

MIND THE GAP

Newsletter of the West Midlands SpR/ST4-6 General Adult Psychiatrists

EDITORS

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Liaison Psychiatry Services: An ally for Acute Medical Trusts to make savings.

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UPCOMING EVENTS IN WEST MIDLANDS

A reduction in the NHS budget is inevitable over the next few years. There has been an increased demand to reduce costs in the NHS, which has led to significant reductions in services in general. More recently there has been renewed emphasis on community mental health teams and inpatients teams, but liaison psychiatry is being neglected.

There is a high prevalence of psychiatric disorders in patients in general hospitals. A quarter of all patients admitted to general hospitals have psychiatric illnesses, and about 60 % of people aged 65 and above who are treated in general hospitals will develop a psychiatric illness during their admission. Left untreated, their comorbid conditions result in poor outcomes for them, their carers and increased costs for services.¹

There is a significant variation in provision of liaison psychiatric services throughout the country and even within Birmingham. Team funding varies from having one psychiatric liaison nurse for the entire general hospital to having 12 members in a multidisciplinary team. Funding is always an issue as liaison psychiatric services are not always explicitly commissioned by primary care trusts and acute trusts are reluctant to pay for such services using their own budgets. Cutting the

liaison psychiatry budget is short sighted and will be counter productive in the long run. A recent pilot in Birmingham called "The Rapid Assessment Interface and Discharge" (RAID) service providing liaison service to City Hospital has saved the acute medical trust over two million pounds.

Liaison psychiatric services can reduce psychological distress for patients in general hospitals with mental illness and can also reduce the length of stay and overall costs of care. Clinicians in acute medical hospitals are not experts in recognising, assessing and managing psychiatric disorders, hence it is important that liaison services are commissioned to provide patients with the care they deserve.

In conclusion, liaison psychiatry services can positively impact on patient outcome in general hospitals and can bring significant savings for acute medical trusts. I hope that commissioners will realise the importance of investing in liaison psychiatric services that provide seamless psychiatric care for patients in general hospitals.

References:

1. Healthy mind, healthy body: briefing Mental Health network The NHS Confederation April 2009, issue 179.

How would you like to be treated?

Alfred White

Consultant Liaison Psychiatrist

Birmingham & Solihull Mental Health NHS Foundation Trust

A junior psychiatrist (J.P) was referred in great distress on a Friday. J.P was seen for an urgent assessment by a consultant psychiatrist who concluded that J.P required to be admitted for intensive treatment of a psychiatric episode and to reduce the risk of suicide. Ordinarily patients who require admission are re-assessed by the Home-Treatment Team (HTT), but as J.P had previously worked within the HTT, it was felt inappropriate for the patient to be treated by that team.

The assessing psychiatrist entered into a negotiation with the Medical Directors of J.P's trust and that of a nearby trust and it was eventually agreed that J.P would be admitted to the nearby trust later that day. The assessing consultant left work on Friday expecting J.P to be admitted to the nearby trust as planned.

On returning to work after the weekend, the assessing consultant discovered that the Link Nurse had **refused the admission to go ahead** (overriding the Medical Director's initial decision and continued wish) and that the junior psychiatrist was now under the care of the HTT with whom she had previously worked.

To me this case raised several issues. Doctors seem to have given up rights to decide who should be admitted and those decisions can now at times be taken by others with no previous knowledge of the patient and frequently less relevant psychiatric experience than the consultant psychiatrist. Recently at a case conference I was surprised to learn that there was no point in attempting to "section" a patient with chronic delusions for treatment as his very chronicity meant that it would be impossible to find a bed for him!

This raises pertinent questions about the nature of the service we are offering. **What should be the nature of a psychiatric service that needs also to cater for doctors?**

It would be desirable that psychiatric illness should be as easily acknowledged as all other illnesses. However neither psychiatrists nor any other doctors do easily acknowledge whether they have psychiatric problems. In two recent surveys, (1, 2) the first carried out on psychiatrists and the second on non-psychiatric doctors, the results were similar. The surveys looked at personal acknowledgement of psychiatric illnesses and it was found

that neither psychiatrists nor other doctors were keen to have their difficulties acknowledged and therefore treated. A minority would self-medicate and the majority would not wish to be treated in their local NHS unit.

