislation used the catch-all term 'post-natal depression', the group adopted the more inclusive 'perinatal

mental illness' to better describe the desired wider scope of the new arrangements. The service profile reinforced the guiding principles already set out in the earlier addition to the Mental Health Service Framework (Scottish Office, 1999). Subsequently a further service profile to the Framework for Mental Health Services in Scotland was published that set out approaches for an admission template / specification for the organisation of services and supports to facilitate joint admissions, HDL (2004) 6 (Scottish Executive Health Department, 2004).

These policy documents and legislation are unique to Scotland and do not apply to any of the other areas in the UK. Again it is worth noting that the term 'postnatal depression' is evident throughout Scottish Policy since the mid-1990s as opposed to the more inclusive 'perinatal mental illness' which includes all diagnostic groupings and reflects the range of severity of need. This may have influenced the slow diffusion of specific service provision for women with more complex needs requiring hospital admission.

5.5 Chronology of relevant health policy specific to joint admissions and the NHS in England

The UK Government published their mental health strategy for reforming and modernising mental health services in 1998 (Department of Health, 1998a). "Modernising Mental Health Services" outlined the vision for safe, sound and supportive mental health services for working age adults in England. It also set out the Government's plans for raising standards and promoting partnership in health and social services through the establishment of National Service Frameworks (NSF) and a National Institute for Clinical Excellence (NICE) (Department of Health, 1998b). The National Service Frameworks were aimed at improving the quality and consistency of services in a number of key areas. The Frameworks were to cover both health and social care, would set national standards and define service models for a specific service or care group, put in place programmes to support implementation and establish performance indicators against which progress within an

agreed timescale would be measured (Department of Health, 1998). With the strategy came major investment from the Government which it claimed would be targeted to *“tackle the unacceptable variations in service delivery”* (Department of Health, 1998).

The Health Service Circular HSC 98/074 (NHS Executive, 1998a) set out a programme of work to develop the National Service Frameworks. Although mother and baby units were not specifically mentioned in 'Modernising Mental Health Services', they were included in the National Service Framework. The UK Government published the 'National Service Framework (NSF) for Mental Health: Modern Standards and Service Models' in 1999. The NSF detailed national standards for mental health services, what they aimed to achieve, how they should be developed and delivered, and how performance would be measured across services in England (Department of Health, 1999).

Prior to this 'Commissioning in the New NHS' (HSC 1998/198) identified a number of more specialised services and mother and baby units were included on the specialised services national definition set (NHS Executive, HSC 1998/ 198. Annex B. 11). Since 1998 this list has been reviewed twice. The White Paper 'The New NHS: Modern and Dependable' (Department of Health, 1997) noted that a more systematic approach was required to ensure proper co-ordination of commissioning for those specialised services where one centre covered the population of a number of Health Authorities, if fair access was to be guaranteed and if clinical staff were to be supported in developing the most suitable and effective care. Regional Offices were accountable for ensuring that effective commissioning arrangements were established in each Region.

Each definition is drawn up by a process involving providers (clinicians, hospital managers, and information and coding staff), commissioners and patients' groups and is then endorsed wherever possible by relevant national organisations. Finally, when the definition has been signed off by the National Specialised Commissioning Group and the Department of Health in England, it is

published on the Department of Health website. The purpose of a definition is to identify the activity that should be regarded as specialised and therefore within the remit of collaborative commissioning. Mother and baby units remain as an identified mental health specialised service on the list of ten service definitions. The most recent definition published in 2009 is provided below:

No. 5. Perinatal Mental Health Services (Mother and Baby Units)

(ICD 10 codes: F53.1 - Severe mental and behavioural disorder associated with puerperium. Further suggested codes: F20, F23, F25, F30-39)

5a. General description

"...Perinatal mental health in-patient units, or mother and baby units (MBUs) as they are often known, provide in-patient assessment and treatment for mothers with serious mental illness and their babies in an environment where it is possible to supervise the mother's care of the baby and work on the mother / baby relationship as well as the wider family relationships, particularly the father's. Mothers and babies are admitted to MBUs unless there are strong clinical reasons that they be separated. MBUs are stand-alone units run by specially trained and dedicated staff with skills to address both the mental health needs of the mother and care of the baby. A separate area on an acute psychiatric ward is not regarded as a specialist unit. There are 10 MBUs in England".

(Department of Health (2009) SSNDS Definition No. 22 Specialised Mental Health Services (all ages) Third edition. 16).

The rationale given for mother and baby units being included in the Specialised Services National Definitions Set is the low incidence of severe illness in the postnatal period. The definition also provides a description of the specialised service activity that should be provided:

"Perinatal mental health in-patient unit services include:

- *in-patient assessment and treatment of mothers with serious mental illness*
- *assessment of the quality of maternal care and supporting the development of parenting skills*

- *recommendations on whether to place the baby with the mother on discharge*
- *local out-patient follow-up or timely discharge planning and transfer of care to referring organisations and care co-ordinators*
- *community outreach services provided by the specialist unit (these include a multidisciplinary team with a caseload or specialist nurses advising and liaising with local health and social services personnel)*
- *facilities for patients at high risk of postnatal illness to be admitted prophylactically*
- *pre-pregnancy assessments of women with severe mental illness so as to advise on risks in relation to pregnancy (as recommended by the Confidential Enquiry into Maternal and Child Health) Some MBUs admit pregnant mothers with serious mental illness where their care cannot be safely managed on an acute adult mental health ward. A range of other service providers are likely to be involved in assessment and aftercare including the GP, community health services, local mental health services and Social Services”.*

(Department of Health (2009) SSNDS Definition No. 22 Specialised Mental Health Services (all ages) Third edition. 16).

Modernising Mental Health Services (Department of Health, 1998) outlined the Government’s vision at the time for safe, sound and supportive mental health services. To support Health Authorities and Trusts in ensuring all patients would be protected from physical, psychological or sexual harm whilst being treated in mental health facilities, guidance was produced on practical steps that could be taken by NHS staff to ensure safety, privacy and dignity, recognising the needs of male and female patients may be different (NHS Executive, 2000). This guidance published in 2000, and required to be implemented by 2002, outlined the safeguards which Trusts were expected to follow to protect women’s safety, dignity and privacy. The guidance specifically referenced mother and baby units as detailed below:

6.3 Mothers and babies

6.3.1 Mother and baby units should be self-contained and separate from the general psychiatric ward. Health visiting staff or, where appropriate, midwifery staff attend the mother and baby in hospital. Where opportunities arise as a result of refurbishment or the design of new facilities, consideration must be given to providing accommodation that has the flexibility to meet individual needs. (NHS Executive, 2000. 10).

Following this the Department of Health consulted on their women's mental health strategy. The NHS Plan made the commitment to reduce inequalities and develop a comprehensive health service designed around the needs and preferences of individual patients, their families and carers, women being one such population. The Government published a consultation document. "Women's Mental Health: Into the Mainstream. The aim of the document was outlined as *"to provide information, to generate discussion, and to outline a direction to help achieve a mainstream approach to gender in mental health service organisation and delivery"* (Department of Health, 2002).

Section 12.5 outlined their vision for Services for Women with Perinatal Mental Ill Health:

"Nationally, the provision of specialist perinatal mental health services is patchy and uncoordinated. There are at least 10 specialist mother and baby units. It is however more usual for acute in-patient services to offer in-patient care. Generally, the mother and baby (sometimes mother without baby) share facilities and an environment with other patients with differing needs and demands. Local appropriate, dedicated, in-patient provision needs to be commissioned across a number of primary care trusts". (Department of Health, 2002. 87).

As part of the consultation they posed the question, *"what do practitioners / services require to help them develop appropriate responses for this group of women?"* (Department of Health, 2002. 88).

Following the three month consultation, a companion report was produced to provide guidance for

local planning processes for mental health and social care services on the implementation of the strategy for women's mental health (Department of Health, 2003). The report, 'Mainstreaming Gender and Women's Mental Health' was explicit about mother and baby units:

8.8.3 Mother and baby units - Advice on Implementation

Aim: *To ensure that mothers requiring acute inpatient care are accommodated appropriately with their babies.*

Recommended actions for PCTs with specialist mental health services and social services:

To review provision for mothers with young babies requiring acute inpatient care to ensure that:

- *any existing mother and baby unit is run in the best interests of both mother and baby;*
- *mothers are not routinely cared for in general acute inpatient wards with their babies;*
- *in the absence of a local mother and baby unit, PCTs act collaboratively to ensure that mothers within their locality have access to a high quality mother and baby unit within reasonable travelling distance.*

Expected outcome: *Specialist mother and baby units are available for any mother requiring acute inpatient care if this is in the best interest of mother and baby.*

Actions at national level – DH: *The national Specialist Mental Health Commissioning Group is currently considering the best means of assisting primary care trusts in the commissioning of specialist mother and baby units.*

DH (Department of Health) and NIMHE (National Institute for Mental Health in England) are reviewing the need for further research around perinatal mental ill health identified at the consultation stage including research into the effectiveness of mother and baby units (for the mother and for the baby) and the long-term impact of maternal mental illness on children” (Department of Health, 2003. 61-62).

It is clear that the policy makers have linked and connected the various strategies. There is a consistency to the theme of specialist mother and baby units across the government policy on commissioning of specialist services, the mental health modernisation strategy, and the women's mental health strategy. This gives some indication of a policy stream which is discussed in more detail in Chapter 8

In 2007 the NICE Guideline on Antenatal and Postnatal Mental Health was published (NICE 2007). The National Institute for Health and Clinical Excellence (NICE) was established as a Special Health Authority for England and Wales in 1999, with a remit to provide a single source of authoritative and reliable guidance for patients, professionals and the public. NICE guidance aims to improve standards of care, to diminish unacceptable variations in the provision and quality of care across the NHS and to ensure that the health service is patient centred. All guidance is developed in a transparent and collaborative manner and Guideline topics are selected by the Department of Health (DH) and the Welsh Assembly Government, which identify the main areas to be covered by the guideline in a specific remit. The guideline for antenatal and postnatal mental health was commissioned by NICE and developed within the National Collaborating Centre for Mental Health (NCCMH). The NCCMH is led by a partnership between the Royal College of Psychiatrists' Research and Training Unit and the British Psychological Society's equivalent unit (Centre for Outcomes Research and Effectiveness). The group that developed the guideline included two former service users, professionals from psychiatry, clinical psychology, general practice, midwifery, obstetrics, health visiting, social work services and NHS management.

The aim of the guideline was to advise on the clinical management of, and service provision for, antenatal and postnatal mental health. The intention was that clinicians and service commissioners would use the guideline in providing and planning high-quality care for women with antenatal and postnatal mental health problems. Recommendations were included, informed after review of the best available evidence at the time. Unusually for NICE Clinical Guidelines, the antenatal and

postnatal mental health guideline included recommendations around service provision. The specific recommendations for joint admissions are summarised as follows:

“Clinical networks should be established for perinatal mental health services, managed by a coordinating board of healthcare professionals, commissioners, managers, and service users and carers.....Each managed perinatal mental health network should have designated specialist inpatient services and cover a population where there are between 25,000 and 50,000 live births a year, depending on the local psychiatric morbidity rates. Specialist perinatal inpatient services should: provide facilities designed specifically for mothers and infants (typically with 6–12 beds); be staffed by specialist perinatal mental health staff; be staffed to provide appropriate care for infants; have effective liaison with general medical and mental health services; have available the full range of therapeutic services; and be closely integrated with community-based mental health services to ensure continuity of care and minimum length of stay.....Women who need inpatient care for a mental disorder within 12 months of childbirth should normally be admitted to a specialist MBU, unless there are specific reasons for not doing so (NICE, 2007. 265).

The full guideline outlined the function of mother and baby units in detail:

“These units are designed to address a number of challenges, including the need for specialist expertise in the treatment of severe perinatal illness, the need to support the development of the mother-infant relationship through a joint admission, and the provision of an environment that is safe and appropriate to the care of a young infant (for example, the presence of specialist nursery nurses and the avoidance of the severe disturbance seen on many general inpatient wards) and to the physical needs of pregnant and postnatal women. The functions of inpatient services for women with mental health problems during pregnancy and the postnatal period include:

- *assessment of mental illness, including risk assessment and assessment of ability to care for the infant*

- *provision of expert care of women requiring admission*
- *in MBUs, the expert provision of safe care for the infants of women admitted*
- *support for the woman in caring for and developing a relationship with her baby, wherever appropriate fostering the involvement of the partner or other carers*
- *liaison and integrated working with other services, including maternity and obstetric services, GPs, and maternity-based and community mental health services (NICE, 2007. 255).*

The guideline touches on the issue of child welfare very briefly, but almost as a passing comment, and does not expand on this in any detail:

“A key factor in the decision to admit a woman with her infant is consideration of the welfare of the infant. That is, whether it is better for the infant to stay with his or her mother or whether he or she should be cared for by another family member while the woman receives inpatient treatment. Currently, where specialist units are available, women are usually admitted with their infants unless there is good reason not to, for example, the woman preferring not to have her child with her or the child requiring specialist medical care not available in the unit. Admission to a unit will be influenced by geographical proximity (Brockington, 1996). This is a crucial consideration at this important time for women and their families to ensure visiting and contact with family and social networks, on which support after discharge, and early discharge, will depend. The development of MBUs has been determined by balancing this against the need to establish services of sufficient size to be able to maintain necessary skills and resources. This is a challenge that should be addressed by careful planning with the involvement of key stakeholders, taking into account population needs and the influence of related services” (NICE, 2007. 256).

Once NICE guidelines have been published and disseminated it is the responsibility of local healthcare groups to implement them. Full implementation may take a considerable time especially where substantial training needs are identified (NICE, 2007).

In the same year, the maternity services strategy was published and it too recommended:

“Providing specialist perinatal psychiatric services for women with serious mental health disorders and the availability of inpatient mother and baby units for women who require admission” (Department of Health, 2007).

Again in 2007 the National Service Framework for Children, Young People and Maternity Services was published. This NSF included specialist mother and baby unit provision:

“Standard 11: Maternity services

Post-Natal Mental Health Needs: Strategic Health Authorities and all NHS Trusts plan for the provision across Strategic Health Authorities boundaries, of sufficient capacity for specialist inpatient psychiatric mother and baby treatment so that all women who require it can be admitted with their baby (unless there is a specific contra-indication) to a Specialist Mother and Baby Psychiatric Unit” (Department of Health, 2007a).

The National Mental Health Development Unit was launched in 2009 funded by the Department of Health and the NHS. The National Gender Equality and Women’s Mental Health Programme of the development unit hosted a National Perinatal Mental Health Project. One of the aims of this project was to facilitate the development of Managed Clinical Networks within each region and to work across government departments to establish ways to encourage different agencies to work together better (National Mental Health Development Unit, 2011). Managed Clinical Networks for Perinatal Mental Health had been a recommendation of the NICE guideline (NICE, 2007).

The National Mental Health Development Unit (NMH DU) was launched in April 2009. The unit consisted of a small central team and a range of programmes funded by both the Department of Health and the NHS to provide national support for implementing mental health policy by advising on national and international best practice to improve mental health and mental health services. The Gender Equality Programme which was part of the National Mental Health Development Unit,

set up a national project on perinatal mental health aimed at the development of a national strategy to improve perinatal mental healthcare via regional managed clinical (care) networks within each region, which had been a recommendation of the NICE Guideline (NICE, 2007). The vision for the Managed Clinical (Care) Networks was to act as mechanisms for planning and delivering more holistic and responsive models of care. The aim of the program was also to work across government departments to establish ways to encourage different agencies to work together better (NMHDU, 2010. 57).

In 2010 the NMHDU published their findings of the progress that had been made in the implementation of the women's mental health strategy. The report pulled on a range of sources of information including two national surveys of mental health trusts conducted in 2006 and 2007, a wide range of published reports and evaluations, and evidence and observations gathered from service users and voluntary sector organisations. Their findings specific to mother and baby units identified:

“Nearly half of Trusts in the surveys reported significant developments in process to review and develop perinatal mental health services, including mother and baby units and dedicated multidisciplinary teams, but little evidence of a whole system approach”
(NMHDU, 2010. 6).

They identified that there was a lack of robust commissioning practice and identified that some respondents to the 2007 benchmarking survey which had helped inform the report, had highlighted concerns about the lack of local service provision for perinatal mental illness to their commissioners. They noted that improvements in service provision often appeared to be championed by one or two committed individuals (NMHDU, 2010. 42).

In March 2011 the Gender Equality Programme on Perinatal Mental Health published preliminary findings of research they were conducting on black and minority ethnic (BME) women and perinatal mental health (NMHDU, 2011). A number of strategies were used to gather information to compile

the report including a review of the literature, a national survey of provision between September 2009 and March 2010 and a survey of mother and baby units in England, Scotland, and Wales about the ethnic backgrounds of women using their services between May and July 2010 and in the previous 12 months. There were 13 mother and baby unit respondents from the 19 that had been contacted to participate in the survey. Findings identified that in terms of perinatal mental health the evidence base for black and minority ethnic women in the UK was relatively low. As a result therefore it was found to be difficult to effectively advocate for or implement the kind of services that would best meet the needs of these women. It was noted that *“inherent tension in developing services without a robust evidence base was clearly articulated by respondents”*. The conclusion was that evaluation of current provision and new research to establish levels of morbidity and unmet need among BME women was urgently required to bridge the evidence gap (NMH DU, 2011. 28). It was concluded that proposals to develop Regional Managed Clinical (Care) Networks may be an effective means of addressing poor, absent or inconsistent service provision but that further evidence for the clinical and cost-effectiveness of these networks was required. The comment was made in the report that:

“It appears that such networks [Managed Clinical or Care Networks] are often built on the passion and energy of key individuals. This clearly has implications for their sustainability”
(NMH DU, 2011. 30).

This would imply that in the absence of local ‘champions’ there are risks to the long term sustainability of the networks. Notably Dr Margaret Oates who has been referenced several times in the history of joint admissions is the Lead Clinician of the East Midlands Regional Managed Clinical Network.

5.6 Chronology of relevant health policy specific to joint admissions and the NHS in Wales

No specific Welsh policy or legislation that specifically referenced joint admissions or mother and baby units were identified as documentary evidence until 2001.

The launch of the 1989 All Wales Mental Illness Strategy (Welsh Office 1989) influenced the development of local community based services across Wales to support the closure of the large older institutions, which was similar to the policy direction in England. The White Paper 'Putting Patients First' (Welsh Office, 1998) was the Welsh equivalent of 'The New NHS: Modern and Dependable' which replaced the internal market system (Department of Health, 1997), however, the first mention of specialist mother and baby units does not appear in Welsh health policy until 2001 when The National Assembly for Wales launched the adult mental health services strategy for Wales:

"Mother and baby units should be present in each Health Authority area. Collaborative schemes can also provide a range of other support for mothers including foster placements for mother and baby and self-help groups. The National Assembly recognises the difficulties authorities face not only in financing these expensive facilities but in providing such units and making them safe in compliance with child protection guidance. We shall work with authorities to produce a Welsh plan for these units" (The National Assembly for Wales, 2001. 40).

A three bedded unit was subsequently opened in Cardiff in 2003 that would provide for regional admissions of mothers and infants and replaced side room admissions to general adult wards. Again, similar to England, the 'National Service Framework Adult Mental Health Services: A National Service Framework for Wales' (Welsh Assembly Government, 2002) was developed following the publication of the adult mental health strategy for Wales. The NSF aimed to set standards for services in Wales, improve quality and reduce unacceptable variations in the

provision of health and social services. It established practical guidelines to ensure consistent and comprehensive implementation of the strategy's vision across Wales. It differed in some important respects from the English document as there were distinctive differences in emphasis that reflected particular circumstances in Wales. The NSF was revised in 2005 (Welsh Assembly Government, 2005). Included in the revised NSF was the following specific action on psychiatric mother and baby units:

“Key Action 25

A range of specialist services is to be available and accessible across Wales. These should include..... mother and baby units”. By March 2007 LHBs/HCW to examine provision of inpatient mother and baby facilities and develop appropriate services in line with their commissioning strategies” (Welsh Assembly Government, 2005. 25).

At the time of reporting in February 2012 there continues to be one mother and baby unit with three beds in Cardiff to service the population of Wales.

5.7 Chronology of relevant health policy specific to joint admissions and the HSC Northern Ireland

The first reference to joint admissions in health or social care policy in Northern Ireland was in 2005. A review of the policy, practice and legislation relating to mental health and learning disability was commissioned by the Department of Health, Social Services and Public Safety (DHSSPS) of the HSC Northern Ireland in October 2002. A strategic framework for adult mental health services was published in 2005 and this appears to be the first time that mother and baby units featured within Northern Ireland policy. The strategic framework made the following recommendation:

“A regional specialist mental health service should be established for women with mental health problems occurring in the perinatal period. The requirement for inpatient mother and baby facilities should be the subject of a regional needs assessment” (DHSSPS, 2005.

129).

As part of the recommended needs assessment, a cross party group from the Northern Ireland Assembly visited the mother and baby mental health unit in Glasgow in June 2008. The purpose of the visit was for the politicians to see for themselves the design and clinical model of the specialist service provided, to help inform their needs assessment for Northern Ireland. In 2008 a briefing paper on the subject of perinatal mental health services in Scotland was presented to the Northern Ireland Assembly which had been compiled as part of the needs assessment. A consultation document titled 'A Service Framework for Mental Health and Wellbeing' was published in December 2010 (Northern Ireland Assembly Debates, DHSSPS, 2010). It followed up on the recommendation made in the strategy for adult mental health services (DHSSPS, 2005) and included a standard relating to specialist services to be achieved by March 2012:

“All women presenting to maternity service should be asked about past or present mental illness and treatment including at their first contact visit with primary care, the booking visit, the 3rd trimester visit, during the post-natal contact period between 6-10 weeks and up to 1 year postnatal. Where appropriate, they should be referred to specialist mental health services that include access to psychological interventions, additional health visitor support and inpatient care as appropriate and in accordance with NICE guidelines” (DHSSPS, 2010. 173).

The reference to NICE guidelines would indicate that they are taking cognisance of the recommendation within the NICE Guideline 45 (NICE, 2007) that joint admissions should take place within specialist mother and baby mental health units. Responsibility for delivery of the standard in the service framework is stipulated as primary care and maternity services in partnership with specialist mental health. It is of interest and perhaps a bit short sighted that the standard does not put the weight of emphasis on mental health service providers. The final version of the document was published in October 2011 and the standard referenced in the initial draft remains unchanged in the final version although the timescale for achieving the recommendation has been put back until March 2013 (DHSSPS, 2011b. 179).

Prior to the final Mental Health Strategy being published a consultation document on the draft Maternity Strategy for Northern Ireland was published in September 2011 (DHSSPS, 2011a) and although it mentioned that women with mental health problems should be given special consideration and good communication is required across the various services involved, there was no specific mention of joint admissions or specialist mother and baby units. The consultation closed at the end of December 2011 but at February 2012 there is no final strategy document published as yet. It is interesting that in the draft maternity strategy there is not stronger linkages to the mental health strategy.

This concludes the chronology of published evidence in terms of policy documents and reports from across the UK that has relevance to joint admissions. The evidence drawn from each area of the UK clearly identifies that perinatal mental illness, and in particular joint admissions, has had differing degrees of focus and priority across England, Scotland, Wales and Northern Ireland. Devolved decision making on health policy across the four areas of the UK has resulted in increasing divergence in health policy, service commissioning and legislation. In the 25 years that government policy has featured in the history of joint admissions it appears that the decade between 2000 and 2010 has been the most prominent in Scotland in particular.

The next Chapter in the thesis details an autobiographical account of the history of specialist service development in Scotland. This Chapter has been included within the thesis to position myself in terms of the subject under study and to provide a further source of primary evidence.

CHAPTER 6: A PERSONAL ACCOUNT OF THE HISTORY OF JOINT ADMISSIONS IN NHS SCOTLAND 2001-2012

6.1 Introduction

This Chapter will now describe the chronology of events in the development of specialist mother and baby units in Scotland. This evidence has been included as I was fortunate to have personal experience of how specific policy and legislation relevant to joint admissions was developed in Scotland. I was appointed as a nurse consultant in 2001 with responsibility for progressing nursing practice in perinatal mental health and in particular, for improving patient care through practice and service development within NHS Greater Glasgow (later to be NHS Greater Glasgow and Clyde). I had a specific remit to develop services including an inpatient psychiatric mother and baby unit. All nurse consultant roles in Scotland also had an element of national responsibility and could therefore work outside the traditional boundaries of the immediate NHS Board in which they were employed.

It is an unusual event within a clinical career in nursing to get the opportunity to design and develop new services at local, regional and national levels. The insights gained and the direct experience of events that took place that led to the eventual realisation of this goal may be important in informing other Nurse Consultants and clinicians on the process of service commissioning and the diffusion of other health service developments.

This knowledge is therefore a rich source of direct primary evidence to the history of joint admissions, in particular, the history surrounding the withdrawal of side room admissions in Scotland and the development of specialist mother and baby units. The important factors are not necessarily the chronology in itself but the meaning of the events and the relationship between

events that led to the achievement of major practice, service, policy and legislative change in Scotland. These areas will be considered in the analysis in Chapter 8.

The historical narrative starts with information on development prior to my appointment in March 2001 which I later learned had taken place and is presented as secondary evidence. From March 2001 onwards, the information in the chronology is primary evidence from unpublished archives and personal recall of actual events that I was either directly involved in, or was party to. Some of the events have already been referenced in earlier chapters of the historical narrative but are included in context in this Chapter.

6.2 The history of joint admissions in Scotland

As described in Chapter 3, the first reference to joint admissions in Scotland was in an article published in 1969 (Hamilton et al., 1969). The paper detailed work in the psychiatric unit of the Eastern District Hospital in Glasgow involving side room admissions. The paper by Hamilton et al (1969) was the only documentary evidence identified that was specific to joint admission practice in Scotland before the 1990s. However, I had knowledge from earlier in my career of an annexed facility with two dedicated beds for joint admissions in the Royal Edinburgh Hospital in Edinburgh in the 1980's. Attempts to gain more information about the annex through the NHS Lothian Archives and through enquiries with colleagues could not uncover any detail about the history of the practice of joint admissions there or the circumstances surrounding the closure of the beds. Colleagues could recall there had indeed been such a facility but had no further information about it. From sometime in the 1970s the common practice surrounding joint admissions in psychiatric hospitals in Scotland was for side room admissions to general adult acute admission wards. Many colleagues can confirm this was the case and I also had personal experience of this in the 1980s in my own career. Despite specialist units first being developed in England from the 1950s onwards, the unit that opened in Glasgow in 2004 appears to have been the first confirmed specialist unit to be developed in Scotland, some 56 years since the innovation was first introduced.

6.3 Secondary evidence of the history of specialist mother and baby units

The concept of a specialist mother and baby unit was first championed in Glasgow by a consultant psychiatrist Dr Roch Cantwell who had personal experience of working as a junior doctor in the specialist unit in Nottingham where Dr Margaret Oates had been consultant psychiatrist. He had a special interest in the field of perinatal mental illness and provided an outpatient clinic for the client group. Joint admissions were facilitated within the general adult psychiatric wards across the three geographic sectors of the Health Board area. Cantwell had been instrumental in having the Scottish Intercollegiate Guideline Network commission a guideline on postnatal depression and puerperal psychosis and he was an active member of the Perinatal Section of the Royal College of Psychiatrists.

Prior to this, the Scottish Executive Health Department had identified mental health as one of three clinical priority areas for the health service (Scottish Executive Health Department, 2000). The national strategy which was of relevance at the time was set out in a template for the development of locally based mental health services across Scotland between 1998 and 2004: A Framework for Mental Health Services in Scotland (Scottish Office, 1997). Greater Glasgow Health Board, as it was known then, responded to the national strategy by developing a local strategy: Modernising Mental Health Services, which set out a six year programme of local development for mental health services. Within this programme several project groups were set up to develop outlines that the Health Board would then select from and decide on which projects would be prioritised for investment. At a local level Cantwell had influenced decision making to have perinatal mental illness included as one of the considerations under the Glasgow strategy and a project group was set up.

At this time Nurse Consultant posts were new positions within the career structure for nurses. The introduction and funding of 12 new posts had been announced in a press release (Scottish Executive Health Department, 1999) by the Scottish Minister for Health, and were first introduced in

April 2000. The opportunity arose for Health Boards to submit bids to the Scottish Executive Health Department for the development of Nurse Consultant posts. NHS Boards were required to make applications to the Chief Nursing Officer's department at the Scottish Executive for the development of individual posts, evidencing the health gain that the post would bring to the clinical field in question. One of the key roles within the posts was that of service development (Scottish Executive Health Department, 2001). For the first time this formally made it an option for senior nurses to remain in positions of delivering direct patient care but to also have a role in the development of services, not only at local level but also at national level:

Establishing consultant nurse/midwife posts will contribute to better outcomes for patients, clients or communities by improving services and quality of care.....Each post must..... involve working directly with patients, clients or communities for a significant proportion of the time. Posts will be structured around four core functions that exemplify the role: an expert practice function; a professional leadership and consultancy function; an education and research function; and a service development function..... Post holders will contribute to the development of professional practice and service locally and nationally (SEHD, 2001).

The Director of Nursing submitted a successful bid for a Nurse Consultant post in Perinatal Mental Health in Glasgow which was recruited to in January 2001 and I subsequently took up post in March 2001. I had no personal experience of working in a specialist psychiatric mother and baby unit, my only exposure to the practice having been within general adult psychiatric wards and as a liaison community psychiatric nurse providing a psychiatric maternity liaison service to a maternity hospital.

6.4 Primary evidence of the history of specialist mother and baby units

March 2001: At the time of appointment to the Nurse Consultant post in March 2001 there was no specialist facility for joint mother and baby admissions in Scotland. Joint admissions were facilitated in side rooms of mixed sex general adult psychiatric units in many areas of Scotland, including

Glasgow. It was not known how many hospitals facilitated such admissions as no record of any survey of service provision of this nature in Scotland has been identified prior to 2001, but through conversations with colleagues in other NHS Board areas, it was known to be common practice.

May 2001: The first meeting of the Glasgow modernising mental health perinatal project group took place in May 2001. The aim of the group was to develop an outline clinical model and service model based on local need and best practice, detailing why service development for perinatal mental illness should be prioritised for investment. From May 2001 onwards the group which included managers, clinicians, planners and other stakeholders met regularly to carry out a needs assessment and work on the proposal. Visits were made to two psychiatric mother and baby units in England to gather information on clinical and service models from other areas and to learn from the experience of other services.

November 2001: The Scottish Executive Fellowships for Nurses and Midwives were advertised and I was successful in being awarded a Fellowship to undertake a study tour to research the mother and baby units which existed in Melbourne in Australia to help inform the proposal for local service development in Glasgow. The application was made to visit Melbourne because, outside of the UK, Melbourne had the largest concentration of specialist units and had several models to learn from. They also had a positive approach to child health programmes that promoted positive early years, healthy development and good infant mental health. The study tour was arranged for September and October the following year, 2002.

March 2002: A review of the existing local service provision was undertaken to help inform the work of the perinatal project group for modernised services in Glasgow. As part of the review, an assessment was made of the care being delivered to women who were admitted with their babies to side rooms of the general adult psychiatric wards. I had completed this through the use of direct observation of practice, a questionnaire, and through conversation with individual nursing staff. The

general view of staff was that joint admissions were good from the mother's perspective as she could continue to care for her baby where possible and it helped the bonding process by having the mother and baby admitted together. When asked in more detail about why it aided bonding, the staff had limited knowledge as to why they thought this was the case. In discussion with some of the nursing staff, they did raise concerns about the physical safety of the infants due to the presenting nature of some of the other patients on the ward and the potential for them being harmed either accidentally or deliberately, although none could recount such an incident. In the Nurse Consultant role, I was also contacted on an ad hoc basis by nurses from at least three other NHS Board areas seeking advice on joint admissions due to concerns about safety of the babies being admitted to the adult admission wards and a general feeling that their concerns were not being addressed within their local Board areas.

An observation when I was reviewing the practice of side room joint admissions in Glasgow was that there did not appear to be much consideration of the infant's wider needs, separately from the consideration of the mother and infant together. Having had previous clinical experience of working with women with perinatal mental illness in community settings and having knowledge of the evidence base around the potential impact of maternal mental disorder on infant development, part of the review of the practice was to consider how the infant's needs were being met within these adult environments. What was found was that there was no care plan generated for the infant's own needs and there was no record kept either locally or on national data bases that the infant was actually 'admitted' with the patient, therefore the infant had no status either as a patient or as a visitor, technically they were neither. There were no agreed standards of care for the infants within the adult inpatient environments. There were significant risks identified in relation to physical harm, but also in relation to harm from lack of stimulation, lack of primary health care services for the infants and risks associated with multiple care giving. There were no risk assessments or management plans in place for any of the infants. These were obviously issues of concern as the absence of governance around the practice meant the infants were potentially open to numerous

risks as was the organisation in terms of vicarious liability as there was no coordination or monitoring of the child's care, wellbeing or health whilst being under the auspices of hospital care. Albeit the babies were technically under the care of their mothers but, by the very fact they were residing in the hospital, the staff could not absolve themselves of responsibility to ensure the wellbeing, health and safety of the babies.

Using the information on current practice identified during the review, knowledge from research evidence, and giving consideration to the needs of the child in relation to their own development, safety and welfare, a report was compiled on the potential risks associated with the practice at that time. The report was presented to senior clinical directors within the organisation who were concerned at the potential risks to the infants that had been identified with the practice. A draft action plan was drawn up outlining the corrective action that would need to be taken as a matter of urgency to ensure infants were not continuing to be exposed to potential harm if joint admissions were to continue in general adult psychiatric wards in Glasgow. In the meantime it was agreed, whenever possible, all efforts would be made to provide patients with enhanced packages of care at home to reduce the need for joint admissions. Numbers of joint admissions were very low across the various inpatient units in Glasgow at that time with normal rates of only three or four admissions per year spread across five separate hospital sites.

Also in 2002, Cantwell conducted a case record audit of local admissions and identified that women separated from their baby during hospital admission were more likely to have longer lengths of stay and were more likely to be detained under mental health legislation than a comparable group of women who were admitted to hospital with their babies (Cantwell, 2002).

In July 2002, a few months after the review of local practice, a patient was to be admitted during the postnatal period to one of the psychiatric hospitals in Glasgow. The report presented to the senior clinical directors had heightened awareness amongst clinicians of the potential risks associated

with side room joint admissions to adult wards. The patient's consultant psychiatrist therefore took the view that the ward environment at the time was not conducive to a joint admission being facilitated and decided to admit her without her baby. The patient was distraught at being separated from her baby and after her discharge from hospital she contacted her local MSP about her experience.

August 2002: As previously mentioned, the Nurse Consultant role had both a local and national remit. The Mental Health and Learning Disability Nursing Officer at the Scottish Executive was keen to put a structure in place that would support the strategic elements of the role, enabling opportunities for networking and for direct two way communication between the nursing directorate of the health department and the mental health and learning disability nurse consultants working in the health boards. He set up regular meetings which helped to support the development of the national aspects of the role. These meetings provided the opportunity to raise the concern about nursing practice that had been identified locally surrounding the practice of joint mother infant admissions as something that was not peculiar to Glasgow. I was able to inform him of the concerns that nurses in other NHS Board areas had also raised when they had contacted me seeking advice on the subject. The concerns for the safety of the infants in general adult wards, was clearly something that was not just an issue locally in Glasgow, and it was highlighted that it would need to be addressed at a national level.

October 2002: An article was published in a local evening newspaper in October 2002, reporting on the patients' concerns and on her MSPs actions to highlight the position of the absence of joint mother and baby units in Scotland (Currie, 2002). The article reported that the MSP had tabled a series of parliamentary questions and had put down a motion expressing concern about the lack of service provision for women and babies affected by postnatal mental illness in Scotland. The article also claimed that the MSP had written to the Minister for Health and Community Care and to the Chief Executive of the Health Board (Currie, 2002). Later that same week a Scottish tabloid Sunday

newspaper (White, 2002) also published an article on the patient's dilemma which had the headline:

*"SCANDAL: Not one Scots hospital lets baby-blues mothers stay with children.
If she had been in jail Lyn would've kept her baby but she was ill...so she couldn't"*

The author also highlighted the differences in service provision between England and Scotland:

"while most major cities in England have dedicated mother-baby psychiatric wards, there is none north of the border" (White, 2002. 39. See Appendix 2).

The article included an interview with the patient who made the comparison between the differences in provision between women with mental illness and women who had committed crimes and were imprisoned but were able to have their infants with them in Cornton Vale, the only women's prison in Scotland, as there was a mother and baby unit at the prison. There was a quote included in the article from her MSP who it was also reported in the article had written to the Health Minister calling for mother and baby units and was quoted as saying, *"This is unacceptable and I will urge the Scottish Executive to take action."* (MSP Bill Butler quoted by White, 2002).

November 2002: The Fellowship study tour was undertaken in September and October 2002. It was a requirement of the Fellowship Awards that winners produced a report and attended the awards ceremony the following year to give a presentation on the outcomes from their awards. At the ceremony in November 2002, The Scottish Minister for Health and Community Care was present during the presentation on the outcomes from the review of specialist mother and baby units in Australia. At the end of the awards ceremony the Minister approached me for more information on current service provision in Scotland and was keen to learn why England and Wales and indeed Australia, had services and yet there were none in Scotland. He was also interested in the work that was being done in Glasgow Health Board area on the development of our proposal to have a specialist service commissioned. This interest was likely to have been roused by the communication mentioned above between the Minister and the patient's local MSP who by this time

had been successful in securing a debate by the Scottish Parliament. The debate was to take place two weeks after the Fellowship Awards.

December 2002: A members' business debate was held by the Scottish Parliament on the subject of the provision of dedicated mother and baby services for women with Postnatal Depression on 4th December 2002. The extract of the debate is included in Appendix 6. The motion was led by the MSP Bill Butler and included cross party representations by a further 11 members of the Scottish Parliament. The motion debated was:

“That the Parliament expresses its deep concern regarding the lack of proper facilities within the NHS in Scotland that would allow women with postnatal depression (PND) to continue to care for their children whilst undergoing treatment; recognises that the lack of dedicated mother and baby services for women with PND is completely unacceptable; notes the recent Scottish Intercollegiate Guidelines Network report which detailed the shocking lack of appropriate services for women with PND, and considers that the Scottish Executive should ensure that NHS Boards throughout Scotland take the swiftest possible action to remedy the alarming poverty of provision of mother and baby units” (Scottish Parliament, 2002).

The debate was opened by the MSP Bill Butler with details of his constituent's case and her experience of not being able to be admitted to hospital with her baby who was three and a half months old at the time of her admission:

“The total lack of provision of dedicated mother and baby services for women with postnatal depression is a gap in health service provision of which, I must confess, I was ignorant until two months ago.....when my constituent...arrived at my surgery.

Because no specialist mother and baby units are available in the Greater Glasgow NHS Board area or, for that matter, anywhere in the Scottish national health service, my constituent was able to see her baby only at visiting times. In effect, L (the patient) was

separated from H (her daughter) at a critical time in the development of the relationship between mother and child”.

Since first meeting L and H at my surgery, I have made it my business to highlight the alarming poverty of provision of suitable mother and baby units. I am grateful to the Evening Times and the Sunday Mail for publicising that unacceptable deficiency in the National Health Service.

I acknowledge that, in its initial response, Greater Glasgow Primary Care Trust informed me that a business plan to provide an interim six bed unit will be tabled at the Greater Glasgow NHS Board's December meeting. I welcome that as a reasonable first step. However, we need a country-wide or region-wide strategy that will enable permanent mother and baby units to be provided.

From the minister's response to my written question, I know that he acknowledges that there is an unmet need and is sympathetic to the speediest possible resolution to the problem. I ask the minister to use his position to take whatever action he thinks would be appropriate to galvanise health boards into purposeful action, which should concentrate their minds wonderfully. Mothers across Scotland demand and deserve no less” (Bill Butler, Scottish Parliament, 2002).

In his response to the presentations delivered in the debate, The Minister for Health and Community Care at the time, Malcolm Chisholm, congratulated Bill Butler on raising and pursuing the issue. He continued to convey his support by stating:

“I turn to the main subject of the debate and to a key factor that has been identified as having a bearing on the effectiveness of inpatient care; namely joint admission of an ill mother with her baby. There is strong support among patients, professionals and the health department for units that are designed around joint admissions.....That is an aspect of provision in which I want significant progress to be made throughout mental health

services.....I will ask the regional planning groups to consider the benefits of providing joint admission services for post-natal depression on a regional basis”.

The Minister for Health and Community Care made specific reference to Greater Glasgow NHS Board and what he knew of the work that was being progressed:

“That is not to say that no progress is being made in addressing the needs of mothers and babies together. As Bill Butler reminded us, Greater Glasgow NHS Board has announced that it is moving ahead to draw up detailed plans for a specialist facility for mother and baby admissions. That is fully in line with the published guidance and it is an excellent example of an NHS Board responding to patients’ needs in a specialised area of treatment.....I was pleased last week to speak to the nurse consultant in Glasgow on perinatal mental health. The NHS Board there has recognised that it will take time to deliver its plans and it is therefore providing an interim arrangement for the admission of mothers and babies until the proposed specialist unit becomes available. Where Glasgow is leading, I want other areas of Scotland to follow. I believe that working on a regional basis is the way forward....We congratulate Greater Glasgow NHS board on its announced plans and on leading the way. I give members my personal commitment that I will do everything that I can to ensure that there are improvements in services throughout Scotland for postnatal depression in general and the development of mother and baby units in particular”

(Malcolm Chisholm, Extract from Scottish Parliament Debate on Postnatal Depression, 2002. 8-9).

Notable points in this speech were two statements made by The Minister for Health and Community Care: *“the NHS Board.....is therefore providing an interim arrangement for the admission of mothers and babies”* and secondly, *“We congratulate Greater Glasgow NHS Board on its announced plans”*. At the time the Minister made these statements, the NHS Board in Glasgow had not actually made a decision to commission the development of the service. The proposal from the perinatal sub group of the modernising mental health services programme was to be presented to

the Board meeting the following month. A copy of the extract from the debate (Appendix 6) was forwarded to me by one of the civil servants as it had made mention of the conversation with the Minister at the Fellowship Awards presentation. The Board was subsequently made aware of the statements made by the Minister and the content of the debate. The statements made by the Minister in his speech were thought to have had quite an influence over the Board's decision making in terms of the proposal. With this issue being in the political spot light, a decision by the Board not to support the development of the mother and baby unit in particular would have been difficult to justify in light of the interest and publicity from the media and politicians around the lack of service provision.

January 2003: The proposal paper developed by the Modernising Mental Health Perinatal Project Group in Glasgow was presented to the Glasgow NHS Board meeting, seeking approval for the commissioning of a specialist perinatal service, which included a specialist mother and baby unit. The proposal was supported and it was agreed that an outline business case including an options appraisal should then be carried out to identify the best geographical site and the various capital costs in terms of the building options.

March 2003: At the time the service proposal was being prepared in Glasgow, at a national level there was work underway to review the mental health legislation, which at that time was The Mental Health (Scotland) Act 1984. In 2002 a complete reform of mental health law in Scotland was undertaken and presented as the Mental Health (Scotland) Bill (Scottish Parliamentary Corporate Body, 2002). The first draft of the Bill was considered by MSPs and amendments subsequently put forward and considered. The Stage 2 amendments included a proposed addition specifically on joint admissions. The original proposed amendment read:

Stage 2 amendment – Proposed by: Margaret Jamieson (MSP with Labour Party and Deputy Convenor of the Health and Community Care committee)

Supported by: Bill Butler (MSP with Labour Party) this was the same MSP who had raised the motion for the earlier debate after his constituent had requested his help on the absence of mother and baby units.

After Section 19 insert –

Provision of services and accommodation: mothers with babies –

A Health board shall provide for any woman who is the mother or adoptive mother of a child aged under two years; cares for the child; and is not likely to endanger the health or welfare of the child; and who is detained under Part 5 or 6 of this Act or has been admitted to hospital, whether voluntarily or not, for the purposes of receiving treatment for a mental disorder, such services and accommodation as are necessary to ensure that the woman is able, if she wishes, to care for the child in hospital.

Mr Adam Ingram (MSP with Scottish National Party)

After 'wishes' insert 'and it is in the best interests of the child'.

(Scottish Parliamentary Corporate Body, 2003. 14).

This amendment was one of only a few amendments that progressed to Stage 3. I was informed verbally by a civil servant that this amendment was able to progress to the next stage because the committee considering the amendments ran out of time to vote on it specifically. No documentary evidence could be found to confirm this however.

Stage 3 amendment – Proposed by: Bill Butler. Supported by: Scott Barrie (MSP for Labour Party), Margaret Jamieson.

After Section 19 insert –Provision of services and accommodation: mothers with babies –

A Health board shall provide for any woman who is the mother or adoptive mother of a child aged under one year; cares for the child; and is not likely to endanger the health or welfare of the child; and has been admitted to hospital whether voluntarily or not, for the purpose of receiving treatment for postnatal depression, such services and accommodation as are necessary to ensure that the woman is able, if she wishes, to care for the child in hospital.

Each Health Board shall collaborate with other Health Boards to whatever extent is necessary to fulfil its duty under subsection (1) above (Scottish Parliamentary Corporate Body, 2003a. 4).

This Stage 3 amendment had the notable addition of a requirement for NHS Boards to collaborate with other NHS Boards to provide appropriate services for joint admissions, perhaps to secure the commitment made by the Minister for Health and Community Care in his speech during the earlier debate that he would ensure regional planning to improve services throughout Scotland (Malcolm Chisholm, Extract from Scottish Parliament Debate on Postnatal Depression, 2002. 8-9. See Appendix 6).

Further additions in the Stage 3 amendment was the change in the age of the child from two years to one year and the specific reference to postnatal depression. There is no particular evidence in the literature as to why most mother and baby units in the UK only admit mothers with babies up to the age of one year. Anecdotally however, staff who work in mother and baby units say it becomes very difficult to maintain the safety of the child once they start to crawl and more difficult again when they start to walk. For a large number of children, this milestone is reached around the age of twelve months and for this reason, they generally will not admit a mother with her baby beyond this age.

The inclusion of postnatal depression as a diagnosis within the wording of the amendment was a curious inclusion, or perhaps if taken literally, could have been perceived as an exclusion of women who did not have this diagnosis but still required hospital admission after child birth due to the serious nature of their presenting condition. It is more likely that the use of the term 'postnatal depression' reflects a point highlighted earlier in the thesis that Scotland in particular had a propensity to use this term as a 'catch all' for all perinatal mental illness and had featured in earlier policy mandates in Scotland.

The Stage 3 amendment was accepted and the final provision that appeared in the final Draft of the Bill (Scottish Parliamentary Corporate Body, 2003) and the final published Act read as follows:

24 Provision of services and accommodation for certain mothers with post-natal depression

(1) A Health Board shall provide for any woman who –

- (a) Is the mother or adoptive mother of a child less than one year old;*
- (b) Cares for the child*
- (c) Is not likely to endanger the health or welfare of the child; and*
- (d) Has been admitted to hospital, whether voluntarily or not, for the purpose of receiving treatment for post-natal depression*

Such services and accommodation as are necessary to ensure that the woman is able, if she wishes, to care for the child in hospital.

(2) Each Health Board shall collaborate with other Health Boards to whatever extent is necessary to fulfil its duty under subsection (1) above

(Scottish Executive, 2003a. 14).

April 2003: The Mental Health (Care and Treatment) (Scotland) Act 2003 received Royal Assent and the Act implementation date was set for April 2005. This set a timescale for when NHS Boards would need to be compliant with Section 24 of the Act as detailed above (Scottish Executive, 2003). The Scottish Executive knew however that NHS Boards across Scotland were not providing such services as those set out in Section 24 of the Act and could face a legal challenge if the services were not provided when the Act became operational.

May 2003: Because Scotland did not have any existing specialist services, the Scottish Executive took a decision to produce guidance and standards for NHS Boards to assist and support them in their planning for the requirements of the Act set out in Section 24. A short life working group was subsequently appointed to produce outline guidance to help inform the preparation and planning

processes required by agencies to comply with the new provisions in the Act, and through that process contribute to the successful implementation. The aim of the guidance was to anticipate what would be needed in terms of care, quality standards and accommodation to comply with the legislation and to serve as an agency planning and audit tool. The guidance which would become an additional service profile to the Framework for Mental Health Services in Scotland (Scottish Office, 1997). I was appointed to chair the short life working group, which as a nurse was apparently very unusual as traditionally when clinicians were identified to lead and chair short life working groups, it had always been medical staff who were asked. Apparently this decision had been informed by the Chief Nursing Officer and the nursing officer for mental health and learning disability who were aware of the work already undertaken in Glasgow to scope out the practice issues with side room admissions to general adult wards, and the experience I had gained from the Nursing Fellowship study tour to Australia. The group was tasked with producing the guidance and report for Scottish Ministers by December 2003.

June 2003: Locally in Glasgow the outline business case and options appraisal had been completed and it was agreed that the best option to be commissioned was an interim six bed unit to be built on the Southern General Hospital site, which would serve the population of Glasgow. The needs assessment had identified that Glasgow required four beds to meet the needs of the local population but to staff this size of unit was the same revenue costs as it would be to staff a larger unit. The Board therefore took the decision to open up the facility to the West of Scotland Regional Planning Group and based on birth rates for the neighbouring NHS Boards it was calculated that an additional two beds would be sufficient to meet the needs of the population in those areas. The Glasgow planning group knew that the other Board areas would also need to comply with the forthcoming Mental Health Act in terms of inpatient provision for joint admissions and this would be a more financially viable solution for them, with the costs of running the unit being shared across the Board areas. It was agreed that the unit should be opened by June 2004.

January 2004: The Scottish Executive sought responses from the Regional Planning Groups in Scotland setting out local proposals to ensure regional progress on the development of joint services for the admission of mother and babies. NHS Boards were required to have Local Implementation Plans for the forthcoming implementation of the Act and were required to submit regular updates on progress. These implementation plans were required to update specifically on plans for implementation of Section 24 regarding joint admission provision. The Head of Mental Health Commissioning in Glasgow presented a paper to the West of Scotland Mental Health Planning Group which set out the proposal for the six bed mother and baby unit in Glasgow. The proposal was that four beds would be funded by Glasgow and the remaining two beds should be funded by other West of Scotland Boards. The unit was scheduled to become operational in June 2004.

March 2004: The additional service profile to the Framework for Mental Health Services in Scotland that had been produced by the short life working group of the Scottish Executive received Ministerial approval and was circulated to NHS Boards as HDL 6 2004 (Scottish Executive Health Department, 2004). This set out standards and guidance for the provision of services for perinatal mental health. Although the Act had specifically made provision for inpatient services, it was identified by the short life working group that inpatient services would only address the needs for a very small percentage of the population who actually were affected by perinatal mental disorder, with the majority could have their needs met if there were appropriate community based services. The profile was therefore inclusive of the whole patient journey across all tiers of service. In addition, the profile had been developed with a wider scope than just for those women with a diagnosis of postnatal depression, as had been set out in the Act. It was acknowledged that the service profile should be inclusive of women with all categories of perinatal mental ill health who required hospital admission and not just those with postnatal depression.

June 2004: The completion of the mother and baby unit at Glasgow was delayed due to building issues but the recruitment of staff had been completed and the community service became operational on schedule.

September 2004: The six bed mother and baby unit at the Southern General Hospital in Glasgow opened for admissions on 24th September 2004 and had its first admission that morning. When the unit opened, the unit had a service level agreement with only one other NHS Board in the West of Scotland, NHS Dumfries and Galloway, to provide for inpatient admissions. Shortly afterwards NHS Ayrshire and Arran, followed by NHS Lanarkshire, indicated they also wished to enter into service level agreements. This would ensure they had arrangements in place to comply with the forthcoming implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003.

October 2004: The mother and baby unit in Glasgow had its official opening on 29th October which was conducted by the Minister for Health and Community Care at the time Shona Robinson. There was much media attention around the opening of the unit with newspaper, radio and television coverage. It was regarded as a very positive development and the media reported it as 'a good news story'.

The Scottish Executive supported a national conference to try to encourage and support other NHS Boards in developing services. The consultant psychiatrist from Glasgow and I arranged the conference and shared learning from the experience of setting up the Glasgow service with the other NHS Board areas in Scotland.

The East Scotland regional planning group were progressing discussions around setting up a mother and baby unit and invited the Glasgow consultant psychiatrist and I to be involved in some of the planning on a consultancy basis. There was shared learning across the team involved in the development of the Glasgow service and the consortium who were planning the service in West

Lothian to serve the East of Scotland. Policies developed to support the delivery of the service in Glasgow were shared with the team developing the service in West Lothian.

October 2005: The Mental Health (Care and Treatment) (Scotland) Act 2003 (the Act) came into force on 5th October 2005, six months later than originally planned. The Scottish Executive decided that they would formally launch the new Act at the Glasgow Mother and Baby Mental Health Unit and the Deputy Minister for Health and Community Care at the time Lewis MacDonald was assigned to carry out this duty.

June 2006: The second specialist unit in Scotland was opened at St John's Hospital in Livingston and it would serve patients from the East Region of Scotland. This was also a six bedded unit. The funding arrangements for this unit were agreed via a consortium arrangement between NHS Lothian, NHS Tayside, NHS Highland, NHS Borders and NHS Fife, as opposed to the service level agreement arrangement for the Glasgow / West of Scotland Unit. By this time an agreement had been reached with NHS Western Isles that they would arrange any necessary admissions with the unit in Glasgow and pay for this on a case by case basis. NHS Argyll and Clyde was taken over by NHS Greater Glasgow and Clyde so admissions from that former Board area came under the catchment area of Glasgow. This left NHS Orkney, NHS Shetland and NHS Grampian and NHS Forth Valley as the NHS Boards without specialist provision for joint admissions.

August 2007: Two single bed facilities with a sitting area and kitchen area annexed within adult mental health wards were opened in NHS Grampian at Aberdeen and Elgin in response to the provision made in the Mental Health (Care and Treatment) (Scotland) Act 2003. The facilities did not have dedicated staffing and relied on staff being allocated from the other mental health wards as necessary so there was limited opportunity for the staff to build up a concentration of knowledge and skills.

February 2012: Although the planned two-bed annex facility at NHS Forth Valley was built into the plans for the new mental health hospital at Larbert the beds have not been used for the purpose of joint admissions. The unit was not resourced with permanent staffing and the consultant psychiatrist with a special interest in perinatal mental illness does not therefore support the admission of women with their babies. NHS Forth Valley therefore have no formal arrangements to provide joint admissions and are reliant upon negotiating with the two regional specialist units in West Lothian or Glasgow on a case by case basis.

There are plans for the regional unit in Glasgow to be moved from its current site to another hospital site in Glasgow later in 2012 due to plans for hospital redesign on the current site. There are discussions underway about the possibility of increasing the number of beds in the re-provided unit.

NHS Scotland is a late adopter of specialist mother and baby units. It was over 50 years since the first unit was opened before Scotland opened its own specialist unit. Diffusion has been progressed along the continuum from diffusion to dissemination by the influence of government policy and legislation. Side room admissions were practised widely across Scotland but the same policy and legislation that has influenced specialist units, has all but eradicated the practice of side room admissions across Scotland. The single bed facilities developed in NHS Grampian would perhaps constitute annexes more so than specialist units. They differ from the side room admissions to general adult wards as in NHS Grampian the rooms are separately annexed to the main adult wards and have their own sitting areas and kitchens but they do not have dedicated permanent staffing. It is likely in the absence of the specific mental health legislation that these facilities would not have been developed as the Board area did not identify a need for a specialist unit and developed the annexes to meet their responsibilities as part of their compliance with the mental health legislation.

This chronology completes the Chapters that have detailed the documented evidence of the history of joint admissions in the UK. Evidence has been selected from both primary and secondary sources in the form of published papers by clinicians directly involved in the practice of joint admissions, from published reports, policy documents, transcripts, legislation and from personal accounts of events.

CHAPTER 7: FINDINGS

7.1 Introduction

The theoretical framework 'diffusion of innovations' (Rogers, 2003), as detailed in the literature review in Chapter 1, is being used to present the results of the historical narrative and facilitate an analysis of the findings. This theoretical framework was further expanded by Greenhalgh et al (2004) for use in healthcare organisations and takes the framework beyond innovation diffusion along the continuum to dissemination as detailed in Figure 3. Before presenting the results of the pattern and rate of diffusion of the innovation of joint mother infant admissions within the theoretical framework, comparisons of the ways in which the innovation was introduced have been outlined to provide clarity of the innovation that has been the focus of the study.

The results will thereafter be presented as follows:

1. The rate of adoption of the practice of joint admissions
2. The evidence considered against the variables in the framework which determine the rate and frequency of adoption.

7.2 The innovation

As defined, an innovation is an idea, practice or object that is perceived as new to an individual or another unit of adoption (Rogers, 2003.12). The innovation development process consists of all the decisions, activities and their impacts that occur from recognition of a need or problem, through research, development and in some cases commercialisation of an innovation, through diffusion and adoption of the innovation by users, to its consequences (Rogers, 2003. 166). It has been identified from the evidence that the innovation of joint psychiatric mother infant admissions developed in two different hospitals around the same time but for the purpose of finding solutions to differing identified needs. The basic practice was the same; mother and child being admitted together to psychiatric wards for the purpose of treatment of the woman's mental illness.

Thereafter, how it was initially executed in practice differed considerably. The innovation is presented in Table 4 to provide clarity around the innovation that has been studied.

TABLE 4: Comparison of the innovation of joint psychiatric mother and baby admissions

	Version A – 1948 - 1955 (published by Main, 1958)	Version B – Early 1950s – 1956 (published by Douglas, 1956)
WHY: identified need for the innovation	A woman required admission to hospital for treatment of neurotic disorder but had no alternative child care arrangements.	Recognition that women with puerperal schizophrenia had high rates of relapse after resumption of their parenting role upon discharge from hospital following the period of separation from the child.
AIM	Practical facilitation of hospital admissions for mothers needing hospital treatment for neurotic disorders	To test the hypothesis that women with puerperal schizophrenia would have better outcomes, reduced rates of relapse and would not pose a serious risk to their babies if they were not separated from them in the postnatal period.
INNOVATOR	Thomas Main, psychoanalyst in a position of authority within Cassel Hospital	Gwen Douglas, trainee psychiatrist and colleagues at the mental observation ward in West Middlesex Hospital
RECIPIENTS	Women with neurotic disorders in the postnatal period requiring admission to mental hospital and their infants.	Women with postnatal psychotic illness requiring admission to a mental observation ward and their babies.
DESIGN	Mainstream admission ward in mental hospital with psychoanalyst and mental nurses	Mental observation admission ward with specific joint intervention of mental nurses, psychiatrists, midwives, paediatric nurses

The findings are presented for each version of the practice and comparisons have been made between Version A and Version B. For the purpose of reporting on the findings of the study, Version A, which originated from the practice described by Main (1958), is classified as side room admissions or admissions to annexed rooms within larger wards largely for the pragmatic facilitation of women's admission to hospital for treatment in the postnatal period. The data on the annexed facilities has been grouped with the data on side room admissions as the annexes were not specialist mother and baby units by the definition used in the study and could not be

extrapolated from the documentary evidence to enable joint admissions to this type of facility to be reported as a discreet version in its own right. Version B of the practice, similar to that described by Douglas (1956), is classified as admissions to specialist units for the specific treatment largely aimed at preventing relapse and improving outcomes for both the women and their babies.

7.3 The rate of adoption of joint admissions

The rate of adoption is defined as the relative speed with which an innovation is adopted by members of a social system (Rogers, 2003. 23). The rate of adoption can be measured in two ways, 1) cumulative totals of facilities that have adopted the practice of joint admissions which when plotted over time produces the S-shaped curve, and 2) frequency of adoption of the practice of joint admissions when plotted over time produces the bell-shaped curve.

The S-curve model has been criticized because it assumes a homogeneous population of potential adopters that have the same needs, which is argued to be unrealistic (Tidd, 2010. 14). This criticism was considered but in conclusion it is less of a concern in this study of joint admissions as the practice is directed at a specific patient population who are evident in every geographical area serviced by the NHS across the UK. Although the services for joint admissions are not homogenous the patient population is considered to be homogenous. Tidd (2010) concluded that the simple epidemic model or S-curve model appears to provide a good fit to the diffusion of new processes, techniques and procedures. It has therefore been used to analyse the results in this study as it is the most appropriate model of adoption for this innovation type.

The evidence from the published surveys is not robust as the methods used in each of the reported surveys were weak. The weaknesses are largely due to the lack of evidence of any means used to check the reliability of the returned data in any of the survey designs. Also there is was uniformity as to who returned the responses. Researchers targeted hospital managers (Aston and Thomas, 1986), district medical officers (Shawcross and McRae, 1986), senior nurse managers of individual

psychiatric units in hospitals (Cassell and Coleman, 1990) and health authorities (Prettyman and Friedman, 1991). There would have been varying levels of awareness of local and area practice dependent upon the position of the individuals within their organisations. The findings are reported with this weakness in the quality and reliability of the survey data acknowledged.

The reported survey data provides evidence of cumulative totals of joint admissions however the data in the surveys is a combination of both Version A and Version B of the practice. The evidence from the published surveys provides information on the spread of knowledge about the innovation and additionally, the surveys provide evidence which enables the estimation of the rate and pattern of diffusion of the two versions of the practice over time. The data from the surveys does not, however, give a complete picture. Some of the surveys did not differentiate between side room admissions, annexes and specialist mother and baby units therefore it was difficult to extrapolate the data for each version of the practice from those particular studies. The surveys published later in the history specifically excluded side room admissions to general adult psychiatric wards and were concerned with only collecting data on specialist mother and baby units, however, this was in the absence of a nationally agreed criteria for what constituted a specialist mother and baby unit. None of the surveys used a standardised criteria for what constituted a mother and baby unit. The data is further weakened by the dearth of evidence from Scotland and Northern Ireland. The data as a whole is therefore not comparable over time. The data identified from the primary and secondary evidence on both versions of the practice has been collated in Table 5:

TABLE 5: Published data for both Version A and Version B joint admissions in the UK

Year(s) of survey	No. of facilities reported as providing joint admissions	Areas of UK included in survey	Reporting Source	Comments
1977	13 (A+B)	List provided by the author of what he knew of existence of units across all UK	Bardon 1977	2 units were reported to have been closed or re-provided by 1977.
1981	12 (A+B)	South East Thames Region, London, England	Kumar et al 1986	Survey was conducted in only one region of England. Facilities ranged in size between 1 and 6 beds
1985-86	141 (A+B)	All hospitals in England and Wales (n=293 responses from 305)	Aston & Thomas, 1986,	All hospital facilities that provided for joint psychiatric admissions were included
1986	23 (A+B)	Medical officers in all districts in England (n=29 responses from 42)	Shawcross & McRae, 1986	Six of the 23 facilities had between 2 and 14 beds
1990	38 (B)	Senior Nurse Managers of hospitals in 6 regions of South England and Wales (n=103 responses from 120)	Cassell & Coleman, 1990	
1991	173 (A+B)	All health authorities in England and Wales (n=194 responses from 201)	Prettyman & Friedman, 1991	Mix of side room admissions and specialist units
2003	21 (A+B)	Medical directors on mental health trusts England only (73% response rate from 78 trusts)	Oluwatayo & Friedman, 2005	
2003	8 (A)	14 NHS Boards in Scotland (2 of the 16 NHS Boards in Scotland were special health boards)	NHS QIS, 2006	This was 50% of all NHS Boards in Scotland. No specialist units were identified in this data
2005	26 (A+B)	Trusts in England only	Elkin et al, 2009	Criteria of a minimum of 4 beds applied to define specialist units: 13 units met the criteria.
2006	19 (B)	All UK	MIND, 2006	
2011	21 (B)	All UK	RCPsych	Specialist facilities of 3 beds or more.
2011	5 (B)	Scotland	Scottish Government	3 of these facilities are annexes with only 1 or 2 beds.

Where the evidence allows, the data has been categorised into Version A and Version B of the practice and the diffusion curves for each version have been plotted in Figure 5 and Figure 6 using the available evidence that was extrapolated for each.