Friday, 07, Aug 2009 12:00 Press release Royal College of Physicians

A majority of doctors would avoid seeking professional advice for mental health issues in an outpatient setting, according to a new survey published by the Royal College of Physicians in the journal *Clinical Medicine*. Nearly three quarters of respondents said they would rather discuss mental health problems with family or friends, than seek formal or informal advice, citing reasons such as career implications, professional integrity, and perceived stigma of mental health problems.

The survey of over 3,500 doctors in Birmingham is the first of its kind of this scale looking at (non-psychiatric) doctors' preferences for disclosure and treatment in the event of becoming mentally ill. Key among the findings is that only 13% of respondents would choose to disclose their illness to a GP or another health professional and that when it comes to inpatient treatment, 79% would opt for treatment in either a private or distant facility, rather than be treated by local NHS services. In both cases the decision appears most often to be based around concerns that personal information would not be kept confidential and that this may compromise career and/or reputation.

The findings include:

- 73% of respondents to the study would be most likely to disclose mental health problems to family or friends, rather than seek formal or informal advice.
- The most important reasons affecting that decision were issues such as career implications (33%), professional integrity (30%), and stigma (20%).
- 41% of respondents would seek informal advice for outpatient treatment, but 8% would either self-medicate or opt for no treatment at all.
- 79% of respondents would opt for inpatient treatment in either a private or distant facility, rather than be treated by local NHS services. (Only 25% make this decision based on quality of care).

- 55% would make the decision about inpatient care based on confidentiality or stigma issues.

The study had a response rate of over 70%, indicating that this is an important issue for doctors.

Doctors who are reluctant to seek professional advice for mental health issues may be putting themselves, and possibly also their patients, at risk and we are concerned that there are a lack of options for doctors who feel they are mentally unwell.

Doctors suffer higher levels for depression and substance misuse, as well as higher rates of suicide than the general population. The apparent lack of confidence in the current system protecting doctors' confidentiality may exacerbate these trends.

“Greater emphasis is needed to educate doctors on mental health and to improve and extend the options open to them for accessing mental health support.”

Results: 1807 (73.4%) doctors would most likely choose to disclose a mental illness to family and friends rather than to colleagues, or professional institutions. 800 (32.5%) respondents cited career implication as the most frequent reason for failure to disclose mental illness. For outpatient treatment 1259 (51.1%) would seek formal professional advice and 1002 (40.6%) would choose informal professional advice. For inpatient treatment, 1010 (41.0%) would choose a local private facility, with only 520 (21.1%) choosing a local NHS facility. 306 (12.4%) respondents indicated that they had, at some time, experienced a mental illness that had affected their personal, social and/or working life.”

Conclusions:

Stigma to mental health is prevalent amongst doctors of all grades. At present there are no clear guidelines for doctors to follow in order to facilitate the mental healthcare of working doctors. Confidential referral pathways to specialist psychiatric care for doctors would be welcomed.

I return to the question, **how would you like to be treated?** What systems are required to treat all doctors for both minor and more serious psychiatric disorders?

I would suggest that the following are essential requirements

1. An easily accessible point of contact for assessment in which there is full confidence of absolute

confidentiality. Assessment and treatment on an outpatient basis by an individual with the necessary skills.

2. Access to both outpatient and inpatient therapy when necessary again in conditions of confidence.
3. Without the above doctors will not seek help rendering themselves or their patients at risk.

I would like to propose the following with the intention of encouraging ideas and dialogue. Alternative suggestions are welcome and I would particularly encourage that all doctors pressure their Trusts to establish a viable service.

How about the following pathway?

1. Self referral to local Occupational Health Department.
2. When necessary, referral onto a psychiatrist that is attached to the Occupational Health Department or one of a panel of psychiatrists willing to take on this role for a region.
3. The psychiatrist/s will then initiate treatment as appropriate and /or refer onto another professional e.g a psychologist for continuing treatment.
4. If necessary there will be access to more intensive services on an out/inpatient basis but this would be likely to be in a distant unit where confidentiality would be maintained.
5. Notes would be held separately either as written or as computer data so that again complete confidentiality would be maintained.

Well that's my suggestion – please let me have yours.