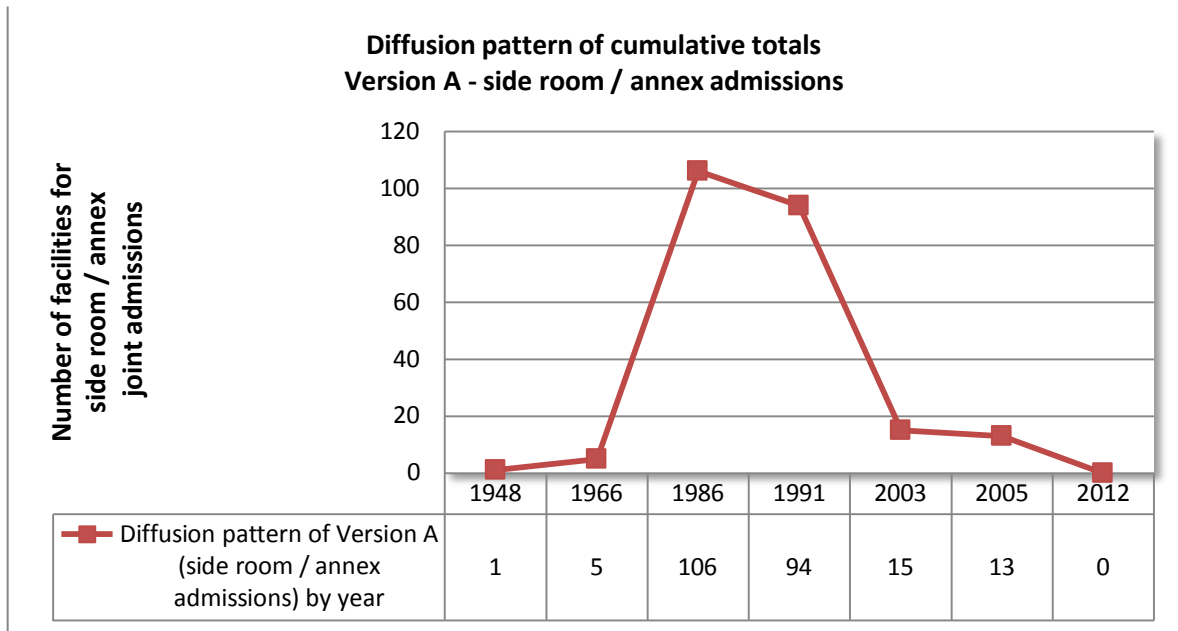
In a normal S-curve distribution of adopters the S-shaped adopter distribution rises slowly at first when there are only the innovators and a few adopters in each time period. The diffusion curve would then be expected to start to climb as more and more people adopt the innovation in each successive time period. In this study the time periods are viewed in years rather than months due to the slow rate of adoption and the system of adoption in this study is the NHS. The curve then accelerates to a maximum until half of the individuals in the system have adopted. Eventually the trajectory of the rate of adoption increases at a gradually slower rate and begins to level off, as more and more clinicians or areas have adopted and there are fewer and fewer still to adopt. Finally the S-shaped curve reaches its asymptote¹⁷ and the diffusion process is finished (Rogers, 2003. 23). This normal adopter distribution for an innovation is expected because of the cumulatively increasing influences upon the adopters to adopt or reject the innovation through the increasing knowledge about the innovation resulting in the activation of the peer networks in the system (Rogers, 2003. 273).

7.3.1 Version A

The adoption curve of joint admissions to side rooms and annexes of general adult psychiatric wards in terms of cumulative totals is demonstrated in Figure 5, evidenced from the data reported in the history of joint admissions in Chapters 3-6. It is clear from Figure 5 that the adoption of Version A of joint admissions does not follow the predicted S-curve pattern:

¹⁷ An asymptote is a line that draws increasingly nearer to a curve without ever meeting it.

FIGURE 5: The diffusion curve for cumulative totals of Version A - side room / annex admissions



The pattern of adoption follows the traditional curve up until the late 1980s. It appears that critical mass, the point at which enough individuals in a system have adopted an innovation after which further diffusion becomes self-sustaining, was reached around the late 1960s or early 1970s. This is evidenced in Figure 5 by the steep incline between the data points at 1966 and 1986 and is supported by the secondary evidence referenced earlier from Brockington (1996) that there was a, “proliferation of joint admissions throughout Britain, mainly to side room facilities” in the 1970s and 1980s (Brockington, 1996. 560).

The data point at 1991 informed by the survey by Prettyman and Friedman (1991) appeared to show a decline in Version A being practiced. This may, however, be explained by differences in methodology between the surveys of Aston and Thomas (1986) who received 293 responses from 305 hospitals, and Prettyman and Friedman (1991), who received 194 responses from 201 health authorities. Both surveys were conducted only in England and Wales. The next available data on Version A includes evidence from England and Scotland separately but the data was obtained in the same year, 2003, and it confirms that only 15 areas were offering side room or annex

admissions at that time. This is obviously a considerable reduction in provision which indicates there has been a complete rejection of Version A over the last 20 years. In all probability the gap in the available data can explain the steepness of the decline in the curve but in reality it was more likely to have been a gradual decline in the provision of Version A joint admissions.

The data available on the practice of side room and annex admissions after the data point at 1991 is limited due to the majority of the later surveys excluding side room and annex admissions from their data collection. The cumulative totals plotted on the adoption curve are known to be an under representation of the actual numbers of adoptions of Version A admissions as the majority of surveys were conducted in England and Wales only. There was a gap in the recorded data for numbers of areas practising side room and annex admissions in Scotland between 1969 and 2002 however I have personal knowledge that side room admissions were practiced widely in Scottish psychiatric hospitals during this time period. It is known there was an Annex with two beds at the Professorial Unit of The Royal Edinburgh Hospital where joint admissions were facilitated in the late 1970s. It closed sometime in the 1980s but there was no documentary evidence available from the archives of NHS Lothian pertaining to its closure. Side room admissions were still being facilitated in the Scottish NHS Board area in Scotland in which I worked until 2004. I also had contact with colleagues in other geographic areas across Scotland and England who confirmed the practice was also in place in their general adult psychiatric admission wards.

Published evidence that the specific practice of side room admissions were still taking place in the early 2000s is referenced in the SIGN evidence based guideline (SIGN, 2002). The expert group that developed this guideline advocated for specialist mother and baby units in Scotland when at that time none existed. They specifically stated that side room admissions in general adult wards should not take place due to perceived associated risks, which would indicate probability that the practice was still common at the time of publication in 2002 (SIGN, 2002). This is further evidenced in responses received to a survey conducted in 2003 as part of a national audit of postnatal

depression in Scotland. Half of the 14 NHS Boards included stated they made provision for joint mother and baby admissions, with a total of eight facilities across Scotland but none of these admissions were to specialist mother and baby units (NHS Quality Improvement Scotland, 2006). In the evidence for Version A, although there is a gap in available data for most of the decade from 1990 until 2000, the data available from 2000 onwards is more of an accurate reflection of the number of areas providing Version A of joint admissions.

The diffusion pattern of Version A has also been unusual in terms of the length of time that it has taken for the practice to diffuse across the UK. It is known from research that the normal time for the diffusion of new innovations into practice once developed, is between 10 and 15 years (Jaffe, 1986). The innovators and early adopters were quick to adopt the practice within just a few months or years and it appears to have peaked around 1990 some 40 years after the first introduction. The large degree of variation in the services identified by Shawcross and McRae (1986) indicated that as the practice diffused it was not homogenous and had been modified or 'reinvented' in many areas to meet local requirements or to reflect local views. In comparison to the adoption rate, the rejection rate of the practice in the 20 years between 1990 and 2012 appears to have been more rapid.

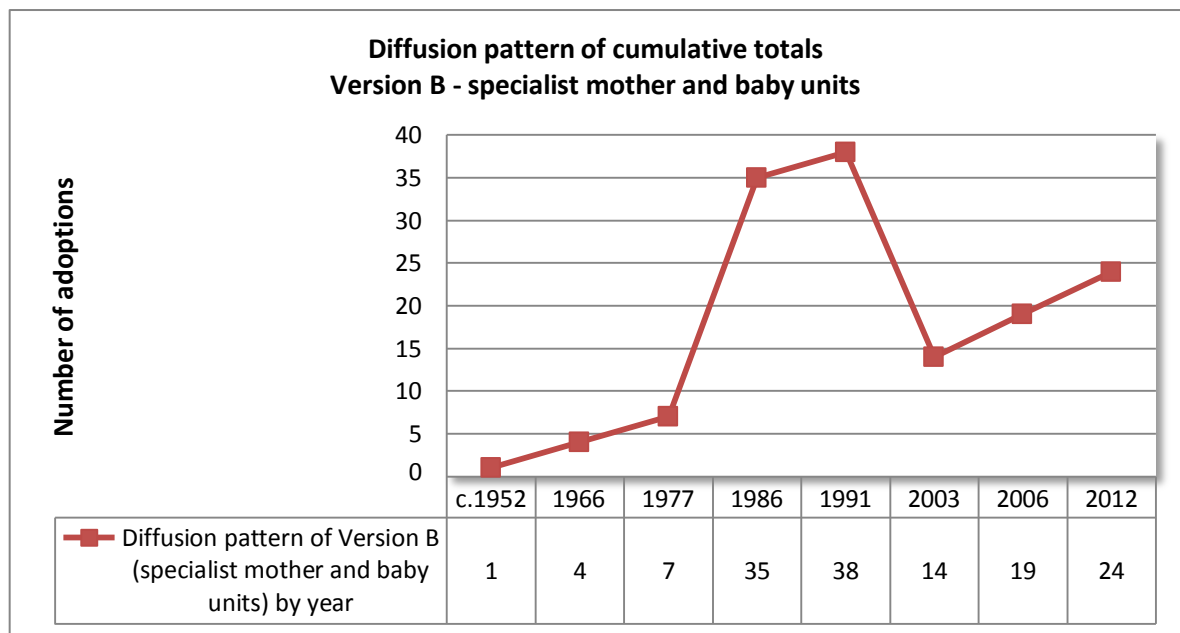
There is evidence that in some areas Version A was provided but was later replaced by Version B. An example of this was found in Shenley Hospital where side room admissions were introduced in 1956 and replaced by the development of a specialist unit with 10 beds in 1959 (Bardon, 1977). Indeed Main the innovator of Version A later rejected his version of joint admissions in favour of Version B when he developed a specialist unit and started admitting women with psychosis (Main, 1958). This pattern was also evidenced in Glasgow with side room admissions reported to be happening in 1966 by Hamilton et al (1969) and the rejection many years later in favour of the development of a specialist unit in Glasgow in 2004. There are several other possible reasons for the unusual diffusion pattern and the influencers to the rejection of Version A. There was an

increasing focus in the literature on the issue of risk of harm to the babies. The evidence also identified that during the 1990s there was an increasing focus on joint admissions within policy documents and national reports and there was an increasing emphasis being placed on the development of Version B. The extent to how these factors influenced the eventual rejection of Version A are considered in detail and analysed in Chapter 8.

7.3.2 Version B

The adoption curve of specialist mother and baby units in terms of cumulative totals is demonstrated in Figure 6 as evidenced from the data reported in the history of joint admissions in Chapters 3-6.

FIGURE 6: The diffusion curve for cumulative totals of Version B – specialist mother and baby units



Similar to Version A, Version B, also has an unusual pattern of diffusion. The data suggests the diffusion of Version B reached its critical mass in the late 1970s and the diffusion curve for Version B reached its peak about five years after Version A as evidenced from the survey by Aston and

Thomas (1986) and the survey by Prettyman and Friedman (1991). Similar to Version A there is a sharp decline in the provision of Version B during the 1990s. From the history this appears to coincide with the publication of the Griffiths report (DHSS, 1988) which introduced the internal market to service purchasing and provision, and the NHS and Community Care Act (1990) which led to a major reorganisation of the NHS. During the 1990s there was also the first evidence of specific reports on the subject of perinatal mental illness (RcPsych, 1992) which was perhaps the first influence through policy of Version B being promoted over Version A. Similar to the pattern of diffusion of Version A there are several probable and possible reasons for the unusual diffusion pattern and apparent rejection of Version B during the 1990s. Causation is considered in more detail in Chapter 8.

What is not demonstrated in Figure 6 is the evidence in the history that as specialist mother and baby units have opened, units in other areas have closed. The cumulative total plotted on the graph is therefore not a true reflection of the total number of adopters over time; it is a reflection of the number of adopters at points in time. Bardon (1977) reported that by 1977 the locations of the original innovations at the Cassel Hospital and at West Middlesex Hospital had stopped joint admissions but he did not give reasons why this was the case. By 1977 the unit at Banstead had also closed but it had been replaced by a unit nearby at Springfield (Bardon, 1977. 31).

The diffusion patterns of Version A and Version B are both unusual and do not follow the traditional S-curve pattern of diffusion. The difference evidenced between the diffusion pattern in Version A and the pattern in Version B is that the pattern of diffusion in Version A is completed by total rejection around 2006, whereas, there is strong evidence that the diffusion of Version B of the innovation is still in process. From Figure 6 it appears that the number of adopters of Version B has either been gaining momentum during the last nine years or else the number of rejecters of established units has slowed, creating an apparent increased number of cumulative adopters of specialist mother and baby units across the UK. New specialist mother and baby units have opened

during the last six years in England and Scotland. Replacement units have also seen additional investment and growth in capacity in some areas of England in the last two years. East London replaced a three bed unit with a new ten bed unit in January 2010. Nottinghamshire also replaced their mother and baby unit for the second time early in 2011 (this unit was originally opened as an annex in 1974 and replaced for the first time in 1984). At the same time the mother and baby unit at Springfield Hospital in Tooting has been closed and a two bed unit in York was closed temporarily in 2010 but it was later announced in March 2012 that due to the unit “not being accredited” it was being closed permanently. Admissions of women from York were to be transferred to the five bed unit at Leeds, more than 30 miles away (BBC News, (1st March 2012) accessed online September 2012).

In Northern Ireland the innovation-decision stage is evident in terms of consideration within central policy decision making and the commissioning of a needs assessment for the provision of specialist mother and baby unit services, however the move to implementation or rejection has not taken place as yet (Northern Ireland Assembly, 2010). The current number of facilities across the UK at September 2012 is 24 although not all of them are currently operational. A list is included in Table 6 and is plotted on the map in Figure 7.

Table 6: Location of Version B joint admissions in the UK at September 2012

ENGLAND	WALES	SCOTLAND	NORTHERN IRELAND
Birmingham	Cardiff	Aberdeen (1 bed annex)	
Bournemouth		Elgin (1 bed annex)	
Bracknell (Ascot)		Glasgow	
Bristol		Larbert (2 bed unit not in use)	
Chelmsford, Essex		Livingston, West Lothian	
Derby			
Eastbourne			
Leeds			
Leicester			
London (Kent)			
London (Acton)			
London (Hackney)			
Manchester			
Morpeth, Northumberland			
Nottingham			
Staffordshire			
Welwyn Garden			
Winchester			

The data obtained for the number of specialist mother and baby units at September 2012 are accurate to the best of knowledge of experts in the field.

FIGURE 7: Locations of facilities for joint admissions in the UK at September 2012



Location of Version B mother and baby units in September 2012

Infant: 2 views
 Created on Aug 5, 2012 by - Updated Oct 16, 2012

- Abandon
- Ascot, Bracknell
- Birmingham
- Bournemouth
- Bristol
- Cardiff
- Chelmsford, Essex
- Derby
- Eastbourne
- Elgin
- Glasgow
- Lebert (not currently in use)
- Leeds
- Leicester
- Bethlem Royal Hospital, London
- Combe Wood, Acton, London
- Hackney, London
- Wythenshaw, Manchester
- Morpeth, Northumberland
- Nottingham
- Staffordshire
- Welwyn Garden City
- West Lothian
- Winchester

It is known that the individuals in a social system do not all adopt an innovation at the same time (Rogers, 2003. 267). After knowledge of an innovation's existence is obtained, the length of time an innovation takes to diffuse is dependent on several variables that determine the rate of adoption of an innovation. The study evidence is considered and presented against several of the variables identified by Rogers (2003. 222) below:

- i) Perceived attributes of the innovation
- ii) The type of innovation decision employed
- iii) The communication channels involved
- iv) The nature of the social system involved.

7.4 Attributes of the innovation of joint mother and baby admissions and the rate of adoption

From research it is known that certain perceived attributes of innovations are indicative of how rapidly the innovation will be adopted (Rogers, 2005. 15-17). Rogers identified five characteristics of innovations that predict the rate of the adoption of the innovation, dependent upon individual perceptions of each of the characteristics or 'attributes'. These five attributes are: relative advantage, compatibility, low complexity, trialability and observability. The attributes of the innovation of joint admissions detailed in Version A and Version B in Table 4, are presented below. It should be noted however that generalisations about the attributes are provided below. 'Perceived' attributes may vary from adopter to adopter as perception is not a definitive fact but an attitude or impression one gets from their observations.

7.4.1 Relative advantage

This is the degree to which an innovation is perceived as better than the idea it supersedes. The important factor is whether an individual perceives the innovation as advantageous (Rogers, 2003. 15). The decision whether or not to adopt an innovation is influenced by the ability of the potential adopter to judge whether the benefits of using the innovation will outweigh the risks of using it. The

more benefits people anticipate from adopting the innovation relative to what they already do, the more rapidly it will be diffused (Cain and Mittman, 2002).

The alternative to joint admissions was for women to be treated in hospital, separated from their infants who would be cared for elsewhere by a family member or surrogate (Howard, 2000). There would be differing perceptions as to whether or not the practice of joint admissions was more advantageous to previous practice or not. Early in the diffusion pattern it was not common practice for children even to briefly visit their mother in any type of hospital. Main (1958) stated there were various reasons why this was the case:

“The reasons vary: a sick woman should not be bothered by children; children increase the risk of infection in a hospital; they are too noisy and disturb other patients. Such reasons are based on the partial truth that children are a nuisance; but others are based on a different half-truth – that the children will be harmed. People say that a hospital for sick adults is no place for a healthy child; that a visit or stay there will prove disturbing to it; that it cannot get from a sick mother the attention it should have; and that it would be better with its granny” (Main, 1958, 845).

These were widely held views at the time both Version A and Version B were introduced so admitting a child to hospital with its mother was indeed innovative.

7.4.2 Relative advantage: Version A

For those women with neurotic disorder described by Main (1958), one can identify the practical advantages of women being able to be admitted to hospital with their child. They could continue to be the main carer for the child whilst receiving support from nursing staff and inadvertently from other patients in the ward. They would not have had the worry of trying to identify suitable alternative child care arrangements, which in some cases would have involved foster care as it was noted that other family members were not always available (Main, 1958; Kumar et al., 1995).

Having this flexibility would have made it easier for women to agree to hospital admission on an

informal basis when previously they may have been reluctant to leave their young child at home, thus it is probable that it was easier for psychiatrists to treat such women.

There were also only minimal additional costs involved in the adoption of Version A for the hospital so the need to identify additional finance was not necessary and costs therefore would not have been a barrier to adoption of Version A.

The issue of risk in terms of the safety of the infants was considered to be low early in the diffusion pattern although notably there is no evidence of any objective measurement in terms of how this conclusion about the degree of risk was reached and is likely to have been based on subjective judgements (Main, 1958; Baker, et al., 1961). This factor changed over time, however, after evidence emerged in the late 1960s, 1970s and 1980s of potential and actual risk to infants (Hamilton et al, 1969; Bardon, 1977; Lindsay and Pollard, 1978; Sneddon et al.,1981; Margison and Brockington, 1982; Brockington, 1996). The issue of risk is considered in more detail in the analysis in Chapter 8.

One can therefore identify how the innovation in Main's (1958) example could be perceived by peers as beneficial in terms of the relative advantage early in the diffusion pattern, a perception which seems to perhaps have changed after the publication of the incidents of death and harm and the introduction of clinical governance in health care policy in the late 1980s and early 1990s. Probable and possible causation is explored further in Chapter 8.

7.4.3 Relative advantage: Version B

In Version B early in the diffusion pattern it was women with psychosis who were admitted to the specialist units. The perception of relative advantage would have been influenced by the judgement of risks involved in adopting the practice much earlier in the diffusion pattern with this particular client group. At the time the practice was introduced there was a strong belief that women with

psychosis were a direct risk to their children and puerperal schizophrenia was considered to have a bad prognosis, so the normal practice was therefore to remove the children from their mother's care (Howard, 2000). The introduction of Version B of the innovation was far more daring in terms of perceived risks as it was going against strongly held beliefs and practice that had been around since at least the nineteenth century (Howard, 2000). As previously mentioned, it was not only in mental hospitals that mothers were separated from their children, but any hospital. Main (1958) had described how at the time,

“it was not thought proper for children, especially young children, to go to see their sick mothers even on visitors' day” (Main, 1958. 845).

However, when the positive outcomes from Version B of the practice of joint admissions were presented the balance of risks may have been considered as being relative early in the diffusion pattern before the evidence of harm referenced above, became evident. The paper published by Douglas (1956) evidenced that their hypothesis had been proven: women had a much reduced incidence of relapse, were able to continue to care for their child after going home from hospital, and there were no particular concerns about the safety of the infants as there was the support of the paediatric nurses on hand during the period of admission. The women were also monitored for a period after discharge from hospital to monitor for signs of relapse or for any issues with their child care. The practice would presumably have been thought to have long term positive implications for the health and welfare of the children as they were not subject to the detrimental effects of separation that had earlier been evidenced by Crandall (1897) Spence (1925), Spitz (1945) and Bowlby and colleagues (1952).

Most individual general adult psychiatrists will only encounter a handful of patients with severe postnatal illness throughout their careers due to the relatively small incidence of severe postnatal disorders requiring hospital admission in a geographic area. This is likely to make it difficult for the majority of psychiatrists to see the demand or need for such services and therefore may not see

specialist mother and baby units as having relative advantage. Where psychiatrists specialise in the field of perinatal psychiatry, the relative advantage of facilitating joint admissions is far more evident to them as they are routinely dealing with more women and families who potentially could benefit from the innovation and who they would have difficulty in caring for informally if joint admission was not available.

A further factor of relevance to the ability to judge relative advantage from the evidence is the limited research on effectiveness of the practice of joint admissions. There is a general notion amongst the professionals in the field that joint admissions are a good thing to do however there has not been a great deal of research published that actually evidences the effectiveness of the provision of Version B which is perhaps a barrier to NHS service planners and commissioners seeing the relative advantage of such services. It is known that specialist mother and baby units are significantly more expensive to provide in comparison to Version A of the practice or to admit the women to hospital without their babies. The absence of economic evaluation of Version B is also a barrier to perceived relative advantage. These factors are considered further in Chapter 8.

7.5 Compatibility

This attribute is described as the degree to which an innovation is perceived as being consistent with the existing values, past experiences, and needs of potential adopters (Rogers, 2003. 15). The more an innovation can integrate and coexist with practice and social patterns already in existence, the greater its prospects for adoption and diffusion (Cain and Mittman, 2002).

7.5.1 Compatibility: Version A

In Main's example of joint admissions of women with neurotic disorder, he described how the practice was not initially difficult to facilitate within the adult psychiatric ward setting. At the time the hospital were experimenting with the concept of the 'hospital community'. This was to try to make the mental hospital less of a social vacuum from the stresses and strains of domestic and industrial

life and more of a place of treatment where patients were kept in touch with their responsibilities and occupations. For women, childcare was considered at the time to be 'her job' and her children were part of the stresses and strains of domestic life (Main, 1958. 845). The practice of joint admissions was therefore compatible with society's thinking and the position of women in society at that time but this thinking has changed in recent decades.

The practice was also compatible with the experimental approach and existing values evident within the hospital at the time of its introduction. The 'therapeutic community' was an experimental concept described in a publication by Main in 1946. This concept was a more democratic, patient-led form of therapeutic environment with the central philosophy being that the patients were active participants in their own and each other's care and treatment. They also actively participated in the day-to-day running of the ward environment or 'community', sharing responsibility with the staff (Main, 1946). In theory, the practice of joint admissions would have been easy to integrate and coexist as part of the therapeutic community model. There would have been potential for joint admissions to diffuse as an integral part of the diffusion of the model of the therapeutic community which was adopted in several areas in the UK in the 1960s.

The perception of the attribute of compatibility has varied across disciplines and has changed over the time frame of the diffusion pattern. Differing perceptions of attributes would not be unusual in large organisations where there are large groups of staff and disciplines with differing perspectives. There is evidence from oral history and personal experience that nursing staff in many areas felt the practice of joint admissions to side rooms in admission wards was less compatible with their experience of being responsible for the care of the babies in the potentially volatile environments that general adult acute admission wards can be. The nursing staff were tasked with ensuring the safety of the child, an insurmountable task given the nature and the function of the wards and the mental state of some of the patients therein. The nursing staff however had less influence than psychiatrists in terms of decision making. It is also known from personal experience and oral history

that concerns about the safety of the practice from the child's perspective expressed by nursing staff, were often disregarded, or perhaps were not fully appreciated by those who were not responsible for providing the direct care and protection for the babies on an hour by hour basis. As evidenced in the history the practice of side room admissions continued in many areas until very recently despite many nursing staff being apprehensive or concerned about it. Version A therefore was no longer compatible with modern nursing values, past experiences and social patterns during the last 15 years or so.

7.5.2 Compatibility: Version B

The Version B innovation of joint admissions provided by Douglas (1956) for women with psychosis is likely to have been perceived as less compatible with the existing values and past experiences at the time of its introduction. As previously mentioned, women with psychosis were considered to be a direct risk to their infants' safety. Introducing joint admissions with this particular client group was not therefore compatible with these strongly held beliefs, previous experiences and practice. Paediatric nurses were included as an integral part of the clinical team, to ensure the needs of the infants were being met when the mother was too distressed to do so herself and to lessen the degree of risk of harm. This inclusion is likely to have increased the compatibility of the innovation but this would have been a more expensive option as paediatric nurses would have had to have been on duty in the ward at the same time as psychiatric nurses. One would expect that views on compatibility would have varied between individual clinicians in the early days of the practice being introduced. The evidence of the positive outcomes of the model of care and treatment is likely to have influenced the early adopters such as Baker and colleagues (1961), who also admitted psychotic women with their babies and referenced Douglas's work in their own publication.

In modern times there is possibly more of a perception of compatibility of Version B with today's values, past experiences and social patterns but this is variable. Practitioners in the field of perinatal mental health care will regard specialist units as compatible with their values, past

experiences and knowledge of social patterns, however, for those not directly involved in the delivery of specialist services there are still concerns with some areas of this practice due to the evidence that where Version B is provided, it is not homogenous across service areas and until the last few years there were no standards for practice within the specialist units. The slow rate and frequency of adoption and the frequency of rejection of this version of the innovation is an indicator that the attribute of compatibility is perceived ambiguously.

7.6 Low complexity

Complexity is defined within the diffusion of innovation theoretical framework as the degree to which an innovation is perceived as difficult to understand and use. New ideas that are simpler to understand are adopted more rapidly than innovations that require the adopter to develop new skills and understandings (Rogers, 2003. 16). Perceived complexity is likely to be a barrier to adoption.

Both versions of joint admissions are perhaps a more complex innovation than first perceived, and this possibly contributes to the variation that has been evidenced in the implementation of each version of the practice. Mental health nurses who are the predominant care givers in terms of time spent with the patient, and inevitably the mother-infant dyad, are ill-prepared during undergraduate training for the specialist field of practice unless they are one of the very few who have access to a clinical placement in a specialist unit (NHS Education Scotland, 2006).

7.6.1 Complexity: Version A

Version A of the practice is unlikely to have been viewed as complex during the early introduction of the practice. It was initially a very pragmatic solution to make it easier for women to be admitted to hospital and there were no other drivers or aims of the practice that are likely to have been perceived as complex. The perceived low complexity of side room and annex admissions would have been a factor in Version A of the innovation being adopted more frequently than Version B.

Later in the adoption pattern there is a possibility that the perception of complexity changed in response to increased knowledge and understanding of child protection issues and the increased focus of risk assessment and management with the advent of clinical governance in the late 1980s and early 1990s. A further consideration that may have affected the perception of complexity of side room and annex admissions was the shift in policy focus to more community based care and a reduction in hospital admission beds in the 1990s. This essentially meant that those patients who were admitted to the fewer available beds tended to have more severe presentations of illness, more complex behaviours and more complex issues of management. With this shift in the ward milieu it would have been more difficult to ensure the welfare and safety of the babies and thus Version A of the practice gradually would have been perceived over time as becoming more complex than originally perceived. It was evidenced that there were differing views among clinicians on the complexity of side room admissions versus those to specialist units (see correspondence by Pandita-Gunawardena (1986. 190) in response to the article by Shawcross and McRae, (1986) in the Bulletin of the Royal College of Psychiatrists).

7.6.2 Complexity: Version B

Most qualified nurses or other staff that work in specialist units have very little prior experience or no experience at all of joint admissions. Services in the form of Version B have not been widely provided therefore those providing the educational and academic experience to undergraduate nursing students and postgraduate practitioners are even less likely to have had any clinical, theoretical or research experience in the field. Postnatal depression tends to dominate teachings as incidence of this illness is higher, however there is a wide spectrum of severity of this condition and again, very few of these patients are admitted to specialist units. Medical professionals, who have a predominant role in the treatment of the pathology of mental illness, likewise do not have frequent exposure to pregnant or lactating women with severe mental illness. Treatment packages for this group of patients can be particularly complex but unless nurses, psychiatrists and other

professionals specialise in the field of perinatal mental illness and are able to work with a concentration of cases, they have infrequent opportunity to gain expertise in the field of practice.

Complexity also exists where the service 'sits' within traditional mental health service organisation within the NHS. Services are generally organised into 'adult' services for those aged 18-65 years and 'child and adolescent' mental health services (CAMHS) for those up to age 18 years. In the UK, specialist mother and baby units are managed under adult services. Interestingly, in France and Belgium specialist mother and baby units are predominantly provided within the child and family mental health services. Infant mental health is an emerging speciality within the NHS in the UK which has particular importance to the field of perinatal mental health care but is largely provided from within children's services. There has been a dominance of the bio-psychiatry model within adult services since the 1960s and it has only been in the last decade that there has been a strong revival of psychological approaches to treatment within adult service provision. Unless there are good joint working arrangements across professionals with the relevant expertise in working with adults, infants and families, using a combination of treatment modalities, care and treatment is at risk of not meeting the needs of all those affected by the presence of mental illness in the mother. In the UK this is a particularly complex challenge due to the existing organisation of services into either adult or child services when the focus of care and expertise should be from the perspectives of the collective adult, child and wider family. The operational delivery of the innovation is therefore not straight forward whether it sits either in adult or CAMHS services in the NHS.

7.7 Trialability

This is defined as the degree to which an innovation may be experimented with on a limited basis. The ability or opportunity to try an innovation before taking the decision to adopt or reject it is one way for an individual to give meaning to an innovation and to find out how it works under one's own conditions (Rogers 2003. 258). Trying out an innovation allows potential adopters to reduce their

uncertainty about the risks and benefits. Personal experience can have more weight than the presented evidence for or against the reputed benefits (Cain and Mittman, 2002).

7.7.1 Trialability: Version A

From the evidence it was identified that in some areas Version A was practised for a period of time before it was replaced in the same area with Version B. This would indicate that on some occasions Version A may have been adopted as a trial for Version B. This was not the case in all areas however as many areas adopted Version A but never adopted Version B. As evidenced in the history, the practice of side room admissions (Version A) diffused much more rapidly than the development of specialist units (Version B). Side room admissions had become common practice by the 1970s / early 1980s and continued in many areas until as recently as approximately 6 years ago. Version A was easier to implement as it largely did not involve modification to existing structures or changes in the function of existing services. It could be tried with minimal disruption to the existing service and required little in terms of additional equipment or resources. This attribute was therefore clearly evident in Version A of joint admissions.

7.7.2 Trialability: Version B

In the case of specialist units, they are difficult to trial without a high degree of difficulty as it requires the setting up of a specific unit with dedicated staff, infrastructure and other resources, which would have significant capital and revenue cost implications. There would also be a considerable degree of planning required in terms of the initial set up and continued operational running of the service. The cost implications are significant therefore the opportunity to trial Version B even for a short time as part of the innovation decision process before adoption is highly unlikely.

7.8 Observability

Observability is the degree to which the results of an innovation are visible to others (Rogers, 2003, 258). It is seeing how an innovation works by watching someone else use it and then acknowledging the innovation is safe and / or beneficial. The more obvious the evidence of improved experience, increased functionality and better outcomes, the more likely it will be adopted by new users (Cain and Mittman, 2002). The lack of published research on effectiveness of mother and baby units is likely to be a major factor in the observability attribute of the innovation. The early case series publications describe the practice in detail in examples of Version A and Version B however the evidence of effectiveness is largely not available and therefore not visible to potential adopters.

7.8.1 Observability: Version A

Version A of the innovation would have generated a large audience as it was delivered in a considerable number of hospitals which would have influenced the knowledge spread of the innovation. The more clinicians who observed the practice of side room admissions the more likely it was that they too would have believed they could also introduce it or could participate in its implementation. This attribute was therefore likely to have been a factor in the more frequent adoptions of Version A than in Version B.

7.8.2 Observability: Version B

Throughout the published literature on joint admissions, from the early innovators through to the late majority, there have been repeated calls for more research to evidence the effectiveness of Version B in particular (Irving and Saylan, 2007). The cohort studies and case series provide some evidence of effectiveness but these were conducted many years ago. The descriptive accounts of the practice give some idea of what is involved and are likely to be helpful in generating a desire for more information on the subject, but from a practical view point it is not easy for people to actually

witness the innovation in practice. The specialist units are diversely spread geographically, with a concentration in the south of England and the Midlands. The only way to observe the work of the specialist units would be deliberate, either by being placed there during training or by making a concerted effort to travel to one for the purpose of informing the decision making process. The opportunity to happen upon the innovation in the units by chance was therefore highly unlikely. For professionals in training, due to the small number of areas that facilitate joint admissions it is also not easy to get experience of this field of psychiatric care and treatment, therefore diffusion through the networks of trainee psychiatrists, nurses, nursery nurses, psychologists, allied health professionals and social workers is reliant upon the very few who get the training opportunities, rather than on the masses who do not.

7.9 Communication channels and influence

Communication is a process in which participants create and share information with one another in order to reach a mutual understanding (Rogers, 2003. 5). The exchange of information on the innovation is a communication process recognised as an important stage within the theoretical framework, indeed the decision to begin diffusing the innovation to an audience of potential adopters is viewed as the most crucial choice in the whole innovation development process (Rogers, 2003. 155). Not to communicate information of the innovation is termed 'gatekeeping' within Rogers' (2003) model. The S-curve model assumes that innovations spread via information transmitted by personal contact, observation and the geographical proximity of existing and potential adopters. This model suggests that the emphasis should be on communication, and on the provision of clear technical and economic information (Tidd, 2010. 14). Douglas and Main both took the decision to communicate with peers on the practice of joint admissions.

7.9.1 Communication channels: Version A

Main's presentation to the Royal Medico-Psychological Association (RMPA) and his publication in the Lancet in 1958 were ten years after the first joint admission apparently took place. The reason

for this apparent delay in him deciding to communicate on the innovation is not clear from the documentary evidence. It may have been due to the fact the practice was not introduced initially with any particular hypothesis as its basis. Main had not conducted any studies of the patients until 1955; therefore there were no reported outcomes or 'empirical findings' for him to share with colleagues before this date. It was this work from 1955 onwards that he presented to his peers at a professional meeting of the psychotherapy and social psychiatry section of the RMPA in 1958 and also published in a volume of the same UK professional journal that Douglas had published her work two years earlier.

The later publication by Fowler and Brandon (1965) focussed on Version A, which appeared in the same peer reviewed medical journal, has been quoted in many of the later publications in the history whereas the publication by Hamilton et al (1969) which was in a nursing and midwifery journal does not appear in any of the later evidence. We already know that psychiatrists had a greater authority and powerbase than nursing staff within the structure of the NHS in terms of decision making and influence and it was highly unlikely that psychiatrist colleagues regarded nursing and midwifery journals as sources for their own education or learning. Despite the fact that one of the authors, Hamilton, was a consultant psychiatrist, the report of the work at Glasgow does not appear to have had much influence on the diffusion pattern. This would indicate that the choice of professional journal used to communicate with peers was significant to the future spread of knowledge of Version A.

7.9.2 Communication channels: Version B

Douglas (1956) took the decision to communicate the development of Version B within a respected professional peer-reviewed journal. The fact a journal is peer-reviewed implies a level of quality of the work that has been accepted for publication. It is probable that Douglas's publication in 1956 may have influenced Baker and colleagues' presentation of their preliminary report to the Zurich International Congress in 1957 and their own publication in the same peer reviewed journal as

Douglas (Baker, et al., 1961). It is probable that both of these communications may have influenced Main to communicate and publish his own work in 1958. The combination of the publications and presentations at local and international networks clearly has significant relevance to the further diffusion of Version B to other parts of the country and also to America as there would have been little opportunity for people to observe the innovation for themselves due to the early adopters being concentrated in the London area.

The geographical proximity of the adopters between 1948 until the early 1980s has been plotted from the evidence identified in the history and is illustrated in Figure 8. The adopters of both Version A and Version B in the first 30 years of the diffusion pattern have been plotted on the map in Figure 8 in sequence of their adoption to help illustrate the extent and geographic spread of the communication channels. Each version of the practice has not been illustrated separately. Data that was produced by Brockington (1996) and has been replicated in Figure 9 which also included a combination of Version A and Version B and Figure 8 has been included on the following page in order for a comparison to be made between the two sets of data.

FIGURE 8: The sequence of the diffusion of Version A and B joint admissions across the UK 1948-1981



Just five years later, the practice had diffused much further as was evidenced in a map provided by Brockington (1996) with plotted locations of joint admissions as identified by Aston and Thomas (1986). The map, already presented in Chapter 3 has been replicated again below to enable a visual comparison to be made between the map produced in Figure 8 representing diffusion by chronological order up to 1981 and the visual representation of the diffusion of the innovation identified in the survey across England and Wales up until 1986.

FIGURE 9: Reproduced from Brockington (1996. 561) demonstrating the distribution of adopters of joint admissions in England and Wales, in 1985-86, as surveyed by Aston and Thomas (1986).



As evidenced in Figure 9 in 1985-1986 there was a concentration of provision of Version A and Version B in the London area and also in the Midlands in the main, but diffusion across England and Wales was relatively widespread. The north of England has evidently fewer adopters.

Unfortunately there is no data available for Northern Ireland or Scotland for the same time period, with the exception of the information on Version A of the practice in Glasgow from 1966-1969, although as previously mentioned, from personal experience it is known that side room admissions were wide spread in Scotland.

Due to the uneven and diverse geographic spread across the UK, it is more difficult for potential adopters to observe the practice or have personal contact with earlier adopters, and the emphasis for successful diffusion therefore falls on communication of the practice through various media. The London area is a densely populated area where communication channels and networks can be formed easily with opportunities for personal contact with peers, for observation of the practice and as can be seen from Figure 8 and Figure 9, the geographical proximity of adopters has had a clear impact on the diffusion of services in the London area and the slower diffusion in the north. The evidence confirms in the early years after each version of the innovation was developed, knowledge of the practice of joint admissions was spread through word of mouth, presentations at professional meetings, the international congress in Zurich and through publication in professional journals.

Diffusion networks are interpersonal networks where subjective evaluations of an innovation flow and in this study it has been identified that professional networks have been of particular relevance to the diffusion of joint admissions. At the centre of the diffusion process there is modelling and imitation by potential adopters of their peers experiences with the new idea. In deciding whether or not to adopt an innovation, individuals depend on the communicated experience of others much like themselves who have already adopted a new idea (Rogers, 1996. 331). This would be true of those networks detailed in the evidence: the Royal Medico Psychological Association (RMPA), the Marcé Society and the Perinatal Section of the Royal College of Psychiatrists which have been identified in the history as influencers to the diffusion pattern.

In summary Chapter 7 has focussed on the presentation of the findings of the study using the diffusion of innovation theoretical framework (Rogers, 2003) to guide the presentation of the results. The versions of the innovation of joint admissions were identified in the history were side room admissions, admissions to annexes within larger wards and specialist mother and baby units. The findings for each version have been presented as Version A (side rooms and annexes) and Version

B (specialist mother and baby units). The diffusion curves for each version of the innovation have been demonstrated to have followed an unusual pattern. The findings have included some preliminary analysis but further interpretation and analysis of the results within the framework of diffusion of innovation (Rogers, 2003) is provided in more detail in Chapter 8.

CHAPTER 8: ANALYSIS OF FINDINGS

8.1 Introduction

Evidence and results have been interpreted within the context of the diffusion of innovation framework (Rogers, 2003) which informs the development of the argument around the subject. To try to answer why each of the diffusion curves do not follow the pattern of a normal diffusion curve the influencers from the theoretical framework are considered below. An analysis of the findings presented in Chapter 7 is provided below.

The influencers are considered in two groupings:

- 1) Influences in the inner context of the units of adoption, which are focussed on the innovation itself and the social system and sub systems of actual or potential adopters.
- 2) Influences from the outer context, which are focussed on policy and external influences on decision making.

8.2 Analysis: Inner context influencers

Throughout the evidence in the identified history of Version A and Version B of joint admissions, psychiatrists dominate the literature. Disappointingly, nurses feature far less frequently or strongly in the published data in the history of joint admissions with only a couple of publications written by mental health nurses as co-authors. However, this perhaps is not surprising as generally nurses publish their work much less frequently than medical colleagues and joint admissions in particular have been a medically led innovation. The few publications in the history that have been authored by nurses have been co-authored by psychiatrists. Interestingly in the early publications psychologists and social workers feature more often than nurses as co-authors. The article by Hamilton et al (1969) included a very detailed and informative account of the nursing perception and experience of side room admissions however as previously mentioned, this article was not referenced in any of the later publications on the subject which would indicate the strong probability that knowledge of its existence within the field of practice was extremely limited. The influence of

psychiatrists in particular on the innovation decision process has therefore been identified from the history as an area that warrants further consideration within the inner context of influencers in relation to their role in influencing the decision making process in the adoption of joint mother and baby admissions.

8.3 Influence of individual psychiatrists on the innovation decision process

The innovation decision process in the context of diffusion of innovations is the process through which a potential adopter moves from gaining initial knowledge of an innovation, to forming an attitude towards the innovation, to making a decision to adopt or reject it, to implementation of the new idea, and to confirmation of the decision (Rogers, 2003. 168). The innovation decision process is much more complex within large organisations. Within the NHS there will have been several types of innovation decisions relevant to both versions of the practice of joint admissions. The implementation of an innovation usually involves a number of people and not everyone will be supportive of the decision to implement the innovation. Environmental and institutional characteristics of relevance to the decision making process include economic factors such as the market environment and sociological factors such as communications networks. The particular role of psychiatrists in the innovation decision process for each diffusion pattern is considered below.

8.3.1 Innovation decision process: Version A

Applying the diffusion of innovation theoretical framework (Rogers, 2003), the decision by Thomas Main to introduce joint admissions at Cassel Hospital appears to be an example of an optional innovation-decision. This innovation decision process is particular to individual adopters. The Cassel Hospital that was the location of the first introduction of Version A was in close geographic proximity to the hospitals of the innovator and early adopters of Version B. This close proximity would have facilitated local communication channels. This was confirmed by Main in his own publication (1958).

As evidenced, from the start of the NHS in 1948 until around the late 1970s psychiatrists who were medical superintendents or directors had a great degree of autonomy in their decision making. In accordance with the mental health legislation at the time mental hospitals were governed by the medical superintendent or director who was also the 'chief officer'. The other areas of the NHS had a voluntary hospital arrangement whereby each consultant was autonomous and medical policy was agreed collectively. This relative freedom within the NHS as an organisation for individual senior psychiatrists to make decisions would indicate that early in the diffusion pattern, the decision to adopt the practice and the subsequent implementation would not have been particularly complex. This position changed over time however, precipitated by a change in policy through the Cogwheel Report (Ministry of Health, 1967) and the strengthening of the nursing position within the management structures.

By the 1970s the position and authority of medical superintendents was phased out in England and Wales through the revision of the mental health legislation, although they continued in Scotland for several more years. When the NHS was reorganised in 1974 separate management committees for mental hospitals were abolished and mental hospitals came under the same administration bodies as general hospitals (Department of Health and Social Security, 1971). The general management model introduced in 1974 put an end to consultant psychiatrists autonomously developing local services as they had chosen, although the psychiatrists did continue to be influential to a lesser degree within the new NHS mental health care system (Freeman, 1999. 15) and had a relative degree of autonomy for the direct clinical practice and clinical models within individual wards. This would perhaps contribute to the causation of the continued increase in frequency of adoption of Version A until around the 1990s in the timeframe of the diffusion pattern although this cannot be confirmed with documentary evidence.

8.3.2 Innovation decision process: Version B

The decision to introduce Version B of the practice at West Middlesex Hospital by Douglas and colleagues was likely to be an example of collective innovation-decision making. Baker and colleagues (1961) were the first early adopters of Version B of the innovation and they applied the findings and recommendation from Douglas' (1956) research to their own studies of women with puerperal schizophrenia. Baker and colleagues went further and followed through on Douglas' recommendation, developing a specialist unit specifically for joint admissions in 1959. Baker was a deputy physician superintendent which implied he was in a strong position of authority. In their publication Baker and the fellow authors acknowledged the support of the Regional Hospital Board and also thanked the Hospital Board for the financial help they received from the research subcommittee for their work around joint admissions and the development of the unit at Banstead (Baker et al 1961. 239). Another early adopter of Version B, Glaser (1962. 59), acknowledged her gratitude to the Medical Superintendent and a fellow consultant psychiatrist, *"for their unfailing help and encouragement in the execution of this work"* in her publication of the work at Shenley Hospital between 1956 and 1960.

The two groups of adopters of Version B above clearly had internal and external support at a very senior level for the implementation of the specialist mother and baby units. The decision making in the adoption of the innovation by Baker and colleagues was likely to have been an authority innovation-decision. They presented a preliminary report of their work to an international audience at a congress on psychiatry in Zurich in 1957 (Baker et al, 1961. 237), thus spreading knowledge of the innovation further to other psychiatrists out with the UK. It is highly probable that it was through this communication that American psychiatrists gained knowledge of the practice as it was early in the 1960s that the first examples of joint admissions in America were reported on. The diffusion of the innovation of Version B was therefore in motion quickly after the innovation was first communicated. This was a very short timescale in terms of length of time between the development of the innovation, knowledge of the innovation spreading, the decision being taken to implement,

and the subsequent implementation of the innovation. An important factor to this early adoption is likely to have been the very close geographic proximity of the early UK adopters to the location of the hospital where the innovation was developed, with all three units notably being in West London, so it was highly likely communication networks existed in the area. After this time the shift of power in decision making in the 1970s referred to in the section above made it much more difficult for individual psychiatrists to go ahead and change the function of hospital wards to implement psychiatric mother and baby units and this perhaps forced psychiatrists to find alternative ways and develop alternative skills to enable them to continue to influence service developments from the late 1970s onwards.

The evidence for both Version A and Version B clearly demonstrates that during the first 25 years of each of the diffusion patterns, decision making was at a very local level and the time taken between knowledge of the practice, decision to adopt, and implementation was extremely quick, apparently only months rather than years. The evidence would suggest that from the mid-1970s onwards, the rate of adoption of Version B slowed whilst the frequency of adoption for Version A appears to have increased until changes in policy specific to joint admissions in the late 1990s and 2000s.

The general reduced autonomy for decision making at local level is the probable explanation for the evidence that there has been greater involvement of psychiatrists from the late 1980s onwards in attempting to influence national policy on the issue of joint admissions. Since devolution in the late 1990s, health policy has largely informed and directed service. Individual psychiatrists are no longer in a position to make independent decisions about services as decisions are now made by executive management boards or regional planning groups (of which psychiatrists are likely to be members but with equal authority to other members of the group as a collective). Decisions often now also have to be rubber stamped by the respective government as confirmation that the plan is in keeping with national priorities and strategic direction. The decision making process has largely

turned on its head from being one of 'bottom up' to now being 'top down' which has moved the emphasis of influence from local level to the level of national policy decision making. The policy agenda theme is considered in more detail later in this chapter.

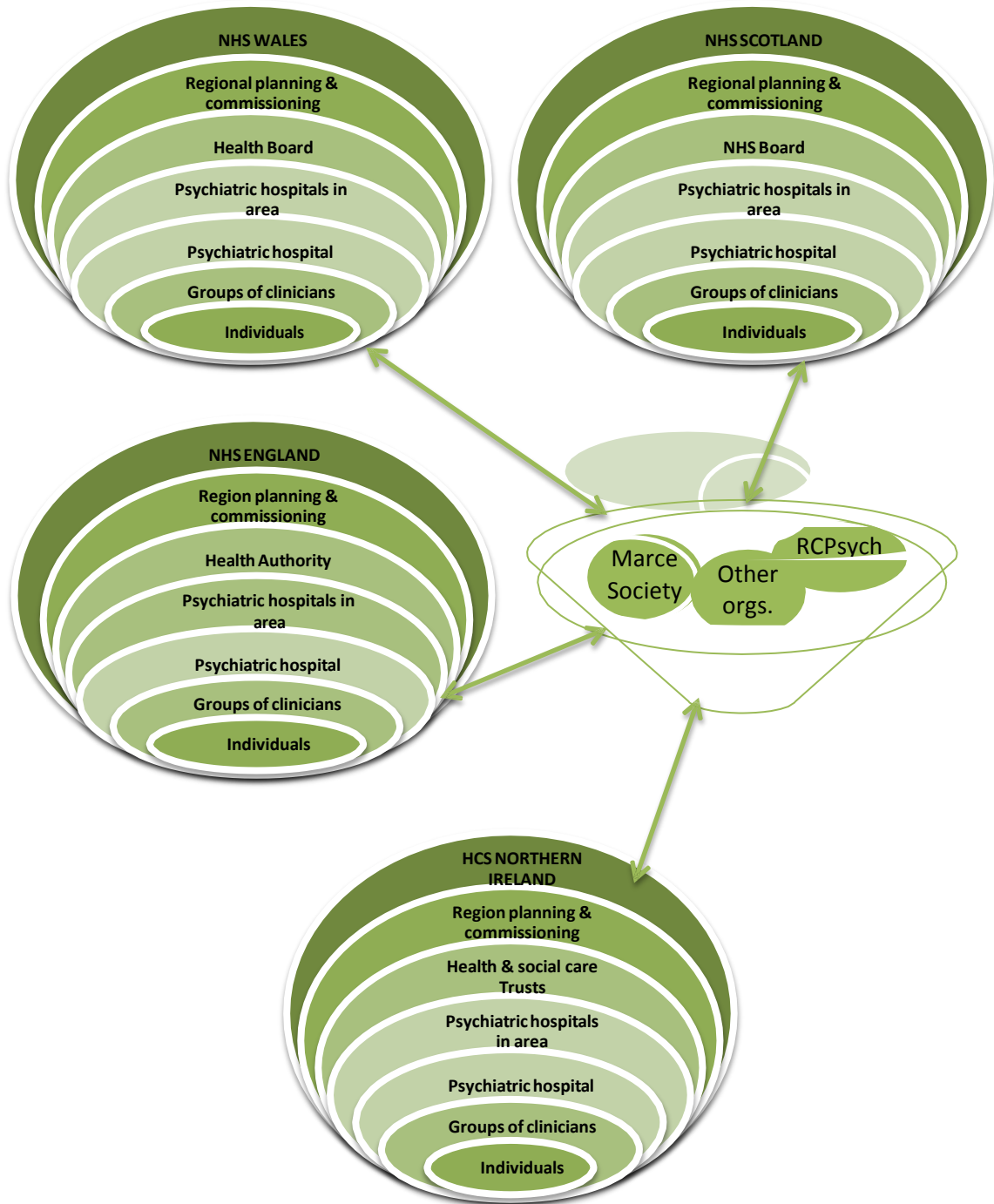
8.4 The influence of the NHS as a social system

A social system is defined as a set of interrelated units that are engaged in joint problem solving to accomplish a common goal. The members or units of a social system may be individuals, informal groups, organisations and / or subsystems (Rogers, 2003. 23). The sharing of a common objective binds the system together. The social system in this study was multifaceted and the units of adoption in this study were therefore not straightforward and can be viewed on several levels. The original innovators of each version of the practice of joint admissions may be viewed as individual adopters. An important factor in the early adopters was the position of the individuals within the social system in terms of decision making and authority. Between 1948 and the early 1970s in psychiatric hospitals what happened in local practice depended entirely on local personalities, and on who could obtain support of the Hospital Management Committee (Freeman, 1999. 3). The evidence from Freeman (1999) confirms that psychiatric hospitals largely operated independently of each other and individual psychiatrists had a great degree of autonomy within the NHS system up until a change in health service management of mental hospitals in the 1970s.

The social connections between the innovators and early adopters appear to have been social systems external to the NHS such as the RMPA which later became the Royal College of Psychiatrists and the sub system of the Perinatal Section. The Marcé Society was also pivotal in the knowledge exchange between individual psychiatrists and psychoanalysts. In diffusion networks it is known that doctors tend to operate in informal horizontal networks and horizontal networks are known to be more effective for spreading peer influence. Nurses on the other hand more often have formal, vertical networks which have been evidenced to be more effective for passing on authoritative decisions (West et al, 1999).

Individual adopters, however, are members of the wider social system of the NHS. Individual psychiatrists work within hospitals. Each hospital is part of a network of hospitals within NHS Boards, Health Boards, Health Authorities or Health and Social Care Trusts areas that deliver the health care in a region. Furthermore, each region is part of the NHS in each of the four areas of the UK. The 'NHS' as an umbrella organisation for either England, Scotland, Wales or Northern Ireland can therefore also be viewed as units of adoption at a higher level. The layers of the social system and adopters are illustrated in Figure 10:

FIGURE 10: The social system of the NHS in the UK as units of adoption of joint admissions



Since the change in the hospital management systems in the 1970s the social systems layered within the NHS are much more interconnected than they were in the earlier diffusion pattern. This is evidenced through the introduction of the regional planning groups, systems for national quality such as the organisations Healthcare Improvement Scotland and the National Institute for Health and Clinical Excellence in England. A much greater focus on target setting and performance monitoring by the respective Governments in each area of the UK has also enforced a system of central planning and decision making as opposed to the earlier ad hoc local decision making processes. These changes have had significant influence over how services are diffused within the UK healthcare system. Most of the specialist units developed in the last 10 to 15 years have been developed as regional services, involving agreement and decisions to be made across more than one Health Authority / Health Board / NHS Board. The influence of these factors on the rejection of Version A has also been significant and is considered later in this chapter.

Greenhalgh et al (2004) identified that the various influences that help the spread of an innovations lie along a continuum between pure diffusion and active dissemination. Pure diffusion involves the spread of the innovation being unplanned, informal, decentralised and largely horizontal or mediated by peers. Active dissemination on the other hand is when the spread of innovation is planned, formal, often centralised and likely to occur more through vertical hierarchies (Greenhalgh et al., 2004. 7). The history indicates that in Scotland in particular there has been a shift in the paradigm from one of service diffusion to one of service dissemination through the introduction of legislation in 2005 which put a legal responsibility on NHS Boards to provide services for joint admissions across Scotland. Implementation of the Act (Scottish Executive, 2003a) is monitored through the Scottish Government and Health Boards are now specifically required to report on progress with this requirement of the Act. This appears to have been the definitive influence on the development of facilities and specialist units in Scotland. Similarly, the development of evidence based guidelines such as the SIGN guideline in Scotland (SIGN, 2002) and the NICE Guideline for England and Wales (NICE, 2007) also affects the balance between diffusion and dissemination.

Recommendations from these guidelines are disseminated downwards through the layers of the NHS social system with a requirement for implementation at the point of service delivery and clinical practice. There are therefore multiple social systems and various layers of social system operating as internally to the NHS in the UK that have been influential to either the adoption or rejection of both versions of the innovation of joint admissions. The social systems external to the NHS are considered later in this chapter.

8.5 Research and development

In this study two versions of the same innovation were developed in what appears to be parallel time periods but as a potential solution to the recognition of differing needs and problems as evidenced in Table 4. Innovation development happens as people exchange information about needs and possible solutions to them (Rogers, 2003. 144). From the available primary and secondary evidence it is not conclusive that informal verbal communication between Douglas and Main, the two innovators, on their respective identification of the problems and their ideas for solutions early in the process did not take place. The two hospitals in which the practice was developed were geographically close in proximity in Surrey so there is a possibility that they were aware of each other's ideas but there is no documentary evidence to this effect. There is, however, confirmed evidence that communication did take place between them after implementation of the innovation, when Main confirmed he had consulted Douglas about her work with women with psychosis and also referenced her work in his own publication (Main, 1958). Rogers identified that the recognition of need often leads to research and development activities that create an innovation aimed at solving the problem or addressing the identified need (Rogers, 2003. 137). Research and development does not necessarily always accompany innovation development however. It is acknowledged that some health care innovations that have little evidence base are widely adopted whilst, in comparison, others with apparently stronger scientific support remain less successful in terms of adoption (Denis et al., 2002).

8.5.1 Research and development: Version A

The development of Version A joint admissions was not driven by the testing of any formal hypothesis, but was a pragmatic solution for the need for child care to facilitate the admission of an adult patient, the child's mother. This version of the innovation was more serendipitous than deliberate research and development. Serendipity is not unusual in the development of innovations and indeed, within the medical field, the discovery of Penicillin was one such serendipitous innovation that had dramatic and long standing impact (Rogers, 2003. 163). Main and colleagues did not actually conduct any research or evaluation of joint admissions until several years after its first introduction and he had himself rejected Version A and adopted Version B by 1955. He reported that it was not until 1955 that the realisation of the potential benefits of the practice led him and his team to start studying outcomes. His reported findings provided a different perspective to those already presented.

Later research on Version A is largely limited to case series reports (Fowler and Brandon, 1965; Hamilton et al., 1969). There has been considerable research conducted on tracing the research and development phases of the innovation development process. 'Tracer' studies, as they are known, are retrospective qualitative studies that reconstruct the sequence of main events and decisions in the innovation development process (Rogers, 2003. 161). Although tracer studies have some weaknesses being reliant on retrospective information, it is worth noting that findings show that innovations take an average of nineteen years from first conception to first realisation (Globe et al, 1973). The very origins of the idea of joint psychiatric admissions in Version A came from Spence's work in 1925. It was 1948 before the first reported joint psychiatric admission which was approximately twenty three years later. This is slightly longer but largely in keeping with the reported average for realisation of innovations as solutions to identified need or problems.

8.5.2 Research and development: Version B

In contrast to Version A, the identified need in Version B of joint admissions by Douglas and colleagues (1956) led to them trying to find a treatment programme for women with psychosis that addressed their psychotic symptoms and their feelings of hostility towards their baby. Improved long term outcomes for the babies, in terms of their ability to form good relationships later in life, was a driver for their research. The main focus of the research was for mothers to be able to continue to care for their child after discharge from hospital without an increased risk of relapse (Douglas, 1956. 124). In this example (Version B, Table 4), research was an evident part of the innovation development process from the outset. Finding a solution for the identified problem led to the development of the practice and model of care. At the end of the publication Douglas made the recommendation that specific mother and baby units should be developed. This communication of the practice and recommendation for others can be viewed as the start of the diffusion pattern of the innovation.

Throughout the publications identified and included as evidence in the historical narrative there are repeated calls for 'more research' on the effectiveness of psychiatric mother and baby units yet there are still considerable gaps in the evidence base. It has been concluded that this appears to have been an influencer to the slow rate of adoption of Version B. The NHS has in the last 25 years been increasingly focussed on the delivery of evidence based practice and care. This ambition has been supported through clinical governance, the development of the respective NHS quality assurance bodies detailed in Appendix 1 and through the work of the evidence based guidelines development groups including SIGN and NICE. Business cases for new service developments are influenced by several factors including identified need, cost and evidence that the service or intervention will actually be worth investing in over a long term basis.

The types of studies that have been conducted in Version B are largely qualitative including case series reports and cohort studies with quantitative elements in some of the cohort studies and

surveys. The case series reports are largely detailed and some provide very good qualitative examples of where such service provision can have a major impact on the lives of women who are admitted to them, but they are few in number. The early research conducted by Douglas (1956) and Baker et al (1961) is particularly powerful in terms of possible benefits of Version B but it was conducted more than 50 years ago. There have been significant efforts made to address the variability of Version B across geographic areas in the last decade by recommending and monitoring standardised practice aimed at improving the quality of care delivered by services through the development of guidelines and the establishment and subsequent work of the Perinatal Quality Network. The standards developed by the Quality Network for mother and baby units are based on expert opinion in the absence of evidence from research.

The spread of both Version A and Version B of the innovation appears to have been a focus of enquiries with several surveys conducted, largely around the types of service being delivered, but less so in terms of the actual clinical model and interventions delivered within services. The dates of the various surveys have been presented earlier in Table 5 in Chapter 7. It appears that the authors who published the various surveys were trying to gain better understanding of the spread of the adoption of the innovation at points in time. Despite the lack of quality research in terms of effectiveness of joint admissions and long term outcomes for mother, child and wider family members in recent decades, the available 'evidence based' guidelines both recommend that Version B joint admissions should take place and specifically state Version A should not be practised (SIGN, 2002; NICE, 2007).

It is not known why the recommendations for further research made by earlier researchers have not been progressed. There may be several reasons for this. Taking into consideration the evidence and personal knowledge on the subject, the following are proposed as probable and possible reasons:

1. A possible reason is a lack of funding from internal and external sources to conduct research in this field. To attract research funding, the researcher usually has to have an established reputation in research. Early in the diffusion pattern, several of the authors of the published research were clinical academics so whilst working in both the clinical setting and the universities they would have had the time needed to conduct research and to write for publication. Clinicians not within clinical academic roles would have more difficulty in finding time to conduct research and to submit their research for publication which makes it more difficult for them to build up a research portfolio and reputation. Also medical colleagues are generally more interested in the pathology and treatment of clinical conditions and much of the research funding is provided by pharmaceutical companies so research into the effectiveness of joint admissions to psychiatric mother and baby units would not be a research area of interest that would attract funding from these companies. Funding for research from central Government is strongly linked to the political agendas and priority areas for health gain. It is unlikely that research funding to evidence the effectiveness of specialist mother and baby units would be viewed as a priority within the political agenda when there are areas of much greater health gain that affect much larger groups of the population than the relatively small numbers of people requiring psychiatric hospital admission after child birth;
2. Dependent upon study type, a probable explanation is difficulty in obtaining ethical approval due to the sensitive nature of the field of practice. It would be extremely problematic to attempt to conduct a controlled trial as it would be complicated by the many uncontrollable variables. This does not explain the lack of qualitative research however;
3. A further probable cause may be anxiety that there may be implications for litigation if negative consequences are identified in later years after the admission;
4. For those clinicians already involved in delivering services, because services have already been established in their own areas there may be an apathy to conduct research in this particular area of perinatal mental health care, having identified other priorities for research;

5. For those clinicians already involved in delivering services there may be a possible bias towards evidence that Version B is effective for fear that the service may be rejected by the organisation if effectiveness could not be evidenced due to the high costs of delivery of these services.

There is significant scope for qualitative research. It is acknowledged, however, that quantitative research is not easy to conduct in this area due to the many variables involved. It would be extremely difficult to adopt an experimental research design due to ethical considerations and it would also be extremely difficult to separate out impact of different influences in the variables across the patient groups, the babies and the wider family dynamics and relationships. That said there is clearly scope for more research on longer term measurable outcomes, particularly around the unknown impact of admission on child development and separation of the baby from the other family members.

Further research is also needed on what interventions may work best in the various aspects of care and treatment delivered as part of the whole purpose of the joint admission, however the evidence suggests that in some areas the purpose of the practice is still not clear or fully understood and admissions are arranged without clarity on the purpose of the admissions or what it is hoped will be achieved for the mother and separately for the baby during the period of the joint admission.

Research on cost effectiveness is also necessary to inform continued investment in existing services and the potential of further services being developed. In the current economic climate it is perhaps short sighted not to have robust studies of cost effectiveness and it leaves the specialist field of practice vulnerable in terms of sustainability of current services or to make the case for future service development.

The S-curve model suggests that the emphasis should be on communication and on the provision of clear technical and economic information (Tidd, 2010. 14). The findings from the study suggests that the lack of evidence on effectiveness of Version A or Version B joint admissions, the absence of economic analysis and the lack of identification of short and long term benefits for the women, children, family relationships and wider population health have been probable causes of the slow rate of diffusion of both versions of the innovation and this lack of evidence from research may also have implications for Version A being rejected in favour of Version B despite the lack of research evidence to support this drive.

8.6 Influence of perception of risk on the adoption of joint admissions

The consequence of the innovation is the final phase in the innovation development process and must also be considered in the decision to communicate an innovation. The consequences are the changes that occur to an individual or social system as a result of the adoption or rejection of an innovation (Rogers, 2003. 436). From the outset of the development of an innovation there is likely to be uncertainty and unpredictability around the consequences of an innovation in the long term, and in this study there appears to be a relationship between the consequences of the innovation itself and the risks associated with adoption of the innovation.