References:

1. White A., Shirka U, Hassan T, Galbraith N, Callaghan R. Barriers to mental healthcare for psychiatrists. *Psychiatric Bulletin* 2006;30:382-4.
2. Hassan, Tariq M, Ahmed, Syed O, White, Alfred C, Galbraith, Niall A postal survey of doctors' attitudes to becoming mentally ill *Clinical Medicine*, Aug 2009.

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The Annual West Midlands General Adult Psychiatry Higher Trainees Conference

Date: TBC

Venue:Uffculme Centre

If the trainees are interested in submitting their abstracts for a poster presentation please email Dr Salman Hashmi at sjhashmi@doctors.org.uk or Dr Sridevi Sira Mahalingappa at drsridevi@doctors.org.uk.

Details of the conference will be circulated soon.

Acute in-patient psychiatry: how in-patient activity has improved with the move to a new centre of excellence for mental health.

Dee Desai, Elizabeth O'Rourke, Paul McDonald, Jayne Greening, Belinda Brown.

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Introduction

In 2008 a newly built mental health hospital opened in Birmingham and patients were transferred from the previous site which had been built in 1991 and was subsequently demolished. We conducted a survey to capture changes in in-patient activity before and after the move to the new hospital to see if the improvements in building, staffing levels and Occupational Therapy (OT) reorganisation had led to improvements in in-patients activity levels. Why is this important? It is thought that increasing the level of activity may be one of the concrete things that can be done to protect patients from harm and to prevent patient abuse and patient assault¹.

Method

Four adult wards at each hospital were included in the study. During data collection visits the activity of each patient on each ward was noted at a single point in time, Monday to Friday, 9 am to 5pm but excluding lunchtimes. Data collection took place in October 2007 and May 2008 in the former hospital (period 1) and during June 2008 and November 2009 (period 2) in the new hospital. During data collection visits the observer placed each patient's activity into categories relating to engaged and disengaged activities.

Engaged activities	Disengaged activities
Interaction with staff	Standing or walking
Interaction with others	Alone in bedroom
Receiving care	Sitting socially disengaged
Interaction in bedroom	
Organised activity	

Table 1: Engaged and Disengaged activities

Analysis

Data was inputted on the Statistical Package for Social Scientists (SPSS), version 17.0. To test the reliability of data, simultaneous observations of activities on all participating wards on the same afternoon were conducted by 3 independent raters. Inter-rater reliability was found to be good.

Results

Engaged activities

There was a significant increase in the total number of engaged activities in the new hospital (New H) compared with the old hospital (Old H). In the Old H, 335 (13.4%) activities were categorised as engaged, compared with 448 (25.5%) in the New H. There was a significant increase in the median number of organised activities. In Old H there were 35 organised activities observed (median 0.00 and 10% of all Old H engaged activities), increasing to 123 (median 1.00 and 28% of all New H engaged activities=0.00).

	Old hospital				New hospital				Mann-Whitney U Wilcoxon W
	N	%age	mean	median	N	%age	mean	median	
Organised activity	35	10%	0.22	0.00	123	28%	0.79	1.00	p=0.000
Interaction with others	147	44%	0.93	0.00	193	44%	1.26	1.00	p=0.011
Interaction with staff	153	46%	0.97	1.00	124	28%	0.80	1.00	p=0.056
Interaction in bedroom	0	-	0	0	5	<1%	0	0	-
Total(%) and median number	335	13.4		2.00	448	22.5%		3.00	p=0.000

Table 2: Engagement activities, Old H and New H

Disengaged activities

There was a significant decrease in the total number of disengaged activities in New H compared with Old H. In Old H, 2179 (86.6%) activities were categorised as disengaged, compared with 1327 (74.5%) in New H. There was a significant decrease in the median number of patients observed as being alone in the bedroom. In Old H, 1092 patients were alone in the bedroom (median 7.00, 50%) compared with 728 (median 5.00, 55%) in New H (p=0.000). There was also a significant decrease in the median number of patients who were sitting socially disengaged.