Risk has been defined as the possibility that human actions or events lead to consequences that harm aspects of things that human beings value (Kates and Kasperson, 1983; Hohenemser et al., 1983). Risk is identified by Greenhalgh et al (2004) as an additional attribute of relevance to the diffusion of innovations theory. They suggest that if the innovation carries a high degree of uncertainty of outcome it is less likely to be adopted (Greenhalgh et al, 2004; Meyer et al, 1997). A central finding of Denis et al (2002) is one in which within health service organisations an innovation's benefits and risks are distributed unevenly among the people involved and at different levels in the organisation. In addition, different people may have different degrees of power to influence the process of adoption as well as different individual appreciations of the same risks and

benefits. The more the pattern of benefits and risks surrounding the innovation maps onto the distribution of interests, values, and power of the actors in the adopting system, the easier it is to create a coalition for adoption and the faster the adoption process (Denis et al., 2002).

Risk can be viewed from different perspectives when applied to the practice of joint admissions. In this study the predominant elements of risk identified were a) the risk of harm to the infants, b) reputational risk to the organisation if an 'innocent' baby suffers harm, and c) financial risks to the organisation of adoption of joint admissions.

8.6.1 Risk of individual harm to infants

Assumptions are made that the introduction of an innovation will produce beneficial results for adopters but it may be difficult to predict the advantages and disadvantages in advance of its implementation (Rogers, 2003). The degree of unknown risk to the safety and welfare of the babies being admitted with their mothers is one potential danger and hence disadvantage to the practice. One must take into consideration the thinking at the time: orthodox opinion held that separation of mother and child was an aid to the woman's recovery and, furthermore, the women in Version B in particular were believed to represent a risk of physical and psychological harm to their babies because of their perceived feelings of hostility towards them (Grunebaum et al., 1975; Howard, 2000). The consequences could potentially have been severely damaging for the babies, the women and the hospital if the hypothesis that the women were not a direct risk of harm to their babies proved to be wrong.

The consideration of harm would have existed in the early introduction of the innovation but would also be a potential consequence for each potential adopter across the time span. Potential adopters would have sought reassurance that the potential risks of the innovation were negligible or manageable. The longer term effects or consequences of introducing the innovation of joint admissions would not have been known at the time the decision was taken by Douglas (1956) or

Main (1958) to communicate their work. As evidenced in the literature from the 1970s and 1980s, some years after the diffusion pattern was underway, babies could be seriously harmed or killed during the implementation of the innovation (Bardon, 1977; Lindsay and Pollard, 1978; Sneddon, 1981; Margison and Brockington, 1982).

The burden of proof is on the innovation to demonstrate its safety. This is challenged by those who advocate that innovation is important and instead there should be a risk or cost benefits approach to risk acceptance (Power, 2004. 20). The overall risk benefit ratios of joint admissions are difficult to assess due to gaps in outcome data. The evidence from the literature review would suggest that incidents of harm to infants during joint admissions has not been the focus of much research or open discussion in this field. The lack of collated data on the subject does not however mean that harm does not occur. Brockington metaphorically referred to the sense of foreboding felt by staff working in specialist mother and baby units, thus:

“The risk of harm to the infants hangs like a sword of Damocles over the heads of those who work in these units” (Brockington, 1996. 566).

The first reported account of direct risk to infants in Version A of the innovation was by Hamilton et al (1969). In Version B, Bardon (1977) reported the killing of one child and another 10 children who were exposed to physical violence by their mothers *“to a degree that caused concern”* during joint admissions. This last quote would perhaps indicate that there were incidents of violence of a degree not to cause concern which brings into question the subjectivity of severity of risk. An acknowledgement that such severe risk existed within the specialist units was not evident in the published literature on the subject up until that point. This was followed in the chronology by Sneddon et al (1981) who described how they dealt with the issue of risk of injury to the babies from other disturbed patients admitted to their three bed annex. Of the 48 mothers admitted to this unit, five had tried to injure their child on the ward.

A study by Margison (1981), referenced by Margison and Brockington (1982. 231), was the only study that specifically focussed on the subject of harm to babies during joint admissions. The subjective nature of the assessment of risk was clearly evident in the account given of the violent incidents which took place in the Manchester unit (Margison and Brockington, 1982. 231). Indeed, the assessment of severity of risk and resultant harm by these authors was arguably minimised and underestimated by what we know today of what constitutes harm and its effects on child health and wellbeing. Similar to Sneddon's findings (1981), more than eight per cent of children admitted during a five year period were subjected to an act of non-accidental injury, some infants experiencing more than one incident (Margison, 1981). From the list of incidents reported Margison and Brockington concluded that the incident where the child sustained a fractured skull was the only one in which an infant suffered injury. They go on to state that the results of the study:

"confirm that babies are at risk but that real injury is remarkably uncommon on these wards" (Margison and Brockington, 1982.231).

This judgement reflects the different views and thresholds for perceived or actual harm that were evident at that time in comparison to today's values and knowledge. Although there were reports of risk of harm in the publication by Hamilton et al (1969), as previously mentioned, it does not appear from the literature that this article was accessed by many in the field of practice. Despite it containing very detailed information on the clinical model delivered and the reporting of positive results of the research in Glasgow, the article is not referenced in studies published later in the history. The impact of the document therefore was not influential to the future diffusion pattern. It is suggested therefore, that it is more probable that the later emerging reports of actual harm to the infants during joint admissions that appeared in the literature over a five year period from the late 1970s until the mid-1980s had more influence. There is evidence that the published reports of harm to the babies had an effect on the perception of the practice of joint admissions across the social system. In 1982 Margison and Brockington wrote:

“At the present stage of uncertainty and unease about the safety of these units following the recent reports of two non-accidental deaths, there must be a period when admission of potentially dangerous mothers is viewed conservatively” (Margison and Brockington, 1982. 235).

After the mid-1980s the subject of risk of harm to the babies appears to disappear again from the published history with the exception of the later edition of Brockington’s 1996 book chapter. The third edition of the text *Motherhood and Mental Health* provided a summary of reported harm to the infants during joint admissions but went further to give consideration as to whether or not the risk was justifiable under the circumstances and possible alternatives. Brockington recommended that research should focus on the risks of joint admissions and, in particular, a comparison should be made between the risks associated with Version A and with Version B of the innovation (Brockington, 1996. 566-568).

The debate that Brockington (1996) raised about the potential risks to the babies if they were not admitted to hospital is the focus for potential adopters to make a judgement on risk benefit ratios. To do this, information on incidence of harm to infants whilst subject to joint admission must be considered within the context of risk of harm to infants in the general population. Studies conducted by Marks and Kumar (1993; 1996) estimated that the incidence of infanticide in England and Wales was 45 per 1 million of the population and in Scotland (although infanticide is not a legal definition under Scottish Law) the incidence was 43 per 1 million of the population. A recent publication by the National Society for the Prevention of Cruelty to Children (NSPCC) reported on government statistics collated from the four jurisdictions of the UK (NSPCC, 2011). They identified that infants under the age of one year account for between seven and thirteen per cent of child protection registrations across the UK with neglect recorded as the most common reason for infants being placed on child protection registers or made subject to child protection plans in England and Wales. They also identified findings from serious case reviews that showed physical assault, in particular

non accidental head injury, is the most common cause of maltreatment related death and serious injury involving infants (NSPCC, 2011). Compared to older children and adolescents, infants are disproportionately at risk of death or serious injury resulting from abuse or neglect (Connell-Carrick, 2003, Jordan & Sketchley, 2009). It is therefore clear that infants in the community in general are at higher risk during their first year of life and what cannot be measured are the incidents of harm to children that are avoided by the practice of joint admissions and women receiving proactive treatment for their mental illness.

The issue of direct risk appears to have been a greater drive in the rejection of Version A, as opposed to Version B of the innovation in recent years (NHS Executive, 2000; RCPsych 2000; SIGN, 2002), even though the reported evidence around adverse outcomes largely pertains to incidents in specialist units. Although from the documented evidence there appears to be higher incidence of harm in specialist units compared to side room admissions, this may be due in part to the concentration of admissions to these units rather than spread across general adult wards across the country. It also may in part be due to differing admission criteria for some of the units. It is known that some of the units specifically admit women for the purpose of parenting assessment where there are concerns from social work services in relation to parenting ability and the presence of mental disorder. These types of admissions would not have been facilitated within side room admissions within general adult psychiatric wards.

It does appear the focus on risk may in fact have been a lever used by 'champions' or 'policy entrepreneurs' within sub systems to deliberately drive the mass rejection of side room admissions in favour of specialist mother and baby units. This idea is discussed further later in this chapter. An example of this is the statement within the SIGN guideline that:

“There are concerns that admission of mothers with their babies to general psychiatric wards may not adequately ensure the safety and security of the baby” (SIGN, 2002).

A similar example of an external influence focussing on the issue of risk and side room admissions is the Royal College of Psychiatrists Council Report (RCPsych, 2000) which actively discouraged side room admissions.

A further area of potential individual risk to the babies which has not been studied in any detail is the developmental needs of the children. The research literature on joint admissions has focussed throughout the history on the needs of the mother, and outcomes for the children have largely been assessed indirectly in terms of whether or not mothers remain as the primary care givers after discharge from hospital (Douglas, 1956; Baker et al., 1961; Hamilton et al., 1969; Sneddon, 1985; Kumar et al., 1986; Poinso et al., 2002). Many studies have been conducted on the effects of parental mental illness on infant and child development (Murray, 1992; Murray and Cooper, 1997; Sluckin, 1998) and the findings from the research already mentioned in Chapter 1 confirms there are strong correlations between the two however what is not known is whether or not this risk is increased or decreased as a result of joint admission, and this may be because there are so many uncontrollable variables for this to be tenable research. Only two studies were found that studied direct long term developmental outcomes for the infants admitted to a specialist mother and baby unit but the research by Cunningham et al (2004) had a poor study design and the research by Wan et al (2007) was a small study sample.

It is suspected that incidents of non-accidental harm continue to occur in specialist mother and baby units and single tragic incidents can be found in the tabloid press (Levy, 2007. see Appendix 5), but the subject has not been collectively reported or studied since the mid-1990s. To negate the likelihood of direct harm many of the specialist units now specifically exclude admissions of women where there are concerns in advance of their admission about an increased risk of harm towards the baby. The units who admit women specifically for parenting assessment however, carry a higher degree of risk in this area. The introduction of electronic clinical governance reporting systems to the NHS during the last few years could potentially be a rich source of data on this

subject. An enquiry to the central system in Scotland (Datix) identified that although this information would be reported through the system for individual cases it is not collated or compared across Scotland or equivalent systems across the UK as a whole. Version A has been portrayed in the history as having more risks than Version B but there is no empirical evidence to support this. To date, the research that Brockington (1996) and others have recommended has not been operationalised and following the eventual rejection of Version A across the UK approximately 6 years ago, Version B continues to slowly diffuse and disseminate without an examination of the central question of the risk benefit ratio of the innovation.

8.6.2 Reputational risk

The initial conclusion is that research on risk should be undertaken by clinicians working in the field in order for the risk benefit ratio to be established and this could then be used to influence the continued diffusion pattern for the adoption or sustainability of specialist units. This however assumes that the research findings would be favourable towards the benefits of the innovation outweighing the risks to the infants. If the research results were to the contrary, there would be a realisation of secondary risks.

There has been an increasing preoccupation with risk management in the NHS since the 1990s. This corresponds with risk management becoming part of the self-description and self-understanding of central government in the 1990s (Power, 2004). Risk management is much more than a technical analytical practice, it also embodies significant values and ideals, not least those of accountability and responsibility. Historically within health services there has been an ethos of transparency and accountability for scientific expertise in decisions about risk assessment but experts are being made increasingly accountable for what they do and the decisions they make, and thus, clinicians are becoming more pre-occupied with managing their own personal reputational risks. Secondary risks to the reputations of either the individual or the organisation are becoming as significant as the primary risks for which experts have knowledge and training (Power,

2004. 15). It is believed that this trend is resulting in a 'dangerous flight from judgement', to a culture of defensiveness that creates its own risks for organisations in terms of their relationships with their stakeholders and satisfaction with the services provided (Power, 2004. 16).

The UK Governments have become more concerned to manage public expectations with improved service delivery and risk has become the concept for challenging the quality of public services in the absence of commercial markets (Power, 2004. 19). As evidenced in the history in Chapter 4, it was during the 1990s that the NHS regulatory and quality bodies were formed: NHS Quality Improvement Scotland, The Care Quality Commission in England, Healthcare Inspectorate Wales and the Regulation and Quality Improvement Authority in Northern Ireland. It has been suggested that the creation of such bodies is itself a strategy by which the government manages its 'reputational risk' (Power, 2004. 24).

Reputation in organisations such as the NHS is essentially the same concept to personal reputations: the associations attached by others to our names. This implies a value judgement about the attributes of the individual or organisation. Reputation in the context of the organisation is based on perceptions of the characteristics, performance and behaviour of that organisation and those who represent it. It is essentially a reflection of how well or how badly different groups of interested people, the stakeholders, view the organisation (Larkin, 2003). Any issue that might have an impact on the reputation of the organisation which could undermine the confidence of the public and partner organisations is a reputational risk. Reputation is built on trust and belief and adverse public perception on the reputation of an organisation can have damaging consequences for future public confidence (Larkin, 2003. ix). Certain events can be amplified by social and institutional forces beyond the control of individuals or organisations. The media, internet and social networking are sources of this amplification of events. In the face of this global media it is perhaps not surprising that organisations feel compelled to take swift remedial action as the consequence of an

adverse event (Power, 2004. 35) and society has reached a level of unprecedented risk aversion (Larkin, 2003. ix).

It is therefore increasingly difficult for the NHS as an organisation to accept a known risk or to accept an innovation where the risks are unknown. It would be impossible to evidence the harm that might have happened had the decision to admit an individual mother and baby not been taken therefore, it is a probability that researchers have deliberately avoided the subject of assessment of risk benefit ratios for fear of the remedial actions that may be taken by their health authority or board, should the risks to the babies be evidenced to outweigh the benefits.

8.6.3 Cost risks of adoption of joint admissions

There are as many different definitions of the cost of risk, as there are perspectives. Each person's view will depend largely on their responsibility for managing risk within their organisation. At organisational board level, the cost of risk is largely about uncertainty in achieving corporate objectives. As already noted, there is an absence of evidence on economic analysis and data on the cost effectiveness of Version B specialist units that makes it difficult for organisations to calculate the financial benefits or risk of providing such services. Version A was much cheaper to provide as it did not require changes to infrastructure and at most incurred only the costs of an extra member of staff on duty to provide more intensive support and observation, usually to try to ensure the safety of the baby. Specialist units are significantly more expensive to run than conventional general adult psychiatric admission wards. Dependent upon the size of the unit, on average each admission to a specialist unit is approximately 50 per cent more expensive in terms of revenue costs than an admission to a general adult ward. This is likely to have relevance to the rapid adoption of side room admissions in comparison to the specialist units.

There was very little cost attached to the adoption of side room admissions, at the most the costs were for baby care equipment. The increased costs of specialist units are due to the set up costs of

the service, low bed numbers required for an area, longer lengths of stay and the skill mix required to provide care and treatment to both the mother and the child. It is for this reason that many Health Authority areas or Health Board areas collaborate to provide services on a regional basis. Some units in England also try to offset the added costs by charging their local authority counterparts for admissions to conduct parenting assessments that inform either child protection decisions or criminal justice decisions about child custody (Seneviratne et al., 2003). In some areas this has led to lengthy admissions of people who perhaps would not otherwise need that length of stay purely for the purpose of treatment of their mental illness. This has led to concerns, with such a finite resource that these admissions may prevent other more severely ill women from being offered the option of a joint admission.

To reassure Health Authorities and Health Boards that their investment has long term gains, research by health economists would need to give consideration to the short term costs balanced against long term outcomes. This may evidence that the intervention and treatment is less costly than admissions to general adult wards without the baby as many women discharge themselves against medical advice and may be readmitted a short time later, or, in some cases end up with very prolonged admissions (Cantwell, 2002). It is known from the early research that the longer the mother is separated from the baby, the harder it is to return to normal family life and the higher the risk of relapse as evidenced by Douglas et al (1956). The wider costs of the mothers' separation from their baby, costs of untreated illness, effects of maternal mental health on child development and family relationships, and the cost to society of those women who either complete suicide or injure or kill their children as a consequence of ineffective treatment or untreated illness need to be identified. The wider costs to society is also an important element as many women, who are productive members of society and their local community, take long periods off work due to severe postnatal mental illness and in some cases this can be for many years. In cases where children end up in local authority care, the costs are much further reaching in terms of the costs incurred for looked after and accommodated children potentially over the duration of their childhood. Managers

and commissioners of services generally work on short term recurring revenue budgets which pay for staff and supplies and non-recurring capital budgets which pay for buildings and premises, during short financial time frames. Decisions are therefore often made on what the more pressing priorities are for a given period in time and if the 'window of opportunity'¹⁸ is not taken it may be many years before the opportunity arises again, if at all. This concept of 'window of opportunity' is discussed later in this chapter in the analysis of health care policy and policy agenda setting. If economic analysis and evidence on wider costs was available to service commissioners they would be able to set a long term trajectory of cost avoidance through investment in services; the term 'invest to save' may be highly relevant to specialist mother and baby unit service provision but at the current time there is no evidence to support this possibility.

In summary, risk is multifaceted and judgements of probability are subjective rather than absolute and will vary over time depending upon knowledge base and what measures are put in place to pre-empt and manage the perceived risks. The decision to adopt joint admission services will be highly influenced by the confidence that managers and professionals have that the risk benefit ratio is balanced towards benefits and also supported by a confidence in the competency of the care team and the operating systems and processes to ensure governance over quality and safety.

In conclusion the issue of risk in the innovation of joint admissions has been highly relevant to the diffusion pattern. The three main areas of risk identified in the history as influencers to the adoption pattern were direct risk of harm to the infants, reputational risk for individual adopters and the NHS as units of adoption and cost risks of Version B joint admissions in particular. The absence of information on the risk benefit ratio is of relevance to the slow adoption of Version B. It has been concluded that this area of research may also have been avoided within the literature for fear of what the evidence might reveal in an atmosphere of increasing political and organisational risk aversion. It is possible that the absence of information on risk benefit ratios may also be of

¹⁸ The short period of time during which an opportunity must be acted upon, or missed.

relevance to the eventual rejection of Version A, as the perception of risk was given weight in the absence of evidence from research. The absence of economic analysis is considered to be a highly probable influencer to the slow diffusion of Version B

8.7 Analysis: Outer context influences on the diffusion of joint admissions

The outer context which has influence over the diffusion of innovations includes the impact of the socio-political climate, policy mandates and incentives (Greenhalgh et al, 2004). Societal views are also included as an outer influence.

8.7.1 Communication networks external to the NHS

The Royal Medico-Psychological Association (RMPA) was the network through which psychiatrists in the early days of the NHS would communicate their practice and experiences. This may be a possible cause for Thomas Main receiving more of the acclaim as the innovator of joint admissions than Douglas. His account of the date of the first admission was before the research at the West Middlesex Hospital but the communication of his work was two years later than Douglas's but perhaps both his personal characteristics and his chosen means of communication are of relevance here. At the time it is likely he was already well known among peers due to his innovative work with therapeutic communities. His senior position, charismatic personality and perceived authority would have been far more important to the diffusion process in terms of influence within the profession than those of Douglas, a psychiatric trainee (Freeman, 1999). At the time, gender bias in medicine was also significant and there were much fewer women in the medical profession particularly within psychiatry. This was relevant to the dominant position of male colleagues in terms of authority and power within the profession and within the hospitals. Main's more esteemed position within the profession would have had more credence amongst colleagues than that of Douglas and although her research was conducted in partnership with a consultant psychiatrist and others, she was the only author of the publication in *The Lancet*. Main's mode of communication however is likely to be

of importance. Main presented his paper at a meeting of the Psychotherapy and Social Psychiatry Section of the RMPA and published his work in the professional press a few months later.

This links to the findings from diffusion research that social networks are fundamental to the diffusion process. Douglas and colleagues meanwhile do not appear to have used the face to face professional networks to present their case series, choosing instead only to publish it in the professional press. There are therefore several factors which influenced why Main has been perceived to be the innovator of the practice among peers and colleagues, rather than the research element and innovative findings of Douglas's work having more weight. Empirical based practice only really started to have more credence in the health services in the 1990s with the introduction of policy on clinical governance and medical audit (Department of Health 1998). Had this policy driver been evident in the 1950s it is likely that Douglas and colleagues would have been in receipt of the acclamation for their work and been credited as the innovators by their peers and social networks.

The Perinatal Section of the Royal College of Psychiatrists took some time to be established as a bona fide network for the profession. The clinicians who set up the Marcé Society were evidently the founders of the first international diffusion network relevant to joint admissions, several of whom were psychiatrists and also influential in having perinatal mental illness recognised within the College.

The absence of health policy specific to joint admissions or the care of women with perinatal mental illness is evident in the historical narrative up until the 1990s. So clearly it took a considerable period of time for the subject to be given any degree of focus or priority both within the psychiatric profession and in the wider context of government health policy. The reason for this may be that although the senior psychiatrists were influential in their own hospitals and with peers across the profession, the evidence presented indicated they had little influence over health policy (Freeman, 1999). As already noted, it was 1971 before psychiatrists were granted Royal College status which

put them on a par with other medical specialties and other Colleges of medicine. The first report specific to perinatal mental illness was not published by the College until 1992 however (RCPsych, 1992). The formation and change of strongly held attitudes is achieved mainly by interpersonal channels of communication and influence. Face-to-face communication is more effective in dealing with resistance or apathy and for this reason this route of peer communication is important for later adopters and laggards in the diffusion process (Rogers, 2003. 205).

Mass media also has a role to play in the communication of innovations. Mass media channels of communication are means of transmitting messages that involve a mass medium, such as newspapers, radio and television, which enables a source of one or a few individuals to reach an audience of many. The mass media channels are usually the most rapid and efficient way to inform an audience of potential adopters about the existence of an innovation; they can reach a large audience rapidly; create knowledge and spread information; and change weakly held attitudes (Rogers, 2003. 205). This can work either for or against adoption however dependent upon the motivation of the journalist or reporter. Examples in the evidence included various newspaper reports including reports of the opening or closure of services, reports on incidents of harm to infants within services and reports of gaps in service provision (examples are included in Appendices 2-5). Communication of personal stories and experiences of service users or the general public through the tabloid press can have significant influence on decision making by local service providers and can also have significant influence on policy. This was particularly evident in the diffusion of specialist mother and baby units in Scotland (see Appendices 2-4).

The innovation of joint admissions evidently had its champions. Rogers described a 'champion' as a charismatic individual who throws his or her weight behind an innovation, thus overcoming indifference or resistance that the new idea may provoke in an organisation (Rogers, 2003. 414). He also identified that innovation champions can play an important role in boosting a new idea in an organisation and if there is an absence of a champion, then it is unlikely the innovation will be

adopted (Rogers, 2003; Schön, 1963. 84). The champion's role is to initiate the innovation process and to guide the new idea through to approval and implementation (Rogers, 2003. 417). The evidence in the historical narrative suggests that services appeared to develop on the back of individual practitioners with a particular interest in the area and enough influence within their organisations to be allowed to introduce the practice i.e. the champions.

Channi Kumar is identified from the evidence as being one of the main champions in the diffusion of the innovation during the 1980s. He was a founder member of the Marcé society and was based in London at the Bethlem Royal and Maudsley Hospitals from the 1970s onwards. He set up a specialist mother and baby unit at the Bethlem Royal Hospital in 1981. Kumar was highly respected by his colleagues, leading research in the field and became a professor of perinatal psychiatry in the 1990s (Brockington, 2001). He was also the first assessor and author of the chapter on psychiatric causes of maternal death (Department of Health, et al., 1998). After the initial development of the innovation of joint admissions, there are several examples in the evidence of champions being integral to the adoption process, particularly of Version B: Baker and colleagues (1961), Bardon (1977), Brockington (1982; 1986; 1996), the psychiatrists involved in the establishment of the Marcé society who were clearly all champions of the innovation, Oates (1988; 1996; 2000) and Cantwell who it is known from oral history championed for the first specialist unit in Scotland.

The presence of a champion however has not guaranteed that joint admissions and specialist units are adopted. It is known from oral history that practitioners in some health authority areas have tried tirelessly to make the case internally for the development of specialist services in their geographic areas but to little effect. Research has identified that innovation champions cannot be characterised as there are numerous examples of different characteristics of individuals including varying degrees of formal power and different abilities (Rogers, 2003. 417) so it would be of no value to look at the individual characteristics of those champions who have been successful in

influencing decision making around investment in existing services for the purpose of predictors of future success.

8.8 Joint admissions and the policy agenda

Early in the diffusion pattern it could be suggested that there was an absence of policy in the field of perinatal mental illness, joint admissions and specialist service provision. Indeed, it was not until the early 1990s that moves were made to attempt to highlight service provision for perinatal mental illness as an issue for the attention of policy makers. Health policy is a set of decisions or commitments to pursue courses of action aimed at achieving defined goals for improving health and stating or inferring the values that underpin these decisions (WHO, 2012). Health policy broadly describes the actions taken by governments to advance the public's health. It is not a single action and is linked to a range of related regulatory and legislative frameworks. Health care policy is used to prioritise the organisation, financing and delivery of health care services to achieve the aims of the broader health policy. Examining the history of health care policy relevant to joint admissions has provided evidence as to the role it has had in the diffusion pattern. It is important therefore to consider the mechanisms that were involved in getting service provision for perinatal mental illness on the health care policy agenda.

The question of how issues get on the political agenda has been addressed by Kingdon (1995). He also considered how, after the issues are on the political agenda, alternative solutions are devised. In his model, Kingdon (1995) identified participants and processes that explain the emergence of the agenda and the alternatives. Participants may be inside or outside of the Government. He described the processes as three streams: problem streams, policy streams and political streams. Although Kingdon's work focussed on the American political system, the model is applied to the UK political system.

8.8.1 Problem Stream

This can be influenced by a series of studies and reports on the subject; a sudden crisis, or feedback that a programme is not working as intended (Milstead, 2008. 50). The evidence that the policy agenda 'problem stream' around specialist service provision for joint admissions starts to emerge in the UK in the 1990s is the publication of The Royal College of Psychiatrists Council Report (RCPsych, 1992). Prior to this, publications and studies on the subject of joint admissions focus on the communication of the innovation to peers in the professional communities, from both a clinical practice and research perspective, with no real evidence of the publications attempting to influence service planners, commissioners or Government policy. The problem stream picks up momentum with the publication of an article by Oates (1996) where she frames the situation as one of unmet need. The article goes further than just presenting the problem; it also presents the justification for specialist services and offers detailed advice and information on how to influence service commissioning. The article is published in an international peer-reviewed journal which would suggest Oates is attempting to influence peers both within the UK and also internationally. The publication appears to be aimed at like-minded colleagues, encouraging them to be proactive in influencing service developments in their own geographical areas and equipping them with the necessary insights as to how to go about doing this (Oates, 1996).

The publication of the Government commissioned Confidential Enquiries into Maternal Deaths contributed significantly to the problem stream of the political agenda. As already noted in Chapter 4, recommendations for joint admissions to specialist psychiatric mother and baby units were included in these reports from 2004 onwards (Department of Health et al, 1998; Lewis, 2004; Lewis, 2007; CMACE, 2011). The deaths of Daksha and Freya Emson also described in Chapter 4, may be regarded as representing 'a sudden crisis' in the problem stream of Kingdon's model of policy agenda setting and triggered a flurry of activity to develop guidance on practice, service design and commissioning of specialist services. The 2003 public enquiry into their deaths made

four recommendations specific to the policy agenda (North East London Strategic Health authority, 2003. iv), all of which have since been implemented by the Department of Health in England.

8.8.2 Policy Stream

This is characterised by those groups of specialists who have a concern and expertise in certain areas. This group includes those internal and those external to government and are usually known to each other through their publications, reports, professional organisations and networks. Included in this stream is the presence of ideas, criteria for the survival of ideas and the presence of available alternatives (Milstead, 2008. 50). The Royal College of Psychiatrists Special Interest Group was set up in 1995 with the cooperation of the Department of Health, their task being to provide advice on the provision of services for women with perinatal mental illness and progress the recommendations from the 1992 Council Report (Royal College of Psychiatrists, 1992). The special interest group later lobbied for a Perinatal Section within the College, whose membership is now part of the policy community on the subject of service provision for perinatal mental illness. The Marcé society, on the other hand, is not regarded to be part of this policy community as it has always been an international society and service provision is a national policy issue. The Society's focus is on the promotion, facilitation and communication of research across professionals. There is an overlap between the two, with psychiatrists being obvious active members of both the College Perinatal Section and the Marcé society, and although direct political lobbying or influencing government policy does not feature as a key aim of the Marcé Society's function, many of its members are involved in these activities. It is known from oral history and personal experience that in Northern Ireland members of the Royal College of Midwives and a local psychiatrist have been active in the policy community in trying to influence policy to support specialist service development.

Included as relevant to the policy stream in some policy areas are 'policy entrepreneurs' (Kingdon, 1995. 129). Policy entrepreneurship is defined as "persons willing to use their own personal

resources of expertise, persistence and skill to achieve certain policies they favour” (Weissert, 1991). This view is supported by Mintrom (1997) who states that policy entrepreneurs worked hard at developing close ties with people through whom they can realise their policy goals and seek to develop convincing arguments for selling their policy ideas (Mintrom, 1997. 765). There is a combination of autonomous reflexive behaviour with skilled social action (Fligstein, 1997; 2001) and an influential social position (Van der Steen and Groenewegen, 2008). Mintrom (1997), in his study of policy innovation diffusion in the area of school choice, identified that policy entrepreneurs significantly raised the probability of legislative consideration and approval of policy in that area. He concludes that policy entrepreneurs play an important role in articulating innovative ideas onto government agendas (Mintrom, 1997. 765).

The history would suggest that there has been a small group of clinicians who could perhaps be regarded as policy entrepreneurs within the field of perinatal mental illness. One person that appears throughout the published evidence in the form of reports, guidelines and articles from the late 1980s onwards is that of psychiatrist Margaret Oates. It appears she has been the most prominent policy entrepreneur within the field of perinatal mental illness, and most specifically around the policy agenda for specialist services. The majority of reports and guidelines which advocate for specialist mother and baby units and joint admissions have Margaret Oates either as the author of the recommendation, as a member of the group involved in the production of the publication, or as an expert reviewer: the list includes the Royal College of Psychiatrists Council Reports (1992; 2000), The Confidential Enquiries into Maternal Deaths (2001; 2004; 2007; 2011). To be placed on a policy agenda, an idea must first be ‘softened up’ to enable people to get used to the idea before support and acceptance of the new idea is built up, which is often the role that policy entrepreneurs or policy communities play through various communication networks, modes and media (Milstead, 2008. 51). If one tracks the policy stream, Oates’ influence in terms of published journal articles and reports, is clearly evident. Milstead’s notion of ‘softening up’ is also clearly evident in this example of policy entrepreneurship and policy agenda setting for mother and

baby units. Oates's influence has undoubtedly contributed significantly to the diffusion of mother and baby units in the UK.

In England and Wales the mental health policy stream was evident from the very outset of the NHS and the mental health of mothers has been a consideration for several decades. The emergence of a tributary specific to joint admissions was not until the early 1990s and its rise to the forefront of the policy making agenda took a further 10-12 years. Mother and baby units were therefore developed first and the policy stream emerged a number of years later. The subsequent policy stream has had influence on the diffusion through the rejection of Version A and in influencing more standardised practice in the form of Version B. In Scotland there is real evidence that the pattern of diffusion has been strongly influenced through both the political and policy streams in the last decade in particular. Diffusion has now moved along the continuum to dissemination through the development and implementation of legislation.

8.8.3 Political Stream

This is the third stream of Kingdon's model of policy agenda setting. This consists of the public mood, pressure group campaigns, election results and changes in administrations (Milstead, 2008. 51). In Scotland it was the influence of an MSP in response to a plea by one of his constituents that eventually led to the provision of mother and baby units being legislated for in the Mental Health (Care and Treatment) (Scotland) Act 2003. There is no such legal requirement anywhere else in the world. The MSP raised the issue in October 2002 and the elections for the Scottish Parliament were being held in May of 2003. The MSP was seeking re-election for his local constituency, as was his political party within the Scottish Executive. This was likely to be of relevance in terms of the timing of the matter being raised and the heightened focus and attention it received in both the local and national press and in the Scottish Parliament in December 2002. The political stream that followed local attempts to influence service provision has without doubt been the most influential factor in service diffusion and dissemination in Scotland. Health services in

general were seeing a considerable amount of expansion and investment in 2002 and this may also have been an influencer to the suggestion of new services being supported centrally.

The processes of agenda setting are affected by a 'window of opportunity' that allows for the merger of the streams and the setting of an agenda (Milstead, 2005. 48). Kingdon's research is based on organisational decision making being a dynamic, fluid process rather than a linear, sequential one. He identified that a policy idea can be "*an idea whose time has come*" (Kingdon, 1995. 1), but emphasised that policy windows do not happen very often and close quickly (Kingdon, 1995. 167). This fits very well with the setting of the policy agenda in Scotland. The sequence of events that led to the making of the legislation, and the additional framework to the mental health strategy being instructed, were not planned in response to an identified strategy but were somewhat opportunistic.

In Northern Ireland, similar to Scotland, the political stream is now clearly evident with the issue having received significant attention from the Northern Ireland Assembly who commissioned a needs assessment for services in Northern Ireland. The needs assessment led to a cross party group of politicians travelling together in June 2008 to visit the mother and baby unit in Glasgow. This shared policy and political stream around perinatal mental illness, and the visit to Scotland itself, a historic act for all political parties including Sinn Féin and the Democratic Unionist Party (DUP). Prior to devolution it would not have been possible for the different political parties to work together on a shared issue due to the bitter rivalry and warring between the political parties that ceased after agreement was reached on a power-sharing Northern Ireland Assembly in May 2007. Perhaps the argument for improved services for women was a shared issue that would not attract polarised political views from the respective parties and therefore a relatively 'safe' shared policy and political stream.

8.9 Influence of health policy on health service commissioning

The introduction of the policy which created the internal market in the late 1990s forced NHS Trusts to compete for contracts that were often of very short duration, making it difficult to secure the sustainability of some services. Under the internal market hospitals became 'self-governing trusts' run as businesses. There was little strategic planning with decision making responsibility becoming fragmented between approximately four thousand NHS bodies creating competition between hospitals. Such short term instability placed a constant focus on trying to maintain the status quo rather than creating opportunities to plan and implement major improvement. The introduction of general practitioner (GP) fundholding allowed GPs to hold budgets with which to purchase a defined range of services for patients. GP fund-holders could make significant purchasing decisions without reference to the local or wider community whilst at the same time hospital clinicians who had previously held a significant degree of power in terms of influence and decision making had their previous powers encroached upon.

Ironically, against the original intentions set out in the Griffiths Report (DHSS, 1988), the competition across the system also prevented the sharing of best practice as organisations did not want 'the competition' to gain advantage. Quality in services was also variable as the nature of short-term contracts meant the incentive on each NHS Trust was to increase the volume of people coming through their doors to meet financial targets. This also made it difficult for staff to work across organisational boundaries. This would potentially have made it difficult for clinicians to make the case for mother and baby unit provisions and would also have made it difficult for any regional provisions as there would have been no recurring security in short term contracts. The counter argument, however, was that where an NHS Trust was prepared to take the risk, they could attract admissions from a wide geographic area. That said, in the absence of any policy or legal requirement to provide such services at this time, the financial risk could have been significant as there would have been no guarantee that other NHS Trust areas would contract to pay for such services. There was also an increased provision of community-based mental health services from

the mid-1990s onwards and many new out-of-hours services were developed to respond in times of clinical crisis therefore there may have been a perception that the need for hospital admission for mothers and babies was likely to decrease as community-based services became available twenty four hours per day.

The change of government in 1997 brought an end to the internal market and GP fundholding and replaced that system with one of clinically-led local commissioning by Primary Care Trusts aimed at local communities being able to commission better services for the needs of that community. The aim was one of cooperation across areas and agencies rather than competition. It was recognised that mother and baby units were 'low capacity high cost services' and with competing demands for the rebalancing of care to be more community-based than inpatient based, difficult decisions were required as to where resources should be targeted to make most impact to most people. Specialist Service Commissioning therefore may both help and hinder the diffusion pattern as there are many competing priorities for regional service provision across mental health fields of practice. Where the planning groups and commissioners agreed to adopt, however, funding of services would perhaps be easier as each area would only need to commit a percentage of actual costs and therefore the cost risk to each Health Authority or Board would be reduced, thus making adoption more likely. The experience in Glasgow was that NHS Greater Glasgow and Clyde accepted the financial risk to make the specialist mother and baby unit larger in capacity than required for the assessed local need. The Board thereafter made a formal approach through the West of Scotland Planning Group to the other NHS Boards in the area and four of the five neighbouring Boards entered into formal service level agreements for Glasgow to provide joint admissions to the unit for their patient populations. Glasgow had assessed it needed four beds so the cost of the additional two beds was divided across the other four NHS Boards. The operating policy was clear that admissions would be based on clinical need rather than Boards having the perception that they had 'bought a bed'. The cost to each NHS Board was based on the calculation of percentage of expected usage for the first three years, and thereafter adjusted proportionately dependent upon the actual usage by each NHS

Board area over the first three year period. The cost risk that NHS Greater Glasgow and Clyde took was taken in the knowledge that the implementation of the new Mental Health (Care and Treatment) (Scotland) Act 2003 was imminent and that it would be extremely expensive for each NHS Board to develop their own specialist unit in order to comply with the legislation.

Regional planning arrangements may have assisted the sustainability of some of the existing services, as once established, it would be harder to withdraw a service from a whole region than it would be to withdraw a service from a single area. The units that have closed over the diffusion time line have largely been units that service local areas, and if replaced, this has been by regional units. This has resulted in many families having to travel long distances if they wish to make use of the joint admission option, something that could be viewed as a lesser option; geographical distance can make it harder for families to visit as frequently as they might if they lived nearby. My personal insight is that geographical distance is a particular consideration where the family have many miles to travel in order to visit or where there are poor transport links. Distance is a particular issue where there are school age children in the family who have their own needs and desires to spend time with their mother, younger sibling and usually their father who may be looking after them during their mother's admission to hospital, but is having to juggle his time between the hospital and trying to maintain normal routines for the other children.

In conclusion, the diffusion curves for Version A and Version B have been strongly influenced by health care policy. In Version A, health care policy has largely driven the rejection of the practice and conversely, health care policy has been used to influence the adoption and dissemination of Version B. There has been an ever increasing divergence across the four areas of UK health policy since decision making powers for health was devolved in the late 1990s.

8.10 Sustainability and rejection of the innovation

Sustainability has been identified in the history as an issue for both Versions of the innovation of joint admissions. As highlighted by Rogers (2003), very few diffusion studies report on the reasons why an innovation is adopted but later rejected or withdrawn. This issue is not explicitly reported upon within the documentary evidence but probable and possible causal factors can be identified through internal and external criticism and analysis of what available evidence there is. There are largely two issues in the history that need to be considered: why Version A of the innovation is rejected completely, and secondly, in Version B, why new specialist mother and baby units continue to open whilst others close. In Version B the diffusion pattern is still in motion with earlier adopters rejecting the innovation, whilst at the same time new adopters are being identified, thus the adoption curve for Version B is not the normal S-curve.

8.10.1 Version A

The pattern of adoption of Version A follows the normal S-curve distribution until the mid-1990s and then instead of being sustained it has increasingly diminished to the point of complete rejection of side room admissions in the mid-2000s. Health care policy introduced the development of evidence based and expert informed standards and it is highly probable that the publication of the policy documents and guidelines which specifically stipulate that Version A of the innovation should not to be practised is causal to the eventual mass rejection (RCPsych, 2000; SIGN, 2002; NICE, 2007). Standards are noted to be important to the diffusion of innovations and the absence of them can result in inferior innovations becoming 'locked in' prematurely. Conversely, failure to establish standards can slow or prevent diffusion of good innovations (Tidd, 2010. 6). The evidence from the published surveys would suggest that before any criteria or standards were applied to joint admissions there was widespread adoption of Version A of the practice of joint admissions. It is known from oral history and personal experience that mental health nursing staff had been verbally expressing concerns about the safety of side room admissions for some time but with limited

influence over its withdrawal from general adult psychiatric wards. This would correspond with these points about the influence, or indeed the absence of standards for care or service provision.

The formation of the Perinatal Section of the Royal College of Psychiatrists and their collective view that Version A should not be practiced in favour of Version B (RCPsych, 2000) is also likely to have had strong influence on other psychiatrists attitudes and opinions of side room admissions which resulted in them eventually ceasing to admit mothers and babies. It was during the mid-1990s that the Section of Perinatal Psychiatry was established which corresponds with the increasing rejection of Version A. This move towards establishing a sub-specialism within the specialism of general adult psychiatry is likely to have been a probable influencer during the 1990s to a strengthening of the view that side room or annex admissions were 'specialist practice' and thus a role for 'specialist psychiatrists', This would go some way to explaining why general adult psychiatrists gradually rejected admitting these patients to side rooms in the general adult admission wards. This suggested causal factor, however, does not reflect the fact that there were, and still are, gaps in Version B provision across the UK during this same time period. In some areas, therefore, side room admissions have been rejected in the absence of alternative specialist mother and baby unit provision, and instead women are being separated from their babies.

Mass rejection of Version A has also been strongly influenced by the introduction of clinical governance in the 1990s. As already noted, the NHS became more focussed on risk management from this point onwards in the policy history of the NHS. The theme of risk and its relevance to the rejection of Version A has already been considered in detail earlier in this chapter, but is thought to be a highly probable lever in the eventual complete rejection of side room admissions.

8.10.2 Version B

The influencers behind the sustainability or rejection of Version B appear to be more multifaceted and are of particular interest. As identified, Version B continues to have new and renewed adopters

whilst at the same time continuing to have rejecters. It is important to consider the possible and probable reasons for this unusual diffusion pattern:

The policy drive to close the large psychiatric hospitals from the late 1980s onwards resulted in specialist units closing as part of the hospital closure programme. The unit at Shenley Hospital was closed for this reason and admissions transferred elsewhere.

The presence of 'champions' previously identified in the literature as being advantageous to the diffusion and adoption of innovations, may also have disadvantages when considering sustainability. Services that are 'person dependent' have little chance of sustainability once the individual is no longer available to provide and drive the service. It is known from oral history that this has been causal to specialist mother and baby units subsequently closing. Reasons include the retirement of the 'champion', an inability to recruit replacement psychiatrists or, in the absence of the 'champion', there has been a decision taken by managers that the services are no longer required, or have been the subject of cost savings for the organisation (examples include the specialist units that closed in Sheffield and Cambridge for these reasons).

In their survey on service developments to aid their own local decision making in terms of service need, Shawcross and McRae (1986) identified that services in the form of Version B usually developed out of local interest on the part of individual clinicians or groups of clinicians, rather than by means of central planning. They believed the development of such services was motivated by the belief that they added to the quality of care. They do not state however if this was from the mother's perspective, from the perspective of the wellbeing of the child, or both (Shawcross and McRae, 1986. 50). This view suggests therefore that where this local interest was absent, services were not developed. This view was also expressed by others in the international literature. It has been stated that the survival of the units in France and Belgium was partly dependent on the continuing interest of a particular consultant or head of department and that there was risk of unit

closures when interested individuals left. They sum the position up by stating, "*These units are the fruit of local decisions: human and institutional resources available at a given moment, a doctor with a special interest, and a hospital director sensitive to the problem*" (Cazas and Glangeaud-Freudenthal, 2004. 55).

The theme of locally developed services based on personal interest of an individual clinician, coupled with no central or regional planning arrangements up until the mid to late 1990s, are possible influencers to several small services being developed in close proximity to one another. Later in the diffusion pattern when individual hospitals or units at district general hospitals were taken over by larger organisations such as the Primary Care Trusts or the Foundation Trusts in England, the resultant new planning arrangements would have identified benefits to concentrating skills, experience and resource and capital costs in one geographic area for both clinical and financial reasons. Rationalisation of resources across smaller units and a move towards central planning decision making resulted in some units closing and inpatient provision being provided in another geographic locality. A recent example of this in March 2012 was the permanent closure of the two bed unit at York with admissions transferred approximately 30 miles away to the unit in Leeds.

Another example identified during the literature search for evidence for inclusion in the study, was an online petition under the heading "*Save Basingstoke's Specialist Mother and Baby Unit*". Further searching identified that a newspaper article had reported that the unit was to be closed and the facility for joint admissions would be provided from a regional unit in a different part of the country (thought to be the unit that opened in Winchester). This had been a partnership agreement between several NHS Trusts and local authority areas and a joint statement provided in the article gave clear evidence that the decision to close the Basingstoke unit had been a regional planning decision (Martin, 2006).

In some areas there has been a view held that if primary care approaches to treatment were robust and widespread, then specialist inpatient provision would not be required. This was certainly my experience in Scotland when trying to make the case for specialist service provision. There was a strongly held belief by non-mental health professionals in commissioning positions, that if health visitors were trained adequately, there would be no need for specialist mental health service provision. This thinking was largely influenced by the CRAG report (CRAG, 1996) and the prior research conducted by Cox et al (1987) that a screening and counselling approach delivered by Health Visitors was effective in the early detection and treatment of postnatal depression. This was not an evidence base for treatment of psychotic illness, however, the tendency to use the term 'postnatal depression' for all postnatal mental illness in Scotland meant that the more severe illnesses such as puerperal psychosis and relapsing bipolar disorder or schizophrenia were not given the separate attention required to highlight the different approaches to service provision necessary to ensure effective treatment of this group of women. This bias towards 'postnatal depression' from the late 1980s onwards is thought to be a major influencer to the very slow diffusion of Version B in Scotland in particular. Outwith Scotland the authors of a survey in 2003 also made the observation:

“Reports that some Trusts have recently reduced or stopped their services underlie the prevalent view that provision of perinatal services is not considered to be a priority by Primary Care Trusts and that it has generally suffered since the 1999 Trusts’ restructuring.....There is a continuing difference of opinion about the best approach for providing these services” (Oluwatayo and Friedman, 2005. 179).

A further theme identified as a probable cause to the rejection of Version B was staffing. Kumar and colleagues (1986) identified that the facility for joint admissions in one area was withdrawn due to nursing shortages (Kumar et al, 1986. 170). It was reported by Cassell and Coleman (1990. 655) that lack of specifically trained nursing staff, staff shortages and financial constraints were among the reasons why two dedicated units had closed. Staffing shortages were also reported to be

causal of an under-usage of beds in three mental health trusts in England in a survey conducted in 2003 (Oluwatayo and Friedman, 2005. 178). The issue with staffing appears to have been that many units were staffed on an ad-hoc basis with insufficient dedicated staffing resource (Cassell and Coleman, 1990).

Lack of finance featured as a reason for closure of services in France and Belgium (Cazas and Glangeaud-Freudenthal, 2004. 55). As noted in the earlier section in this chapter, finance as a reason for units closing from the international literature must be treated with caution due to the different healthcare delivery systems.

A further influencer in the sustainability of joint admissions was the perception of risks for the infants. This was reported as relevant to the discontinuation of joint admissions in the survey conducted by Cassell and Coleman (1990) although it is not clear from their report if this data related to Version A or Version B as their survey included data from both versions of the innovation. It was explicitly reported, however, that risk of harm to the infants was a critical factor in the closure of the unit in Israel in 1984 after an attempt by a patient to kill her baby although this unit was reopened 15 years later (Maizel et al, 2005). Safety of the infants also featured in the American literature on reasons for rejection during the innovation decision process. The issue of litigation is a feature in American service provision where there is a private health care system in place and people rely on health care insurance to fund their healthcare needs. Findings from the international literature may not be transferrable to the NHS in the UK however due to differences in the funding arrangements for service provision, with most foreign healthcare being funded privately. The issue of health care insurers' liability does not appear to have affected the adoption of Version B in Melbourne, Australia however the health care system in Australia includes both public and private healthcare provision.

What is of interest in the analysis of the influence of risk on the sustainability or rejection of joint admissions is that risk of harm to the babies appears to have been used through health care policy development as a lever for the rejection of Version A, yet there appears to be little consideration of risk as an issue in the sustainability or rejection of Version B. The reported accounts of actual harm and infant death have largely been from specialist mother and baby units but this data has not been used in the same way in health care policy pertaining to specialist mother and baby unit service provision.

8.11 Diffusion and dissemination in Scotland

Taking the development of the practice in Scotland as a more detailed case example, the influencers and drivers for adoption are recounted in the history in more detail due to my personal involvement and knowledge of the processes involved. As already noted the history of joint admissions in Scotland is not well documented. With the exception of the publication by Hamilton et al, 1969, no other accounts of joint admissions are evidenced in documents until the early 2000s (SIGN, 2002). My own knowledge of the events has therefore largely informed the historical narrative from 2001 onwards.

Scotland was the only area of the UK that had a Nurse Consultant post in perinatal mental health. I obviously must declare my own bias as to my analysis of the relevance of this post within the NHS system in Scotland as I was the post holder from March 2001 until July 2008. The development of all nurse consultant posts in Scotland up until 2004 had to be approved by the Chief Nursing Officer of the Scottish Executive Health Department and NHS Boards had to go through a formal and stringent application process to have posts approved. The post had to be directly linked to proposed significant health gain for the population it was targeted at. Having the post approved was therefore in itself an acknowledgement that there was a need for services and nursing practice to be improved upon in Scotland.

Although the nurse consultant post was developed by NHS Greater Glasgow, all posts also had a national remit in terms of professional leadership and strategic influence. This national element of the post enabled issues identified locally to be brought to the attention of the Chief Nursing Officer's (CNO) directorate within the Scottish Executive through regular meetings with the Mental Health Nursing Officer. The nursing officer was therefore aware of the work being progressed in Glasgow at one level to improve the day to day clinical governance of Version A joint admissions, whilst at the same time, the higher level needs assessment and business case were being developed to try to secure the commissioning of a specialist mother and baby unit.

Having a greater awareness of the practice issues and service gaps in Scotland, the CNO directorate subsequently awarded me the study fellowship to visit specialist mother and baby units in Melbourne, Australia to help inform practice and service development in Scotland. The timing of these events was of significance to the issue of joint admissions being brought to the attention of Scottish Ministers. During the time I was away from work undertaking the fellowship a clinical decision was made to admit a woman to hospital for treatment but it was not deemed appropriate for her baby to be admitted with her due to the activity within the general adult ward at that time. This reflected the new governance arrangements put in place to reduce risk and improve practice in perinatal mental illness in Glasgow. It was this woman who subsequently had her experience reported in the local and national press after she highlighted to her local MSP the inequities between the human rights of new mothers with mental illness and those of new mothers who were imprisoned in jail but were provided with appropriate child care facilities to enable them to continue to parent their infant until they were two years of age.

As detailed in the history, the woman's local MSP had been successful in having the issue accepted for debate in parliament. The CNO directorate was asked to prepare a briefing on the subject to prepare the Minister for Health and Community Care for the debate. Because the nursing officer for mental health was fully informed of the work I had been progressing in the Nurse

Consultant role in Glasgow and also knew of the information I had collated on service provision and practice in Australia through the fellowship award, he was able to provide a detailed briefing on the subject and highlight the lack of service provision in the NHS in Scotland. A few weeks prior to the parliamentary debate the Minister for Health and Community Care was present at a national event where I presented the findings from my study fellowship on services for joint admissions in Australia. It was therefore opportunistic that he sought my views on the lack of service provision in Scotland. It is highly probable that the Nurse Consultant role having this national profile and being in a position to influence both professionally and strategically at local and national levels are significant factors to the events that followed in the history of service development in Scotland.

The development and implementation of the legislation by the Scottish Government that puts responsibility on Health Boards in Scotland to provide specialist services for joint admissions is the critical factor in diffusion shifting to dissemination. Thereafter the Government produced guidance on how services should be developed and delivered to support planners, commissioners and providers of services, which was added to the mental health strategy (Scottish Executive Health Department, 2004). As previously identified in the history, I was asked within my role as Nurse Consultant to chair the development of this national guidance, which, as a nurse in clinical practice, this was apparently unprecedented to be asked to chair this type of health policy development on behalf of the Scottish Ministers. I was advised by a civil servant at the time that this position is normally reserved for NHS Board executives or senior medical colleagues. The production of this guidance strengthened the dissemination process.

Diffusion and dissemination are on the same continuum in the conceptual framework provided by Greenhalgh et al (2004). Dissemination accelerates the pace of adoption and increases the number of adoptions of the innovation. It is also used to enhance the quality of innovation implementation or to sustain the use of worthy innovations. The ultimate outcome of dissemination is to demonstrate innovation effectiveness at individual client and client system levels (Dearing, 2008). The

implementation of the mental health legislation was monitored by the Government and Health Boards and Local Authorities had to report on their progress through formal reporting mechanisms so this further influenced service development for joint admissions. To support service delivery NHS Education Scotland supported the development of a curriculum framework which was then used to develop post graduate education for staff working in the field (NHS Education Scotland, 2006).

All these actions have informed and supported Health Boards in Scotland to develop and provide services. However had the legislation, political and policy agendas not been influenced it is very doubtful that services would have diffused naturally to the extent that they have within the timeframe that they have. The sequence of events, influences and influencers which led to these changes was complex but timing of the events was critical to the decision making processes involved. The significance of champions and policy entrepreneurs being actively influential during the 'window of opportunity' in the health policy agenda referred to by Kingdon (1995) has been identified to be of particular relevance in this study.

CHAPTER 9: DISCUSSION

9.1 Strengths and limitations of the research

The strengths of the research lie in the approach taken to the historical method which included the examination of a wide range and volume of documented data that was presented using a combination of narrative and analysis. The search methods adopted were diverse and involved a range of sources including oral history, internet searches, bibliographic searches and hand searches of archived records. Having personal involvement in the diffusion pattern has been a direct source of primary evidence for the study which has helped provide a detailed insight into the processes involved in one example of service development in Scotland.

The method was further strengthened by the use of the theoretical framework diffusion of innovation (Rogers, 2003), to guide the analysis of the data. The study is original in so far as the subject history has never been studied in such depth or in the context of diffusion. This study has been an interesting twist on normal diffusion studies as the subject under examination has essentially been two competing versions of one innovation diffusing over the same time period. Although unusual, this is not unique: if one turns to the area of technology a similar example of competing versions of new innovations diffusing at the same time can be found. An example is the diffusion of video cassette players (VCRs) in the 1970s and 1980s. The Betamax VCR was introduced in 1975 and the VHS VCR was introduced in 1976. The diffusion of the incompatible models and the period of intense competition became known as the 'videotape format war' (Wikipedia, 2012). VHS dominated the market and Betamax was eventually removed from the market in January 1988 (Wielage and Woodcock, 2003). The influencers to rejection in this example were somewhat different to those in joint admissions as VCRs were commercial products rather than a public service such as the NHS service provision. This example is included here as an example of a similarly unusual diffusion study whereby the same innovation was diffusing in

different versions over the same time period. The interesting difference between this example of a commercial product and the study of joint admissions is that health policy and legislation over-ride the 'market' factors of the commercial product.

The normal methodology used in diffusion studies, since pioneered by Ryan and Gross (1943), is the use of questionnaires and interviews to gather information from adopters of innovations retrospectively but neither of these two methods were used in this study. The rationale for questionnaires and interviews not being used was that it would have been extremely difficult to identify who the respondents for inclusion in the sample should be. As detailed in Chapter 8 the social system of the NHS is not a single unit of adoption, but a very complex system with several sub systems. To gain complete data for each area, all members of the sub systems who make up the system involved in the adoption or rejection process of joint admissions would need to be recruited. The identification and then recruitment of the individuals across each Health Authority and Health Board area would have been an almost impossible task and this approach to data collection would have been highly likely to fail. A further consideration on the use of questionnaires was that these may have introduced researcher bias to the study by pre-selecting particular areas to enquire about, which may have resulted in other important information on the diffusion process not being identified.

The limitation of the research is that the data collection was heavily reliant on the published evidence of joint admissions. This approach has limitations as the data being examined is retrospective and has not originally been recorded for the purpose of the research study in question which makes it highly probable that there will have been gaps in terms of the detail of the events. Also the information from personal recollection was not recorded for the purpose of the study, and was a retrospective recall and reflection of events. Recall is affected by the length of time between events and data collection so accuracy cannot be guaranteed.

Time is an important methodological enemy in studying the diffusion process of an innovation however the time variable is central to the research (Rogers, 2003. 126). The majority of diffusion research designs consist mainly of correlational analyses of cross-sectional data gathered in one-shot surveys of adopters or potential adopters of an innovation by the use of interviews or questionnaires (Rogers, 2003. 127). However, in his fifth edition of his text 'Diffusion of Innovations' (Rogers, 2003), Rogers suggested that diffusion studies should ideally rely on 'moving pictures' of behaviour, rather than 'snapshots', because of the need to trace the sequential flow of an innovation as it spreads through a social system. He goes so far as to claim that using surveys in diffusion research is "*intellectually destructive of the process aspects of the diffusion of innovations*" (Rogers, 2003. 127). The accuracy of the data on the time variable in the process of diffusion, measured through a respondents recall at a single point in time, is considered by Rogers to be a weak method of data collection (Rogers, 2003. 127). The length of time involved in the diffusion pattern in this study was more than 60 years in duration which did not support the use of questionnaires or interviews. The survey data used as evidence was historical; however, it is acknowledged that the published surveys had considerable weaknesses in relation to the reliability of the data.

With Rogers' above points in mind (Rogers, 2003. 127), it may be argued that the decision not to include questionnaires and interviews is more balanced towards a strength rather than a weakness of the research method where the aim was to identify the processes that were involved in the diffusion pattern.

The outcomes of the research questions are considered next:

9.2 Research question 1

What is the chronology of the diffusion of joint mother-infant psychiatric admissions in the UK?

The historical chronology of the diffusion of joint admissions spans a period of almost 64 years and is still in process. In identifying the history of the development of the innovation, a key finding is that throughout the literature the innovation of joint mother and baby admissions to psychiatric hospitals has been attributed to Thomas Main as the pioneer of the practice (Baker et al, 1961; Brockington and Kumar, 1982; Brockington, 1996). However, having considered the primary evidence of the original published articles (Douglas, 1956; Main, 1958), it is proposed here that the pioneers of the innovation from an empirical and theoretical perspective were Douglas and colleagues at the West Middlesex Hospital (Douglas, 1956). This is not calling into question Main's claim that the first such admission took place in 1948, rather it recognises to the fact that Version B of the innovation by Douglas, Haldane and colleagues in terms of clinical treatment informed by theory as opposed to the caretaking arrangement which characterised Main's version of the innovation, Version A. In 1955 Thomas Main himself rejected Version A in favour of Version B when he opened a specialist unit and started working with women with psychosis (Main, 1958). Main even acknowledged the help he received from consultation with Douglas in relation to her work with women with psychosis (Main, 1958. 845), but this acknowledgement from Main appears to have been lost in the later history. It is probable that Main got the recognition for the innovation of joint admissions due to his status among peers, his position of seniority within the social system of the NHS and it is possible that the fact Douglas was a female trainee psychiatrist was also of relevance.

9.3 Research question 2

Why has this pattern of service development evolved; what factors and influencers are relevant to the identified pattern of service development?

There were several factors and influencers identified as being relevant to the diffusion pattern of joint admissions across all areas of the UK. The main factor was communicating and sharing of knowledge of the innovation among peers through the various informal and formal networks which led to clinicians in their local areas gaining knowledge and understanding of the innovation.

Publication of the innovation in the professional press and through presentation at international

conference initiated wider knowledge spread of the innovation and subsequent diffusion of both versions of the practice in the UK and worldwide. Communications through other means, such as newspapers, magazines and television, have also been relevant to the diffusion pattern. This has mainly been in support of the diffusion in cases of inequity of service provision, but it has also been relevant in cases which are viewed as scandalous such as non-accidental injury to infants within the mother and baby units and calling to question the very presence of the units.

Reports of actual or perceived risk to the infants is regarded as being a significant factor in the slow diffusion of Version B, specialist units for joint admissions, but also to the mass rejection of Version A of the innovation. There are clearly differing perceptions on this and one suspects a high degree of under reporting on the subject. It is likely that those who considered the risks from the child's perspective were far less likely to adopt the practice. Indeed in the international literature, risk to the infants was a focus of non-adoption or rejection of the practice (Wisner and Jennings, 1996; Maizel et al, 2005).

There has only recently been more emphasis put on the needs of the child being paramount in terms of joint admissions. For many years the focus of the practice of joint admissions has been from the perspective of what was considered to be in the mothers' best interests with the assumption being made, in some cases wrongly, that the child would automatically benefit from not being separated from its mother and that the risks were manageable. This was the view of a large number of those who adopted and championed the practice of joint admission and it has only recently been accepted that there is no automatic benefits. Intervention has to be proactive and targeted at the needs of the mother and child as individuals and secondary to the mother-infant relationship. Consideration is not always given to the child's primary attachment. From personal experience I can recall joint admissions being facilitated even although the child's primary attachment was with the father, which upon reflection, may not have been in the best interests of the child in the long term.

Local champions, acting sometimes as policy entrepreneurs, have been highly relevant to the diffusion of the practice in most local areas, and to influence at a national level, particularly in England, Scotland and Northern Ireland. These champions have in the main, been professionals with a special interest in the field of practice. Local 'champions' however may also have negative consequences to the diffusion pattern. There is clear evidence that where the service provision has been person dependent, usually heavily reliant on the drive of the individual consultant psychiatrist or clinical academic, services close when the individual is no longer there. Succession planning is therefore a critical factor to service sustainability. The role of the Nurse Consultant Perinatal Mental Health in Scotland is also felt to have been relevant to the diffusion pattern in Scotland. This is both in the rejection of Version A and in the diffusion and dissemination of Version B.

In Scotland there is clear evidence of an MSP championing the cause on behalf of his constituent which contributed significantly to a sequence of events which led to legislation and the subsequent dissemination of Version B. Political influence was particularly relevant to Scotland and in Northern Ireland it is political influence that is at the centre of the innovation decision process currently taking place.

Late in the diffusion pattern in Scotland the shift has been from one of diffusion of the innovation to dissemination of the innovation. This has resulted in four of the five areas that have units or annexes in Scotland for joint admissions, developing services initially in the absence of a local champion. This was clearly in response to government policy and the requirement to comply with Scottish Law. In these cases it was executive and managerial responses as opposed to clinical champions who implemented the development of services to support the provision of joint admissions. Glasgow was the only area that had clearly identifiable champions.

Changes in UK health care management policy changed how decisions to adopt were made during the 1970s, 1980s and 1990s. Individual autonomy of psychiatrists and psychoanalysts early in the

diffusion pattern was prominent before a change in the hospital management arrangements in the 1970s. Thereafter decision making was led by a general management structure and in the last decade, decision making has become more centralised and directed by government in all four areas of the UK.

The drive towards shifting the balance of care from hospital to the community since the 1990s has resulted in significant numbers of bed closures across the UK which has resulted in less hospital admissions overall, however there are still gaps in service provision at 2012 when birth numbers across the UK have been rising year on year over the last few years. In parallel the increasing drive to have perinatal mental illness recognised as a sub specialism within the Royal College of Psychiatrists is likely to have had an influence on the rejection of Version A and the promotion of Version B. Influence by policy entrepreneurs and champions on subject policy have seen a policy stream emerge aimed specifically at the development of specialist mother and baby units, rejection of Version A of the innovation and latterly, increasing standardisation of the innovation across the UK. This process was perhaps accelerated in the last decade by the focussing event of the Public Inquiry into the deaths of Daksha and Freya Emson referenced in Chapter 4.

9.4 Research question 3

Are there differences in what factors and influencers were of relevance to service development across the four areas of the UK and what are possible reasons for this?

The main area of difference in influence was through the influencing of the policy agendas in the four areas of the UK from the mid-1990s onwards. As described in Chapter 5, each area of the UK has devolved decision making powers for health care policy which explains differences across the four areas, however it is important to consider what or who the influencers were which may give further explanation why the differences exist.

From the history it has been identified that in England, Wales and Scotland the influence on policy specifically in the area of inpatient service provision for joint admissions did have a positive effect on the diffusion pattern of the adoption of Version B and also an effect on the rejection of Version A. The Royal College of Psychiatrists were the dominant influencing body and within this organisation, itself a social system, the influence of champions who were psychiatrists in the field of perinatal mental illness was also important to the diffusion pattern in terms of the adoption of specialist units and the rejection of side room admissions. This was done through changing the attitude and perception of Version A by peers within their social system and by influencing the policy agenda. The main focussing events which led to further development of national policy, the setting and monitoring of standards, and commissioning prioritisation through regional planning and commissioning groups in England and Wales was the recommendations set out in the Confidential Enquiries into Maternal Deaths. A further focussing event from the perspective of the Royal College of Psychiatrists was the public enquiry into the deaths of Daksha and Freya Emson detailed in Chapter 4 (2003).