	Old hospital				New hospital				Mann-Whitney U Wilcoxon W
	N	%age	mean	median	N	%age	mean	median	
Alone in the bedroom	1092	50%	6.91	7.00	728	55%	4.70	5.00	p=0.000
Sitting socially disengaged	678	31%	4.29	4.00	383	29%	2.47	2.00	p=0.000
Sitting//walking	400	18%	2.53	2.00	216	16%	1.39	1.00	p=0.000
Total(%) and median number	2179	86.6%		14.00	1327	74.5%		9.00	p=0.000

Table 3: Disengagement activities, Old H and New H

Discussion

The level of engagement in organised activities and interaction with other patients increased significantly in the new hospital in line with the new environment and new initiatives put in place by OT services. However the overall level of disengagement for patients remains disappointingly high. Provision of modern in-patient facilities and in-patient activity has been a priority for over 10 years and we have shown that new hospital facilities built in line with recommendations from the Royal College of Psychiatrists² and MIND³, together with new initiatives within OT programmes can increase the level of in-patient engagement in activity.

References

1. Sundram CJ: Strategies to prevent Patient Abuse in Public Institutions. N Engl J Hum Serv 1986; 6:20-25.
2. Royal College of Psychiatrists Not only Bricks and Mortar 1998.
3. MIND (2006) Building Solutions 2: Improving mental health care environments.

CASE REPORT: ISONIAZID-INDUCED ACUTE-ONSET PSYCHOSIS.

Ted Agadagba (Associate Specialist)
Rehan Siddiquee (Consultant Psychiatrist)

Introduction

Worldwide, tuberculosis (T.B) continues to kill more than 1.5 million people per year, (Chaisson and Nachega, 2010). The National Institute of Clinical Excellence (NICE), (2005) guidelines recommend isoniazid and rifampicin for treating both latent and active tuberculosis. Psychiatric sequelae arising from anti-tuberculosis drugs is widely acknowledged in the literature and includes such symptoms as anxiety, depression and psychosis, all of which greatly impact on the patients' quality of life, (Vega et al, 2004).

In this report we describe a case of acute-onset psychosis secondary to isoniazid treatment (INH); we review the literature regarding psychiatric complications following anti-tuberculosis drugs (specifically, isoniazid-induced psychosis) and offer suggestions for managing similar cases. Our patient was successfully treated with olanzapine while remaining on his anti-tuberculosis medications.

Case History

Three years ago Mr B.A developed an episode of cannabis-induced psychosis. He was successfully treated with olanzapine for many months and thereafter he stopped taking his psychotropic medication. Mr B.A. nevertheless remained well. In 2009 he travelled to Pakistan where he contracted TB and was commenced on both rifampicin and isoniazid, two-weeks later Mr B.A developed signs and symptoms of a florid psychotic illness which included expressing paranoid delusions, having persecutory ideas, complaining of auditory hallucinations as well as tactile and visual hallucinations.

Routine investigations, urine drug screen, and MRI scans did not reveal any associated organic aetiology. Mr B.A was therefore treated with olanzapine (20 mg daily) for a relapse of psychosis whilst concomitantly remaining on his anti-tuberculosis medications. Subsequently his florid psychotic symptoms resolved within four weeks of commencing olanzapine. The dose was gradually reduced to 10mg daily to curb metabolic side effects such as weight gain and diabetes. Mr B.A has remained stable in his mental health over the last six-months being on both olanzapine and his anti-tuberculosis drugs.

Discussion:

Psychiatric complications due to anti-tuberculosis drugs have been well documented since the 1950s, (Weidorn and Ervin, 1954). The majority of the significant psychiatric morbidity associated with being on the anti-tuberculosis regimen is accounted for by cycloserine and isoniazid (INH); with ETH, ethambutol and fluoroquinolones accounting for a lesser proportion, [Prasad et al (2008); Vega et al, (2004)]. In their retrospective case series performed among the first 75 patients to receive individualized multi-drug (MDR) TB therapy in Lima, Peru, between 1996 and 1999, Vega et al (2004) noted that the incidence of depression, anxiety and psychosis during MDR-TB treatment was 13.3%, 12.0% and 12.0%, respectively.

The frequently reported INH-induced complications include paranoid delusions, visual and auditory hallucinations, suicidality, irritable mood, and disorientation. INH-associated psychosis has been reported in patients on multiple as well as mono-drug therapies (Alao and Yolles, 1998). In the extensive review of the literature, Pallone et al, (1993) noted that INH-associated psychiatric symptoms appear approximately four weeks after commencement of the drug and among patients of an average age of 35 yrs (range 17-53yrs). They summarized the risk factors as: doses of INH above 5 mg/kg; age 50 yrs or above; co-morbid diabetes mellitus, hepatic insufficiency, alcoholism, hyperthyroidism; and a past psychiatric history. It is important to note that Mr B.A had a previous episode of psychosis and therefore had a past psychiatric history.