In Scotland, health policy was clearly influenced from the late 1990s onwards. Scotland was the first country worldwide to develop evidence based standards which recommended that joint admissions to side rooms should be stopped in favour of the development of specialist mother and baby units. Policy dissemination in Scotland and the development and implementation of legislation have been key factors in both the discontinuation of Version A of the innovation (side room admissions) and the implementation of Version B, specialist mother and baby units.

There was a consultant psychiatrist, Roch Cantwell, who had been a local champion in the Glasgow area for a number of years trying to influence the NHS Board that a service should be commissioned. In addition the development of the Nurse Consultant post specific to perinatal mental illness also helped champion for improved practice, systems of governance and specialist service developments. However, it was largely external influences from a service user, the tabloid

press and MSPs that threatened the reputational risk of NHS Greater Glasgow and Clyde and became the focussing factor in the decision making process of the Board. The premature announcement in Parliament that Glasgow was to be commended on their plans to develop a specialist mother and baby unit was also an influencing factor in the eventual decision by the Board the following month to commission the service.

The Scottish Parliament was the external influence on the development of Version B in other areas of Scotland when they passed specific legislation that made it a requirement for NHS Boards to provide these services. This window of opportunity in terms of legislation was due to the fact the Scottish mental health legislation was under major reform at the time and it was opportunistic on the part of the MSPs to have this aspect added as an amendment before the legislation was finalised. Had this review not been taking place at this time it is highly unlikely that service provision in the form of Version B would have been legislated for separately.

There was a clear lack of evidence on the role of nurses in the history of the diffusion pattern of both versions of the innovation. The one clear difference between the four areas of the UK was that the only Nurse Consultant post in the UK in the field of perinatal mental health was in Glasgow. As already detailed I held this position from 2001 until 2008 so I must declare my personal interests in this section of the discussion and acknowledge that I may introduce elements of bias to the discussion due to my personal involvement.

The Nurse Consultant posts are unique in the nursing career framework in so far as a specific requirement of the posts is that they should have both local and national influence in the subject field and that they should, among other things, develop clinical practice and develop services (Scottish Executive Health Department, 1999). No other clinical posts, nursing or otherwise, have all these aspects as requirements of their role. Service and practice development were component functions within the role yet very few nurse consultants have any prior experience of service

development before appointment (Booth et al, 2006). Many clinicians become involved in these aspects through personal interest and development within their clinical post, but it is not a pre-requisite of the post descriptor. The Nurse Consultant posts can also assert influence over traditional professional and organisational boundaries as the role focus of many of the posts is usually on the clinical pathway that the patient follows rather than restricted by service area boundaries.

In the case of the perinatal mental health nurse consultant post this focus was the patient pathway from pre-conceptual care of women with mental illness through primary care, maternity care, secondary care mental health and tertiary care for those women with very severe illness who required this level of care. The posts work through influencing others rather than managerial authority. Therefore authority lies in the knowledge and experience of the subject and the credibility of the individual posts is largely brought through the clinical focus of the posts. The posts enable clinical nurses to continue to deliver direct patient care and therefore have direct knowledge of the issues affecting patient care, but to also be in a senior position within the NHS Board to inform and influence decision making. The further, and perhaps most powerful advantage if used, is that the post-holders also have access to the policy makers at the government through their national role focus which enables them to take the opportunity to inform and influence policy agendas that are then disseminated back down through the NHS Boards for implementation at local level and therefore affect the direct patient care the patient receives not just locally, but across the country. This was certainly my personal experience of the post in Glasgow. The impact of the post was not just at local level but through a certain level of policy entrepreneurship health care policy could be influenced at national level which in turn effects change in a wider and more sustainable way. This pathway of nursing influence was significantly relevant to the subsequent diffusion and dissemination of the practice in Scotland.

9.5 Research question 4

Have the factors influencing service development changed over time?

The findings suggest that there has been a change in the factors relevant to adoption and diffusion over the time frame of the adoption pattern. The main influence on the adoption of joint admissions was the presence of individual clinicians who put energy into championing the innovation. The layers of the social system of the NHS became much more interconnected as the diffusion time line progressed and decision making authority has shifted up through the layers, in some cases to the highest level of the social system, the health departments of the governments. This shifts the diffusion pattern in some cases along the continuum to one of dissemination. Champions are still required locally to get the knowledge on the innovation known to the board of management in the first place, but what or who needs to be influenced has changed considerably over the time line of the joint admission diffusion pattern. Influencing health care policy is now the lever for influencing and securing service commissioning or development as opposed to individual innovation and decision making with little external scrutiny or accountability. This role is not one that clinicians are currently trained for.

The issue of risk has accelerated as the time line of adoption has progressed. Reputational risk has become a significant focus not just for individual clinicians, but more so for individual health authorities and NHS Boards and at the highest level of government. This in turn has made the NHS much more cautious about accepting known risks or taking decisions to adopt innovations where the risks are unknown.

This concludes Chapter 9. Chapter 10 outlines the conclusions drawn from the evidence and findings and provides recommendations informed by the findings from this research.

CHAPTER 10: CONCLUSION AND RECOMMENDATIONS

10.1 Conclusion

In conclusion, the pattern of diffusion of joint mother and baby admissions to psychiatric hospitals in the UK has been an unusual one, in terms of frequency of adoption and in the length of time the pattern of adoption has taken, but also in view of the fact the innovation continues to diffuse more than 60 years later. The study itself has also been unusual in so far as it has examined not only the pattern of adoption of an innovation, but also the factors relevant to the later rejection of one version of the innovation. Furthermore the common methodology of using questionnaires and interviews to gather oral data on diffusion patterns was replaced in this study by the use of documentary evidence as the method to identify the history of the innovation. The third factor which makes this an unusual diffusion study is that the innovation under study was a non-commercial innovation which had two competing versions diffusing in parallel over an unusual lengthy timeframe.

Influencers on the diffusion of joint admissions changed over the time line of the adoption pattern which corresponded to changes in health care policy across the four areas of the UK. The predominant influencers have been clinical and political champions, social networks, perceptions of risk and policy entrepreneurship. The influencers identified as relevant to the diffusion patterns of each version of the innovation were essentially the same influencers; however, they were used in different ways to affect change which resulted in the rejection of Version A of the innovation whilst at the same time Version B was being promoted as the preferred version of the innovation to be adopted. The drivers for continued service provision appear to have been emotional factors rather than empirical findings as research has not been a strong influencer in the diffusion of this innovation. There are many published studies which report on similar influencers to diffusion of numerous different innovations. Important findings in this study are the considerations of the possible and probable barriers to diffusion which account towards the slow and unusual pattern.

10.2 Barriers to the diffusion of specialist mother and baby units

I have focused the barriers to diffusion on Version B of the innovation as opposed to Version A as Version B of the practice is still diffusing whilst Version A is not. If the future diffusion pattern is to be influenced towards further adoption, it is the barriers to Version B that need to be understood and acted upon. This will allow for further 'in process' diffusion research which Rogers (2005) identified as a considerable gap in the research literature and recommended should be progressed.

The findings suggest there are several barriers to the adoption of specialist mother and baby psychiatric units, Version B of the innovation and these should be considered by those who are endeavouring to have services commissioned. Some of the barriers identified in this example may also be of relevance to other clinical fields of practice where efforts are needed to influence commissioning decisions made by NHS Boards, Health Authorities, regional planning groups, or Government policy makers.

The barriers are listed below:

- 1 Absence of recent quantitative or qualitative research evidence on effectiveness: there have been no published studies on effectiveness of joint admissions, particularly to specialist mother and baby units, for many decades, despite repeated recommendations for this area of research in the literature. This lack of evidence in an era that advocates for the delivery of evidence based health care provision through both government policy and clinical standards is considered to be a barrier to the further diffusion of specialist psychiatric mother and baby units. Cain and Mittman (2002) identified that the more obvious the evidence of improved experience, increased functionality and better outcomes, the more likely adoption by others will occur.
2. The absence of economic evaluation of existing provision: there has been no economic analysis of the comparative costs of alternative treatments but this may be a consequence

of the lack of evidence on effectiveness detailed above which makes it extremely difficult to conduct comprehensive economic evaluation. The societal view point is the broadest one but there has been no published analysis of the costs and consequences of organising and operating such services (capital and revenue), the costs and consequences borne by patients and their families or the costs and consequences borne externally to the NHS, patients and their families, the elements one would expect to be included in an economic analysis of health care provision (Drummond et al., 2005). The absence of this type of evaluation prevents informed and accountable decision making for the use of public money by the Government or the local NHS organisations.

3. Service 'fit' in current divisions of psychiatric service provision in the NHS: Perinatal mental health care currently sits as a sub specialism of general adult psychiatry. This may be appropriate from the perspective of the needs of the women but may also be a barrier to the needs of the infants and to the wider family being given the focus they deserve given the strong evidence from research on the importance of appropriate stimulation and relationships in the early years to future infant and child development and child health outcomes. In some countries perinatal mental health care is delivered from within the delivery arrangements for child psychiatric services but the reverse argument could be had in this arrangement. There is currently a gap in service provision in the UK for the on-going needs of the mothers and infants together with the wider family. Perinatal psychiatric services largely only provide specialist care and treatment up until the end of the first postnatal year. Should a woman have on-going mental illness after the first 12 months, her care reverts back to general adult psychiatric services, where incidentally, it is argued by perinatal psychiatrists that the needs of these women and infants can't be met during the preceding 12 months. This 'cut-off date' appears to have been borne from the view that as a child meets its developmental milestone and starts to crawl and walk, the specialist mother and baby unit is not a suitable environment for their continued developmental mobility needs and the risk of physical harm also increases as a

consequence of their mobility. If the aim of perinatal psychiatry is truly to improve outcomes for not just the mother but for the mother-infant dyad and the wider family then this cut-off date is a significant barrier to this being achieved and sustained.

- 4 Absence of succession planning: it is known from the evidence that several services were very reliant on the continued interest of individual clinicians and academics. There was evidence that units have closed after individual clinicians left the service and either could not be replaced, or decisions were made locally that the service was no longer required in their absence. Some of these posts were clinical academic posts where individuals developed their own research interests, which may not always have been done in the context of the consideration of the longer term sustainability of service provision once the research was complete or their interest shifted.

A further barrier to recruitment, retention and succession planning is that there is currently no higher level specialist training for perinatal psychiatrists within the Royal College of Psychiatry which makes succession planning reliant on the few trainees who get experience of specialist mother and baby units to develop and maintain an interest in perinatal psychiatry, without actually being able to complete legitimate higher level training in the speciality. This approach to developing specialist practice is not an attractive career pathway for some psychiatrists. Efforts are being made to have higher level specialist training approved (Cantwell, 2012) however in the meantime, succession planning remains a local arrangement. With so few specialist units across the UK, consultant level posts are not easy to come by. Most psychiatrists who have an interest in perinatal psychiatry are consultants in either general adult psychiatry or CAMHS services with special interest sessions as a small proportion of their job plans.

Similarly for other professional groups, limited exposure to experience of services and very limited theoretical study in undergraduate training makes it difficult for staff to know in advance if they would enjoy working in this field of practice and often are unfamiliar and

inexperienced with the complex nature of the needs of both the women and infants in an inpatient environment.

10.3 Recommendations for further research

As noted early in the thesis, in-process diffusion studies are very unusual. The diffusion of the innovation of specialist mother and baby units is still in motion and appears to be gaining momentum again in terms of the frequency of adopters. It is therefore an opportunity for further research on the continued diffusion pattern of this innovation to be mapped and examined in process to further inform and influence the pattern in the future.

The second area recommended for future research is in the area of effectiveness of specialist psychiatric mother and baby units. Qualitative research is a rich source of evidence in terms of the experience and perception of benefit for women and their families. If quantitative research is to be sought to evidence effectiveness then there are many ethical barriers that would exclude comparison groups. A suggested progression of evidencing effectiveness through a comparative methodology would be to compare outcomes from joint admissions to specialist units with outcomes from single admissions to general adult psychiatric units in a geographic area that has no access to specialist inpatient service provision. It is recommended that outcomes for mothers, outcomes in relation to the mother infant dyad and outcomes for infants should all be considered separately. The theme of risk of harm to infants should be an element of this recommended future research. The impact of joint admissions on fathers and older siblings may also be a consideration.

Conducting the above research would allow for an economic evaluation to then be completed, which, depending on the outcomes, may assist service commissioning in areas who have no provision or the continued sustainability of services where they may be under threat of closure.

The final recommendation for future research, which is of particular relevance to the nursing profession, is on the potentially very powerful role of nurse consultants in influencing diffusion of innovation through policy entrepreneurship. Health care policy has been identified in this study as having particular relevance to the diffusion and dissemination of the innovation under study. As noted early in the thesis, nurse consultants have a unique position within the professional career framework to legitimately use their clinical and professional position to influence policy agendas in order to motivate the achievement of the service development function of the roles in areas where service gaps exist.

10.4 Recommendations for the specialist field of perinatal psychiatry

Succession planning should be actively considered by NHS organisations that provide existing specialist inpatient services if these services are to be sustained. This should be done in partnership with local higher education establishments who provide undergraduate and postgraduate education and training. A formalised approach to succession planning through existing structures such as the Perinatal Quality Network would strengthen the position of existing services within their NHS organisation. If a standard to be achieved by existing specialist units was for there to be a process for succession planning for all professional groups of staff who make up the multidisciplinary care team, this would perhaps reduce the risk of units closing due to inability to recruit to vacant positions.

A final recommendation is that there should be a revision of the current criteria and definition of how services are organised under the current heading of 'perinatal mental health' to consider the alternative notion of 'family psychiatry' or 'parental psychiatry'. With perinatal psychiatry currently sitting as a sub specialism of general adult psychiatry, it often doesn't have 'a voice' within NHS organisations. Having a directorate or specialist division would give more focus to service provision within the field, as opposed to it perhaps being lost within general adult psychiatry. This would also

allow specialist services to legitimately regard the first three years of the child's life as the most crucial in terms of the needs of the women, children and wider family where maternal mental illness exists, as the evidence base would indicate. This would facilitate the extension of the existing wealth of knowledge, skills and expertise in perinatal mental health care to be focussed on longer term primary prevention for the child, whilst also focussing on better outcomes for the women in relation to what I will term here as 'milestone relapses'. I have no research evidence at this stage to support this theory but from personal clinical experience I have identified that in many cases each significant developmental milestone a young child approaches or reaches, poses a new set of challenges for the women's mental state and her recovery from mental illness. This is often not fully understood or addressed within general adult psychiatric services and it is only through personally working with women for several months beyond the 12 month postnatal period that I observed this to be the case. This needs to be researched and I would hope to pursue this at some point in the future.

This concludes the thesis.

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APPENDIX 1

Health policy in the UK in context

In 1707 the Act of Union abolished the separate Parliaments for Scotland and England and created a single Parliament at Westminster in London. A form of administrative devolution for Scotland was established in 1885 when the Scottish Office was created as a Department of the UK Government, assuming responsibility for many of the issues including health, which in England and Wales were dealt with by Whitehall Departments. The Scottish Office was headed by a UK Cabinet Minister, the Secretary of State for Scotland.

The first move towards devolution in Wales came in 1907, with the establishment of the Welsh Department of the Board of Education. This was followed in 1919 by the Welsh Board of Health. The first Secretary of State for Wales was officially appointed in 1964 and with this position the Welsh Office was introduced. Prior to this, moves towards devolution for Wales had been minimal, with Wales and England generally administered as a single entity.

The National Health Service Act 1946 (Ministry of Health, 1946) came into effect on 5th July 1948, the same year as the first recorded joint admission took place at the Cassel Hospital. The Act created the National Health Service (NHS) in England and Wales. The title would imply that there was one health service established across the whole of the UK but a separate arm of the NHS was established for Scotland through the assent of the National Health Service (Scotland) Act 1947 (Ministry of Health, 1946a). In England and Wales the NHS was accountable to the Secretary of State for Health (the Secretary of State for Wales took over responsibility for health and welfare in Wales in 1969), and in

Scotland the NHS was accountable to the Secretary of State for Scotland. In Northern Ireland, the publicly funded service responsible for delivery of health care was the Northern Ireland Health and Social Care Service which differed from the NHS in the other areas of the UK in that it was also responsible for social care.

In 1998 devolution took place with the passage of The Scotland Act 1998 (United Kingdom Government, 1998c), The Northern Ireland Act 1998 (United Kingdom Government, 1998b), and the Government of Wales Act 1998 (United Kingdom Government, 1998a).

Health provision was included as a devolved responsibility for each area of the UK.

Previously where each healthcare system was accountable to their respective Secretary of State, they would each now operate as an independent body. They are politically accountable to their respective governments: the UK Government, the Scottish

Government, the Welsh Assembly Government and the Northern Ireland Executive. In

2011 the NHS¹⁹ is the shared name of three of the four publicly funded healthcare systems in the UK. The English NHS is called the National Health Service. The Scottish system is NHS Scotland, the Welsh system is NHS Wales, and the health and social care system in Northern Ireland is called HSC Northern Ireland.

A further explanation is now provided on the devolved administrations for each area of the UK.

The UK Government is the central Government for the whole of the UK but has devolved certain powers and responsibilities to the other three democratically accountable governments. In England there is no devolved government, the UK Government governs

¹⁹ The term 'NHS' will be used throughout the thesis for convenience and ease of reference when referring to healthcare providers across the areas of the UK but it is acknowledged that this is not strictly the correct acronym for Northern Ireland health care.

England. The Department of Health (DH) is the UK Government department responsible for healthcare in England.

The Scottish Government is the administrative arm of the Scottish Parliament. It is led by a First Minister who is elected by the Scottish Parliament and a cabinet who are appointed by the First Minister. The Scottish Government (previously Scottish Executive) and Scottish Parliament were officially convened on July 1, 1999. The Scottish Government Health and Community Care Directorate are responsible for administering healthcare in Scotland.

The Welsh Assembly Government is the devolved government for Wales and the Health and Social Services Directorate has responsibility for health. The National Assembly for Wales and the Welsh Assembly Government are two distinct organisations. The National Assembly for Wales is the democratically elected body that holds the Welsh Government to account and is the Welsh equivalent to the UK parliament in Westminster. The Wales Office supports the Secretary of State for Wales in ensuring the smooth working of the devolution settlement in Wales. The first National Assembly for Wales, established under the Government of Wales Act 1998, was elected on 6 May 1999.

The Northern Ireland Assembly is the devolved legislature for Northern Ireland. The Northern Ireland Executive exercises authority on behalf of the Northern Ireland Assembly. Ministers of the Executive are nominated by the political parties in the Northern Ireland Assembly. The Department of Health, Social Services and Public Safety was created in 1999 as part of the Northern Ireland Executive by the Northern Ireland Act 1998 but power was only officially devolved in 2007 after the Irish and British Governments finally reached agreement on power sharing and many years of disagreement across political parties.

In terms of identifying, monitoring, maintaining and improving the quality of healthcare the UK Government, the Scottish Government, the Welsh Assembly Government and the Northern Ireland Executive double up on their responsibilities by not only being the suppliers of healthcare, but also being the assessors of the quality of the healthcare that is delivered through the NHS systems. Groups organised directly by government departments have been set up to service this function. This lack of separation of government from healthcare delivery is particular to the UK, with other countries such as the USA choosing independent hospital accreditation bodies independent of central government to service the quality aspects of healthcare supply. The UK arrangements, although set up to be independent, are often seen as a weakness and have the potential to over-politicise healthcare, especially over issues of funding and geographical distribution of services. The fact that the body which is underwriting the bills (i.e. the respective government) has a political stake in how the NHS runs is potentially divisive. Scandals and other difficulties, often become political issues simply as a result of media coverage, and the response is often driven by political considerations rather than by science or evidence based medicine or practice (Scottish Intercollegiate Guidelines Network, 2011). Further information on each of the respective

In Scotland, Healthcare Improvement Scotland (HIS) is the independent government body which oversees the quality aspects of the NHS in Scotland²⁰. The Scottish Intercollegiate Guidelines Network (SIGN) was formed in 1993 and in January 2005 SIGN became part of NHS Quality Improvement Scotland. In April 2011 it became part of Healthcare Improvement Scotland. The objective of SIGN is to improve the quality of health care for patients in Scotland by reducing variation in practice and outcome, through the development and

²⁰ From April 2011 this organization included NHS Quality Improvement Scotland (NHSQIS) which previously had responsibility for quality in NHS Scotland.

dissemination of national clinical guidelines containing recommendations for effective practice based on current evidence, across the NHS in Scotland (SIGN, 2011).

The Care Quality Commission (CQC) is the independent regulator of all health and adult social care in England. The body that is the equivalent of SIGN for England and Wales is the National Institute for Health and Clinical Excellence (NICE). This NHS organisation was set up in April 1999 with the aim of ensuring equal access to medical treatments and high quality care from the NHS, regardless of where people live in England and Wales. NICE produces guidance on public health, health technologies and clinical practice. NICE and the National Service Frameworks produced by the Department of Health set clear national standards for NHS services and treatments. Once NICE guidance is published, health professionals and the organisations that employ them are expected to take it fully into account when deciding what treatments to give people. Clinical Practice Guidelines produced by NICE are applicable for implementation in England and Wales and they are also normally disseminated in Northern Ireland after general review. Scotland, however, is under no obligation to implement NICE clinical guidelines. NICE quality standards are only applicable in the NHS in England, with Wales and Northern Ireland also having their own systems and processes for setting quality standards for their own healthcare systems.

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of all health care in Wales. HIW carries out its functions on behalf of Welsh Ministers and, although part of the Welsh Assembly Government, protocols have been established to safeguard its operational autonomy. Services are reviewed against a range of published standards, policies, guidance and regulations.

In Northern Ireland the Regulation and Quality Improvement Authority (RQIA) is the 'independent' health and social care regulatory body for Northern Ireland, including Health and Social Care Services (HSC) Northern Ireland through reviews of clinical and social care governance arrangements within these bodies.

SCANDAL: Not one Scots hospital lets baby-blues mothers stay with children

If she had been in jail Lyn would've kept her baby but she was ill..so she couldn't



Beautiful Baby Heather just after being born

EXCLUSIVE
By DONNA WHITE
Chief Writer

PND
The Facts

WHEN Lyn McLeod held her daughter Heather for the first time, she thought the bond between them was unbreakable.

But three months after the birth, she was hit by post-natal depression. And the absence of mother-baby units in Scotland meant Lyn was separated from her child for three months while receiving hospital treatment.

She found herself in a psychiatric ward alongside sedatives and schizophrenia. A woman in the bed next to Lyn looked herself in the mirror and set fire to herself.

New Lyn, 36, is campaigning for mother-baby units to help other mums avoid the nightmare she had to endure.

Even now, as she plays with her daughter at their home in Fisher, Glasgow, Lyn darts back tears as she explains: "The guilt I felt at leaving her was horrendous, and I'm sure it has affected her - how badly, only time will tell."

"If prisons have mother-baby units to avoid separating prisoners from their babies, then I don't understand why hospitals don't."

"Because I was ill with depression, I wasn't."

An estimated 10 per cent of women who give birth will suffer from post-natal depression (PND) - around 5000 a year in Scotland.

Of these, 200 will suffer from severe PND or an even more serious condition, postnatal psychosis (PP).

Some can be treated with specialist psychiatric care in hospital. But while most major cities in England have dedicated mother-baby psychiatric wards, there is none north of the border.

Medical experts claim separating mothers and babies hampers the mother's recovery, while leaving youngsters open to long-term problems.

Lyn, a food service assistant, gave birth to Heather at the end of March. She split with the baby's father a month later, although they remain on good terms.

But three months into Heather's life, Lyn started to have panic attacks.

A lifelong dog lover, Lyn found herself overcome by a steroid poisoning over her two pets. She said: "I was convinced perma from the dog's

POST-natal depression (PND) can appear up to six months after a birth. Symptoms include anxiety, depression, irritability, sleeplessness, loss of appetite and fatigue. PND may develop even when love is strong. The mother then worries in case she should lose her baby by infection, mis-handling or 'cut death'.

The first step to recovery is getting the woman to admit her feelings, so she can be properly diagnosed and treated.

For help with post-natal depression, contact the Association for Post-Natal Illness on 0207 3863868, or the National Childbirth Trust on 0870 4448707

faces would contaminate everything and eventually cause Heather to go blind."

"I developed obsessive compulsive disorder, constantly washing my hands."

"I had to get the NSPCA to take my dog and I couldn't stand being at home because I felt it was contaminated."

Lyn's health visitor had her admitted to Gartnavel Royal Hospital for a week to get over stress. Her sister Irene took a holiday from work to care for the baby.

Within a day of returning home, Lyn rang Heather's father in desperation, begging him to come and look after their child, because she was feeling suicidal.

"I wanted to take a handful of pills, just to end the pain," she said. "But I didn't want to leave Heather alone."

A psychiatric nurse was called and he diagnosed post-natal depression.

Lyn was re-admitted to the psychiatric ward - but only after a stressful series of calls to find out who could look after Heather.

The baby's paternal grandmother agreed to take her to avoid the need for foster care.

Lyn said: "My mother is 75 and couldn't cope. My mother had to return to work. Liberty has anyone else to turn to."



Together again: Lyn gazes adoringly into the eyes of baby Heather after spending three months in a psychiatric unit, suffering from devastating post-natal depression. Picture: WILIE VASS

day because her dad was good enough to bring her to visit me. But for supportive people around me, things could have been a lot worse."

"The period after birth is crucial for development of the mother-baby relationship. Not only do mothers start badly to separate, it will affect the child."

He revealed that Greater Glasgow Health Board were looking at options for a mother-baby unit, but nothing had been decided.

In the most serious cases of post-natal depression - around one in 1000 - women will attempt to commit suicide or murder their babies.

Which is why, aside from recommending specialist units in Scotland, SNM also called for routine screening for PP as well as PND.

Glasgow Anniesland MxP Bill Burder has written to Gartnavel and health minister Malcolm Chisholm, calling for mother-baby units. He said: "It isn't been for Lyn's supportive

family, her child would have been taken into foster care. This is unacceptable and I will urge the Scottish Executive to take action."

An Executive spokesman said: "Recent guidance asks NHS Boards to look at the merits of joint admissions under their present arrangements with specialist facilities can be provided."

PRISONS

CORNTON Vale, Scotland's only all-women prison, has a mother and baby unit. A spokesman for the Scottish Prison Service said: "Our general rule is to allow a mother to be with her child for the first year of life, then we review each case on its merits."

HOSPITALS

NO hospital in Scotland has a facility to allow a patient with PND to care for her baby. In England, most major psychiatric hospitals have a mother-baby unit. At Birmingham's Queen Elizabeth Hospital, which takes women from across Britain, staff nurse Janice Fowler said: "It is imperative that mother and baby stay together. We've had Scots in our ward."



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Wednesday October 30 2002 **EVENING TIMES** 21

Better care campaign for depressed mums

By Brian Currie
Political Editor

THE fight for better care for mothers suffering from post-natal depression has been taken to the Scottish Parliament.

Glasgow Anniesland MSP Bill Butler is calling on the Executive to force health boards to take the "swiftest possible action" to set up units allowing mothers suffering from the illness to take care of their babies while being treated.

Mr Butler was contacted by a constituent, Lyn McLeod, who was separated from her baby for three months while in hospital.

Lyn, 36, from Yoker, was hit by post-natal depression three months after her baby, Heather, was born in March and found herself in a psychiatric ward alongside schizophrenics and others suffering from mental illnesses.

She separated from her husband a month after Heather was born but they stayed on good terms. Because of Lyn's own mother's age, Heather was looked after by her dad's mother while she was in hospital.

She said: "I only saw Heather every day because her dad was good enough to visit me."

Mr Butler said: "It's worrying

that if she had not had family to care for Heather when she was in hospital, the baby would have had to have been fostered."

He has now tabled a series of parliamentary questions and put down a motion expressing deep concern about the lack of mother and baby units within the NHS in Scotland which would allow women with post-natal depression to continue to care for their children while undergoing treatment.

Mr Butler has also written directly to Health Minister Malcolm Chisholm and the chief executive of North Glasgow

NHS Trust asking them what they intend to do to ensure that mothers suffering from the illness are not separated from their children.

He called it a "very serious gap" in health service provision, adding: "Mother and baby units would seem to me to be absolutely essential given the nature of the illness."

The only unit of its kind is in Cornton Vale, the all-women prison and Mr Butler said: "I accept this is necessary and I'm not criticising it, but what we must have is the situation where mothers are able to have a similar service in the NHS."

Brave Lyn wins help for depressed mums

Babies stay with them in hospital

YOUNG mum's anger at her treatment for post-natal depression has led to a change in the law which will mean sufferers can stay with their babies.

Lyn McLeod, 37, was parted from her baby daughter for three months while she underwent psychiatric treatment in a Glasgow hospital.

Distraught and angered by the cruel separation, Lyn began a six-month campaign for proper mother-baby units.

And after her cause was taken up by Glasgow Anniesland MSP Bill Butler, it is now a legal requirement for women and their infants to be kept together during hospital treatment.

Lyn said: "I'm so pleased no other mum will have to go through what I endured. "I'll never get those three months back."

Until Lyn began her campaign, women in prison in Scotland were allowed to keep their babies with them - but those suffering depression were not.

Around 10 per cent of women who give birth will suffer post-natal depression (PND) - around 5000 a year in Scotland.

But while most major cities in England have mother-baby psychiatric wards, here are none north of the border.

Greater Glasgow Primary Care NHS Trust has now spent £500,000 to set up a six-bed unit at the city's Southern General Hospital, which should be in place by the end of this year.

The new law will force other health boards to follow suit.

The Scottish Parliament voted unanimously in favour of Butler's amendment to the Mental Health Bill. Unless it is proved the mum is a danger to the infant, they'll now be kept together.

Butler said: "I am delighted. This much-needed reform is the



Joyful reunion: Lyn McLeod with six-month-old daughter Heather after the mum's discharge from hospital last October.

EXCLUSIVE
By DONNA WHITE

Scottish Parliament at its best."

Lyn, of Yoker, Glasgow, revealed last October in the Sunday Mail how she was separated from her baby Heather after being admitted to a psychiatric ward.

She had split from the baby's father and had to rely on family support or Heather, now 12

months old, could have been put into foster care. Lyn said: "I'll never get those three months back. I still feel guilty for leaving Heather and I don't think I'll ever get over it."

Experts claim separating mums and babies hampers the mother's recovery and leaves children open to long-term problems.

Lyn was hit by PND when Heather was three months old. She developed obsessive compulsive disorder and was

admitted to Gartnavel Royal. Heather's paternal grandmother agreed to take her.

Lyn, who was in hospital from July 15 until October 2, said: "My mum is 75 and couldn't cope. My sister works full-time."

Lyn said: "I missed Heather incredibly. I was feeling suicidal so wasn't allowed out by myself. I only saw Heather because her dad was good enough to bring her to visit me."

The mum, who is still on anti-

depressants and under me supervision, would like more support groups for women with

She said: "I still don't see Heather and I are as close as should be. I hate leaving her even for a moment."

"Nobody should have the right to interfere with the bond between a mother and her child."

● For help with PND, contact the Association for Post Natal Depression, 0207 3860868 or the National Childbirth Trust, 0870 4444

APPENDIX 5

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MailOnline

'Mother' held after baby is thrown out of first-floor clinic window

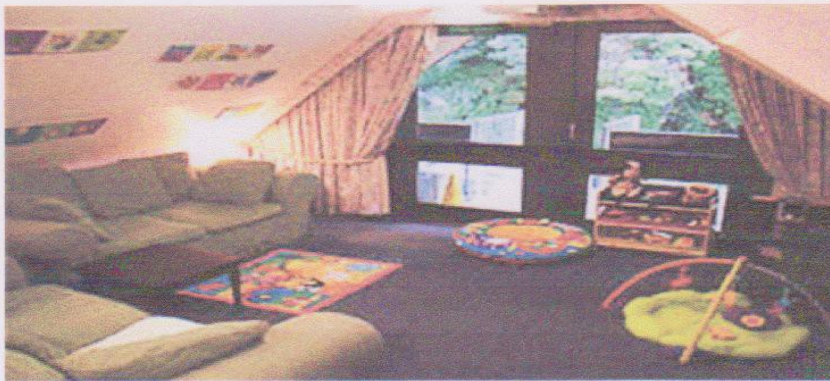
By ANDREW LEVY

Last updated at 14:17 07 June 2007

Baby was fighting for his life last night after he was dropped from a first-floor window at a clinic for mothers with post-natal depression.

The month-old boy was in a critical but stable condition after suffering multiple injuries when he plunged 12ft on to concrete.

A 29-year-old woman, thought to be his mother, was arrested at the private Eastbourne Clinic in East Sussex and detained under the Mental Health Act.



Specialist care: The mother and baby unit on the first floor of the clinic

A source close to the investigation said: "Nursing staff were looking after the woman at the time but they were unable to react as what happened was completely unexpected. They are, of course, absolutely devastated."

After the incident at 7.40pm on Saturday, the boy was taken to Eastbourne District General Hospital, then transferred to St George's Hospital in Tooting, South London.

A spokesman for the clinic said last night: "We are not making a comment at this stage. The police are aware of the incident."

The acute psychiatric unit, which is based in a converted 19th century vicarage, treats patients with psychiatric disorders including depression, manic-depression, schizophrenia and drug and alcohol addiction.

Four women with post-natal depression can be treated in a mother and baby unit on the first floor.

The average stay is just under seven weeks after which a "supervised discharge" is arranged following consultation with local community services.

Although it is independent of the NHS, treatment in the mother and baby unit can be funded by primary care trusts.

Its website says treatment for mothers is provided "in a private and friendly setting, supervised to whatever degree is appropriate".

APPENDIX 6

Extract from the Scottish Parliament Official Report Scottish Parliament

Wednesday 4 December 2002

(Afternoon)

Post-natal Depression (Services)

The Deputy Presiding Officer (Mr George Reid): The final item of business is a members' business debate on motion Si M-3504, in the name of Bill Butler, on the provision of dedicated mother and baby services for women with post-natal depression.

Motion debated,

That the Parliament expresses its deep concern regarding the lack of proper facilities within the NHS

in Scotland that would allow women with post-natal depression (PND) to continue to care for their children whilst undergoing treatment; recognises that the lack of dedicated mother and baby services for women with PND is completely unacceptable; notes the recent Scottish Intercollegiate Guidelines Network report which detailed the shocking lack of appropriate services for women with PND, and considers that the Scottish Executive should ensure that NHS boards throughout Scotland take the swiftest possible action to remedy the alarming poverty of provision of mother and baby units devoted to women suffering from PND.

17:07

Bill Butler (Glasgow Anniesland) (Lab): I express my gratitude to the Parliamentary Bureau for choosing for debate the provision of services for women with post-natal depression. The issue is serious and worthy of serious consideration. I also take the opportunity to record my thanks to the members from many parties who appended their signatures in support of the motion.

The total lack of provision of dedicated mother and baby services for women with post-natal depression is a gap in health service provision of which, I must confess, I was ignorant until two months ago, when my constituent, Lyn McLeod, from Yoker, arrived at my surgery in the Blairdrum neighbourhood centre with her baby daughter, Heather. What she told me shocked me and made me determined to pursue the matter.

Lyn was admitted to Gartnavel royal hospital on 15 July this year and remained there until she was discharged on 2 October. When Lyn was admitted, Heather was aged three and a half months. Because no specialist mother and baby units are available in the Greater Glasgow NHS Board area or, for that matter, anywhere in the Scottish national health service, my constituent was able to see her baby only at visiting times. In effect, Lyn was separated from Heather at a critical time in the development of the relationship between mother and child. Indeed, had Lyn not had a relative who was able to take care of her daughter during that period, Heather would have needed to be fostered for the duration.

Since first meeting Lyn and Heather at my surgery, I have made it my business to highlight the alarming poverty of provision of suitable mother and baby units. I am grateful to the *Evening Times* and the *Sunday Mail* for publicising that unacceptable deficiency in the national health service. I also make it clear that my constituent is—understandably—even more determined than I am that the lack of service be exposed and steps be taken as quickly as is humanly possible to remedy the situation. She is resolved—as am I—to do everything possible to prevent any other mother and baby from suffering such a traumatic experience.

It is a matter of record that no appropriate provision of dedicated units is available in the NHS for mothers with PND. A reply from the minister to my written question S1W-30982 makes that clear. In spite of an acknowledged difficulty in establishing a causal link to childbirth, it is generally

accepted that the incidence of the medical condition stands at 10 per cent. That means that in Glasgow, for example, between 340 and 560 mothers suffer moderate to severe post-natal depression each year. Those figures, which are taken from a perinatal health services briefing document, are in complete accord with figures that are contained in an informative briefing that I received only today from the director of the Church of Scotland's social work arm, Mr Ian Manson. In spite of the obvious need and the principles that are clearly laid out in the Executive's "A Framework for maternity services in Scotland", the minister knows that a serious service gap still needs to be bridged. The framework states that national health service boards "should have local strategies in place ... to develop and implement services for women suffering from postnatal depression".

It goes on to outline the Executive's view that NHS boards should consider reviewing services for women with PND "with a view to developing regional mother and baby units".

Those are fine words and worthy objectives, but women such as my constituent Lyn McLeod need health boards to act.

I acknowledge that, in its initial response, Greater Glasgow Primary Care NHS Trust informed me that a business plan to provide an interim six-bed unit will be tabled at the Greater Glasgow NHS Board's December meeting. I welcome that as a reasonable first step. However, we need a country-wide or region-wide strategy that will enable permanent mother and baby units to be provided. Along with other members, I will listen with great interest to the minister's response to the debate. From the minister's response to my written question, I know that he acknowledges that there is an unmet need and is sympathetic to the speediest possible resolution of the problem. I ask the minister to use his position to take whatever action he thinks would be appropriate to galvanise health boards into purposeful action, which should concentrate their minds wonderfully. Mothers across Scotland demand and deserve no less.

The Deputy Presiding Officer: We have to be finished by 17:55. There is no possibility of an extension. The first three speeches will be of four minutes' length; thereafter, we will have three-minute speeches.

17:12

Mr Kenneth Gibson (Glasgow) (SNP): I would like to be the first to congratulate Bill Butler, not only on securing the debate, but on his passionate contribution to it. Post-natal depression is an extremely important issue, particularly for those of us who have small children and who recall some of the concerns that were associated with the birth of those children.

For many, PND is hard to diagnose. The Scottish intercollegiate guidelines network's guideline 60 states:

"Postnatal depression is regarded as any non-psychotic depressive illness of mild to moderate severity occurring during the first postnatal year. ... It is important to distinguish postnatal depression from 'baby blues', the brief episode of misery and tearfulness that affects at least half of all women following delivery, especially those having their first baby ... Puerperal psychosis ... is a mood disorder accompanied by features such as loss of contact with reality, hallucinations, severe thought disturbance, and abnormal behaviour."

In other words, we are talking about a serious illness. The fact that more than 2.4 per cent of mothers suffer from PND means that more than 1,000 mothers in Scotland have it.

There is a health care network for new mothers but, unfortunately, it is not always possible to detect PND as a specific condition. Across Scotland, there is wide divergence in diagnosis and in how the issue is dealt with. Many people are involved in that process, such as midwives, health visitors, clinical psychologists, obstetricians and psychiatrists. It is important that all those people play their part, not only in identifying PND, but in treating it.

The point of the debate is to call for specific mother and baby units; Bill Butler is not asking for the

earth; he is asking for a small number of units across Scotland, amounting to approximately 30 to 45 dedicated beds for the whole country. That would not be too much of a burden on the health service, but it would be a major benefit to those mothers who go through what is a traumatic, distressing illness.

For those who think that PND may be a passing phase, I must say that, unfortunately for many sufferers, that is not the case. It can lead to other psychiatric illnesses and to a deepening of other underlying pathologies.

Some people have family support to get them through PND; others do not. It makes it much more difficult for mothers to bond with their children if they are trying to deal with the illness at the same time.

I believe that Bill Butler's proposal is extremely worth while, and I hope that the Minister for Health and Community Care will address it positively.

17:15

Nora Radcliffe (Gordon) (LD): Clinical depression is a particularly horrible condition that is often belittled and misunderstood. It is awful for the person who is depressed and equally awful for everybody round about them. A family member who coped with a depressed spouse over a number of years described it as pouring oneself into a black hole, and giving and giving without getting anything back in return. If we translate that into a mother-child relationship and consider the importance for

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both mother and child of forming the sort of bond that enables a child to grow and develop properly, the significance of specialised help becomes glaringly obvious.

Training people how to diagnose PND is an important first step. The condition can be masked by all the normal after-effects of childbirth, such as the adjustments of caring for a new baby, hormonal disturbances and the baby blues. It is important that health visitors and midwives are aware of the symptoms and that they know what to look for. Even more important, when they recognise and diagnose PND, the services must be in place for the mother and baby. The most important part of Bill Butler's motion calls for specialised services to enable mothers to be treated for PND in a way that allows them to have their child with them. If that is done, the service can treat the mother, support the mother-child bond and support the family.

Bill Butler has highlighted an important gap in service provision. If we think of the importance of parenting to the next generation and to the future good of society, the services that Bill calls for are fundamental, and should be in place—yet they are not. I heartily endorse Bill Butler's motion and congratulate him on securing the debate.

17:17

Mary Scanlon (Highlands and Islands) (Con): The Health and Community Care Committee's consideration of the Mental Health (Scotland) Bill gave us a great opportunity to focus on the lack of provision of many services for people with mental illness. Debate arose about the lack of medium-secure units, about problems with placing adolescents in adult psychiatric wards, about the need for units and support services to treat eating disorders, and about the subject of this debate—the lack of services for mothers with PND and their babies.

I am grateful to my colleague on the Health and Community Care Committee, Bill Butler, for raising the topic and for giving the Parliament another opportunity to discuss mental health. If we are to get rid of the stigma that surrounds mental health, that can only be helped by all of us openly discussing the issues. I am particularly delighted that a man has raised the issue of PND. That proves—if proof were needed—that men can equally, adequately and passionately address women's problems.

PND is not just a women's problem. If it remains untreated, it can have a prolonged, damaging

effect on the relationship between mother and baby and a detrimental effect on the child's psychological, social and educational development, as well as on the rest of the family. Mothers often delay seeking help because of the stigma or shame that they feel. They may also experience intense feelings of guilt, failure and inadequacy when they are presented with a bundle of joy and congratulations all round.

I was shocked to hear that between 10 and 15 per cent of mothers have PND. as I know that that statistic is likely to be a gross underestimate.

As Kenny Gibson said, the requirement for 30 to 45 beds for mothers with their babies does not seem a tall order in the grand scheme of things in the NHS. However, I stand by the principle of the least restrictive alternative, as outlined in the Mental Health (Scotland) Bill, because hospitalisation may not be the most appropriate option for all. Day care or community psychiatric nurse support may be appropriate or adequate in some cases.

There is no shortage of drugs for depression, but serious consideration must be given to the fact that the drugs affect not only the mother but, through breast feeding, her baby. There is also concern about side effects and mothers sleeping through a baby crying. I am sure that we have all heard of people who started on anti-depressants following the birth of a child and who, decades later, are still on those drugs. The support of CPNs and health visitors is crucial in cases of PND.

The SIGN guidelines are welcome, but only if they are implemented. Even within health board areas, the implementation of screening is patchy.

I commend NHS Argyll and Clyde on holding a PND event on 5 September in Erskine. I understand that the Deputy Minister for Health and Community Care, Mary Mulligan, was there. The commitment by that health board to addressing PND in an area of considerable remoteness that includes 26 islands undoubtedly is commendable. I look forward to the minister's response to the debate.

17:2 1

Trish Godman (West Renfrewshire) (Lab): I, too, thank Bill Butler for bringing this serious problem to our notice. It is right and proper that we should all demand services that allow women with PND to have their children with them when they are treated in hospital.

Those of us who are mothers know what it is like to have the baby blues—feelings of sadness and despair. Indeed, when I read Bill Butler's motion, I was reminded of the number of times that my mother said to me, "Mrs So-and-so's got the baby blues." In those days, either a neighbour or a friend

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took the baby for a day, or perhaps a couple of days, so there was a community response to the problem. Unfortunately, that is not so much the case now.

Mothers and fathers never forget the incredible fear of the unknown, particularly with the first child. We all remember the first time that we were left alone with our firstborn—there was no one around and it was an incredible shock that the little person relied solely on us. The immense responsibility hits people between the eyes. How difficult it must be for someone to admit to themselves and to others that they have no feelings for the tiny child, or that they cannot accept that the child has changed their life in such a dramatic way: they have little freedom, their career is on hold, and they spend time looking after another human being who, it appears, does not respond to their absolute commitment to them in the early months. How do they face up to those feelings? Medicine recognises that there is such a condition as PND, but it can be difficult even now for medicine to link the signs of depression to childbirth. Indeed, my experience of working in a psychiatric unit is that even in the early 1990s, women were being admitted with diagnoses of depression, eating disorders or excessive stress, none of which was linked to childbirth. In some instances, as Bill Butler said, their children were looked after by foster carers. Some doctors were

of the opinion that there was no such thing as PND, and that someone would suffer from depression only with their first child—they would never suffer from it again.

Maternity services should be geared towards assessing women's circumstances holistically.

Professionals need training and support. Believe me, if someone is in low spirits or is depressed, they can—and will try to—hide those feelings, especially if they believe that they are depressed because they have little or no love for a child. One of the most important pieces of advice that was ever given to me by consultant psychiatrist Dr Raymond Antibani was, "Beware the smiling depression." We see a mother who is outwardly happy, a baby who is well looked after—clean and fed—and nothing more. Then we start to see things deteriorate.

Appropriate multi-agency services, with experienced professionals, must be in place. As Mary Scanlon said, women may not always need medical services in the first instance: they may just need to see a friendly, understanding face.

A review of maternity services is being undertaken. How many of us have asked Bill Butler's question about what services exist in our area for PND sufferers? If members have not asked that question, they should.

I thank Bill Butler again. We can make a difference. The minister has acknowledged the need: let us meet it.

17:25

Elaine Smith (Coatbridge and Chryston) (Lab): I, too, congratulate Bill Butler on securing the debate, which is on an issue that holds great significance for many mothers and families throughout Scotland and, obviously, for Bill Butler's constituent.

As members have said, it is regrettable that we allow the serious issue of post-natal depression to fall victim to trivialisation all too often. In allowing PND to be perceived as simply the baby blues or dismissing it as an overly emotional or illogical reaction to the demands of motherhood, we assist in fostering a society that marginalises many mums who suffer from the condition and we compound the fears of stigmatisation and shame. The SIGN report draws attention to that. I will not read from the report because we do not have time for that, but it talks about the stigma and shame felt by sufferers, who might be reluctant to confess their feelings.

As feelings of embarrassment and failure are symptoms that are often synonymous with post-natal depression, it is essential that any debate on the issue recognises the potentially protracted and detrimental effects that such a depressive illness, if untreated, can have on the mental well-being of not only mothers, but families, and the consequential damage to family relationships.

There is little doubt that ensuring that appropriate support systems that incorporate a wide range of medical, social and voluntary services are in place is central to the treatment and possible prevention of the disorder. Mothers must be assured during the ante-natal and post-natal stages that support exists and can be readily accessed.

The need to establish specialist units in the NHS that provide an option for mothers and babies to be admitted together must be addressed. Other members have raised that and I hope that the minister will comment on the matter when he responds to the debate. I draw attention to a further recommendation in the SIGN report, which stresses the importance of psychosocial interventions as treatment options for mothers and in support for families.

During my extensive contact with breastfeeding mothers, I have come across peer support groups and I have been made aware of research that shows that they play a valuable role in assisting all

women during the post-natal period. I congratulate the Executive on its announcement today that it will provide £60,000 to Ayrshire and Arran NHS Board for the establishment of such a peer support group service in Cumnock. I hope that more money will be provided for other areas. I commend local health care co-operatives for their work throughout Scotland in helping to establish

peer support groups, particularly for PND.

I urge the Executive to ensure continued funding for such ventures. I congratulate Bill Butler again and I agree with his motion.

17:28

Dorothy-Grace Elder (Glasgow) (Ind): I thank Bill Butler for his sensitivity in raising the subject. Principle 7 of the Executive's "A Framework for maternity services in Scotland" notes:

"Trusts should make sure that all professionals receive training and support in ... identification, screening ... and support of women who have or are at risk of developing postnatal depression and other mental illness in a non-stigmatising way".

Obviously, that is not fully happening yet, despite the best intentions of the Parliament and the Executive a year or so ago when the framework was published.

I have had three children and I have not been so unfortunate as to experience post-natal depression, but, like many, I have seen people who have been through it. I have known a few whose families have started to be wrecked through those terrible months, which in some cases extended into many years. One or two women never really recovered from that period.

It is certain that almost all women suffer exhaustion in one way or another for some period after a birth. Cases of post-natal depression as a distinct entity are increasing. We do not know whether the case numbers are truly increasing or whether the increase is a result of better diagnostic techniques. I leave one thought with the minister, which is for him to examine the link between the statistical increase in post-natal depression and the rapidity with which women are ejected from maternity hospitals nowadays. I remember a debate a couple of years ago in which many MSPs congratulated health boards on the turnaround of mothers after birth, which was down to a day or so. I remember that it was the male MSPs who applauded that fact whereas a good number of the female MSPs got to their feet and said that mothers deserved a bit more of a rest than that. Some of us thought that mothers were not budget airlines to be turned around as fast as possible and that women should be cared for a bit longer in hospital, although I should note that many of the women had requested that they leave hospital as soon as possible.

Even if women are desperate to get out, many horrible things can happen immediately after a birth. Surely it is better to have new mothers in a safe environment with the care and support of nurses. I leave this thought with the minister: are there statistics on the long-term effects—post-natal depression and other complaints such as breast engorgement—on women who leave maternity hospital very soon after giving birth?

17:31

Brian Fitzpatrick (Strathkelvin and Bearsden) (Lab): I am pleased that Bill Butler secured the debate. He is to be commended for raising such a serious issue.

I am not sure that anecdote is the best way forward in respect of policy and decision making. Dorothy-Grace Elder made an interesting contribution but, in the great history of maternity services, I am not sure how long women being admitted to hospital to give birth has been a feature. I caution the minister not to waste money on too substantial a body of research into the links to which she refers, but we might want to look at that matter.

I am very much aware of Bill Butler's constituent's campaigning work. I am pleased to say that her work has made its way out to Strathkelvin and Bearsden. That shows the vitality of the campaigning work that Lynne McLeod and others have undertaken on this serious issue. The absence of specialist mother and baby units cannot be supported. I trust that the minister will concede that argument either tonight or in due course.

If we are relying on anecdote, I say that my wife, who is the mother of three children, wanted to get out of hospital as quickly as possible so that she could return home to her family and her own bed. No woman wants to be in hospital. Having had one premature baby and one seriously ill baby, I know that neither my wife nor I could have borne the prospect of not being in contact with them

during those very trying times—holding and touching the baby, while knowing there was nothing that one could do as a parent for a seriously ill child. The converse side of that is that there is no greater offence against sensibility than for a mother to be unable to have contact with her child.
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Trish Godman rightly highlighted how the traditional lines of support by the extended family or friends have altered as a result of changes in social circumstances. Even the impact of distance has meant that people cannot be there for other people any more.

Bill Butler is also to be commended on raising the need for sensitivity on the serious effects of postnatal depression. A number of members highlighted that in their contributions to the debate. I would be delighted to see the minister galvanised by Bill Butler's call. I look forward to seeing its galvanising effects on the minister, if not tonight then at some time in the near future.

17:34

Mr Adam Ingram (South of Scotland) (SNP): I would like to add my congratulations to Bill Butler on securing this important debate.

The World Health Organisation estimates that by 2020 depression will be the second biggest cause of death and disability worldwide. If nothing else, that statistic should concentrate our minds and help us to refocus our health priorities to deliver much more comprehensive mental health services. Research has shown that only one in four cases of post-natal depression is diagnosed and treated by doctors. That lack of effective diagnosis and treatment presents a huge danger to the potential mental health of women suffering from post-natal depression. If not tackled professionally and quickly, it can turn into a chronic and long-term illness. There is also strong evidence of a link between untreated post-natal depression and poor health outcomes of the children concerned. The SIGN 60 guidelines state that there is a need to ensure routine screening for any signs of depression. For that to happen, those who come into contact with new mums must be properly trained to spot the signs of PND. The mental health charity Mind believes that many women go untreated because of a lack of training and because health professionals do not have sufficient time to spend with patients. Health professionals need to be vigilant for signs of PND, as it is very difficult for many mothers to admit to post-natal depression. As Trish Godman said, everyone, including the professionals, expect them to be on cloud nine with a new baby, so many women hide their true feelings. For that reason, I believe that it would be worth while and cost effective for the Executive to focus its attack on that stigma through its 'See Me' campaign.

The SIGN guidelines also recommend that psychosocial interventions should be considered when deciding on treatment options for post-natal depression. Services such as infant massage, cognitive behavioural techniques, couple interventions, social support and counselling should be available. They have been shown to help women suffering from post-natal depression. Given that many women are rightly wary of drug therapies at that time, there is an urgent need for alternatives to be made available. Unfortunately, I believe that, like other SIGN guidelines for mental illnesses, few health boards will implement them, citing a lack of resources. The Executive needs to take responsibility for the implementation of SIGN guidelines, rather than allow them to gather dust on a shelf as happens now. I would appreciate a response from the minister on that point.

17:38

Cathie Craigie (Cumbernauld and Kilsyth) (Lab): Like other members, I add my congratulations to Bill Butler on securing today's debate on what is an important subject. Bill Butler and others have highlighted the lack of facilities across Scotland, especially mother and baby units for mothers who unfortunately require in-patient services. In reality, up to 80 per cent of women suffer a mild, transient emotional reaction after giving birth. As Kenny Gibson, Elaine Smith and Trish Godman have mentioned, that is commonly known as the baby blues. That reaction is considered normal and I am sure that we will all recall experiences from within our own

circle of family and friends of how women have reacted to giving birth.

I want to tell a story that lightens the debate a bit and on which my husband has dined out for almost 18 years. Before the birth of my son, my husband and I agreed that, all being well, we would be out within 24 hours after the birth. I had given strict instructions to my husband not to bring any flowers or fancy presents, as I would not be there very long. My son was born in the morning and my husband came back to visit later in the afternoon to find me with a long face and in tears. He thought that something was wrong with the baby, so he asked, "What's wrong?" I responded by saying, "What's wrong? Just look about this room and you'll see what's wrong." He looked but could not see what was wrong, so I told him: "Everyone has flowers except for me." Members can imagine how the conversation went on from there.

My experience is trivial and fairly normal, unlike the experiences of the one in 10 mothers who suffers post-natal depression. Those women and their families require care and support, but unfortunately, as has been said, provision of care varies across the country. I know from speaking to Bill Butler that

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care is patchy in the Greater Glasgow NHS Board area. Indeed, some parts of Glasgow are simply not covered.

However, some local health teams are doing good work in an area of health care that is sometimes neglected. In Cumbernauld, for example, health visitors and community midwives work together as a team to offer support, help and advice to mothers. They can detect the early signs of post-natal depression by using their observation skills. Through the local health centre, they have formed a group called "Life after Birth", which is also supported by the community psychiatric nurse. The group meets regularly, usually over a 10-week period. It offers women professional help and guidance and an opportunity to talk, have time for themselves and find support from other mothers. The group works—in the most recent course, only three of the 14 women involved required additional support. Thankfully, because of the staff's team approach, the necessary on-going support is in place.

Such schemes, which involve early observation and—when required—intervention, work and are helping to keep women out of hospital and with their babies. However, that approach should not be unusual; it should be the practice in every community in Scotland. I urge the minister to ensure that such an approach is taken throughout the country.

17:40

David Mundell (South of Scotland) (Con): I, too, thank Bill Butler for securing the debate and for arguing his points so forcefully.

I will touch on two or three points that have not yet been covered. I acknowledge the problem that Bill Butler mentioned in relation to his constituent. However, problems are also caused by the practice of putting mothers and babies in more general psychiatric wards that lack specialist facilities. People in such wards are seriously ill and if the ward does not have the infrastructure or if no one on it is trained to deal with mothers and babies, although we might be keeping the mother and baby together, we are also giving rise to a host of other problems.

As the debate has made clear, a whole range of conditions is included under the term post-natal depression. Although depression is a serious element of that, some women also suffer from mania or hyperactive behaviour in the post-birth period, which sets off an underlying psychosis. It can be difficult to pick up such a condition, because, as Trish Godman said, in the post-birth period everyone expects chaos. Moreover, as Brian Fitzpatrick and other members pointed out, first-time parents are never really quite sure what to expect. As a result, behaviour that the family circle might think odd or unusual in other circumstances goes undetected. That is particularly the case where there is no family structure, or no granny and aunts on hand who have been through childbirth and

can identify that something unusual is happening.

We have to get a lot smarter at identifying things. Many people end up in hospital because the condition goes on so long that they cannot find any way back without hospitalisation. Perhaps the problem might be addressed by providing in the pre-birth period packs for families that explain postnatal depression. I know that that might be difficult, because no one wants to frighten or alarm people in describing what happens after birth. I agree with Brian Fitzpatrick that telling anecdotes is not the best way of debating the subject. However, post-natal depression was never mentioned in the prebirth classes that my wife and I attended. For example, no one mentioned that taking the baby home was one possibility within a range of possibilities. I think that that is another key element in tackling the problem.

17:44

Karen Whitefield (Airdrie and Shotts) (Lab): I, too, thank Bill Butler for securing this important subject for debate. Like others, I believe that it is vital to ensure that services for mothers who suffer from post-natal depression are brought into the 21st century. For too long, those women have either received no treatment at all or their treatment has resulted in separation from their babies. We need to ensure that mothers in all parts of Scotland, no matter whether they live in Petersburn in Airdrie or Peterhead, have the same access to levels of support and treatment for their condition. Furthermore, the treatment that mothers receive should allow them to remain with their children during a very important and formative phase in the development of mother-child relationships. I join Bill Butler in asking the minister to do all he can to ensure that mothers in every part of Scotland have access to a permanent mother and baby unit.

I add my congratulations to the Church of Scotland on the success of its post-natal depression project. The two drop-in centres in Edinburgh have provided much needed support and therapy for the women who use them. The project is an excellent example of how the voluntary sector can support and supplement the NHS.

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In order to support women who suffer from PND, we must first identify them and I am pleased that progress is beginning to be made in Lanarkshire. In January, Lanarkshire Primary Care NHS Trust will publish its post-natal depression guidelines. They will set out a systematic approach to identifying before the birth of their babies women who might be most at risk and they will ensure that the widely recognised Edinburgh post-natal depression scale is used to identify mothers who are affected by the condition. Women who are identified will be referred to the local education groups that are run by CPNs and health visitors.

My colleague Bill Butler has highlighted a serious issue. He has identified a need for improved treatment for those who suffer from the most acute forms of PND. The treatment would enable the bonding process between mother and child to continue. We must ensure that the many thousands of women who suffer from PND at home with little or no care are given the level of support they deserve. As a first step, we must ensure that proper, systematic mechanisms are put in place to identify those people. We must ensure that support services are available at a local level for mother, child and other family members. We must ensure that women feel able to talk about the way they are feeling. For too long, post-natal depression has been stigmatised. Many women have felt enormous pressure to put up and shut up—to put up with the depression and keep quiet about the way they are feeling. Such experiences must end and we must work towards a better, more caring response to PND.

17:47

The Minister for Health and Community Care (Malcolm Chisholm): I congratulate Bill Butler on raising and pursuing this important topic. I have listened carefully to what he and others have said. I share his desire for improvements in the care and treatment of women who suffer from what

is a serious condition which, unchecked, can have an adverse effect on mother and child. It is a tragic fact that the second leading cause of maternal death in the United Kingdom is mental illness that is related to motherhood. Although there is a long way to go, mental health services in Scotland are beginning to develop a systematic approach to the prevention, detection and successful treatment of the illness. Karen Whitefield gave an account of what is happening in Lanarkshire. More generally, we are experiencing development in the use of integrated care pathways for sufferers, based on clear standards and regular audit. That is in line with clinical advice and the health department's guidance to the service.

Bill Butler referred to an addition to the framework for mental health services in Scotland, which in 1999 provided a template for the best organisation of co-ordinated care to improve services and support for women who have post-natal depression.

Dorothy-Grace Elder referred to "A Framework for maternity services in Scotland", which in 2000 specified work to be undertaken by NHS Scotland to address the needs of women who have, or who are at risk from, post-natal depression.

Several speakers referred to the SIGN guidelines on the management of post-natal depression and puerperal psychosis that we commissioned. It was published in June 2002. We have also funded a thorough audit of service provision of primary and secondary care in Scotland against the background of the SIGN guidelines. The outcome will provide a national picture and inform future decisions on the planning and delivery of comprehensive services, support and best practice.

I turn to the main subject of the debate and to a key factor that has been identified as having a bearing on the effectiveness of in-patient care; namely, joint admission of an ill mother with her baby. There is strong support among patients, professionals and the health department for units that are designed around joint admissions so that a mother can maintain contact and bonding with her child. That is an aspect of provision in which I want significant progress to be made throughout mental health services. The SIGN guidelines and their references to the proven benefits of providing a service for mother and baby suggest that about 30 to 45 beds are required in Scotland. The recent Executive guidance on regional service planning will help NHS boards in their task of providing regional services. To that end, I will ask the regional planning groups to consider the benefits of providing joint admission services for post-natal depression on a regional basis in the light of the SIGN guidelines and I shall seek a response from them. Of course specialist in-patient care needs to be complemented by a range of community and other support services being made available locally in line with the published guidance, as Mary Scanlon and others have reminded us. That is not to say that no progress is being made in addressing the needs of mothers and babies together. As Bill Butler reminded us, Greater Glasgow NHS Board has announced that it is moving ahead to draw up detailed plans for a specialist facility for mother and baby admissions. That is fully in line with the published guidance and it is an excellent example of an NHS board responding to patients' needs in a specialised area of treatment.

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I was pleased last week to speak to Karen Robertson, the nurse consultant in Glasgow on perinatal mental health. I congratulate her on all the work that she has done in that area—I know that she has been a leading figure in spearheading developments in Glasgow. The NHS board there has recognised that it will take time to deliver its plans and it is therefore providing an interim arrangement for the admission of mothers and babies until the proposed specialist unit becomes available. Where Glasgow is leading, I want other areas of Scotland to follow. I believe that working on a regional basis is the way forward, which is why—as I said a minute ago—I shall ask regional planning groups specifically to pursue the matter and I shall seek a response from them. As well as supporting the development of joint admission arrangements, the department also supports and encourages the screening of new mothers using what is known as the Edinburgh scale

at six to eight weeks and again at three to six months for the earliest possible detection. Women with postnatal depression can be seriously ill and yet the illness can go undetected. Like most disorders, the earliest possible identification of need and speedy interventions offer the best prognosis for improvement. Karen Whitefield and Mary Scanlon mentioned stigma. If we address that issue, sufferers are more likely to be identified early. I hope that the campaign that we are undertaking on that will be helpful.

The mental health and well-being support group, in its second round of visits which finishes this month, has been paying particular attention to what local facilities are available in NHS board areas for the detection and treatment of sufferers from post-natal depression. In line with published guidance, the group looks specifically for the use of the Edinburgh scale and for developments in the creation of integrated care pathways for the best organisation of care. Its findings include a score rating of progress that has been made. That offers an at-a-glance picture in each case and links to the performance and accountability arrangements for the NHS in Scotland.

I do not know whether members read the reports of the mental health and well-being support group, but they might wish to refer to a particular report on post-natal depression and the score for services in their area. The reports are an important feature of the health improvement agenda in ensuring that key issues are addressed and improvements made. One of the key aims of the support group is to ensure that the good practice that is being followed in parts of Scotland is adopted everywhere. That is vital if sufferers are to receive the high quality care that they deserve and if we are to see improved clinical outcomes and therefore better future mental health.

We agree that there should be a spectrum of care and support for the mother, the baby and the wider family. We accept, and shall promote, the merits of joint admission arrangements. We congratulate Greater Glasgow NHS Board on its announced plans and on leading the way.

I give members my personal commitment that I will do everything that I can to ensure that there are improvements in services throughout Scotland for post-natal depression in general and the development of mother and baby units in particular. I again congratulate Bill Butler on raising the issue and on making such progress on it in such a short time.

Meeting closed at 17:55.

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End of Transcript