The precise mechanism underlying isoniazid-associated psychiatric disorders seems unknown (Holtz and Palm, 1964). Some proposed mechanisms for INH-induced psychosis involve INH altering the levels of catecholamines and serotonin by inhibiting monoamine oxidase or by inducing pyridoxine deficiency, or both, (Alao and Yolles, 1998; Pallone et al, 1993).

Our patient, Mr B.A presented with tactile hallucinations and the only other case reported in the literature to present with this was reported by Schrestha and Alao (2009). Schrestha and Alao (2009) mentioned

their patient's symptoms improved with quetiapine and pyridoxine after discontinuation of INH. Mr B.A was successfully managed with olanzapine without stopping his anti-tuberculosis drugs. In the literature we find that treatment with risperidone, without discontinuation of INH, was also shown to be effective, (Duggal and Nizamine, 2000). As noted by Pallone et al (1993), Mr B.A's previous psychotic episode may have been a likely predisposing factor for INH-induced psychosis.

Conclusion:

With the current gradual increase in the incidence of tuberculosis, and the increase in multi-drug resistance, clinicians (including psychiatrists) need to be alert to the increased likelihood of side effects secondary to anti-tuberculosis medications, including psychiatric complications such as acute treatment-induced psychosis. We have demonstrated with our case that it is possible to treat acute-onset psychosis (due to isoniazid) concurrently with antipsychotics without stopping isoniazid therapy.

References:

- Alao, A.O., Yolles, J.C. (1998). Isoniazid-induced psychosis, *Annals of Pharmacotherapy*. 32:889–891.
- Chaisson, R.E., and Nachega, J.B. (2010) Tuberculosis In: *Oxford Textbook of Medicine*; Eds: Warrell, D.A., Cox, T.M., Firth, J.D.
- Crofts, J.P., Gelb, D., Andrews, N., Delpech, V., Watson, J.M., Abubakar, I. (2008) Investigating tuberculosis trends in England. *Public Health*. 122:1302-1310.
- Duggal, H.S., and Nizamine, S.H. (2000). Novel antipsychotic drugs and INH-related psychosis, *Australian and New Zealand Journal of Psychiatry*. 34:343–344.
- Girling, D.J. (1984). Adverse effects of anti-tuberculosis drugs. *Bulletin of International Union of Tuberculosis*. 53:152.
- Health Protection Agency. (2009). Tuberculosis in the UK: Annual report on tuberculosis surveillance in the UK 2009. London, Health Protection Agency.
- Health Protection Agency. (2010). Isoniazid resistant tuberculosis outbreak, 2000 – 2009: Update report May 2010. London, Health Protection Agency.
- Holtz, P., Palm, D. (1964). Pharmacological aspects of vitamin B6. *Pharmacology Review*. 1964;16:113–78.
- National Institute for Health and Clinical Excellence. (2005) Guideline development methods: information for national collaborating centres and guideline developers. London: NICE, 2005. Available from www.nice.org
- Pallone, K.A., Goldman, M.P., Fuller, M.A. (1993). Isoniazid-associated psychoses: case report and review of the literature. *Annals of Pharmacotherapy*. 27: 167–169.
- Prasad, R., Garg, R., Verma, S.K. (2008). Isoniazid- and ethambutol-induced psychosis. *Annals of Thoracic Medicine*; 3(4): 149 – 151.
- Schrestha, S. and Alao, A. (2009). Isoniazid-induced psychosis. *Psychosomatics*. 50:640-641.
- Weidorn, W. S., Ervin, F. (1954). Schizophrenic-like psychotic reaction with administration of isoniazid. *Archives in Neurology and Psychiatry*. 72: 321.
- Vega, P., Sweetland, A., Acha, J., Castillo, H., Guerra, M.C., Fawzi, S., Shin, S. (2004). Psychiatric issues in the management of patients with multidrug-resistant tuberculosis. *International Journal of Tuberculosis and lung diseases*. 8 (6): 749-759.

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Important dates in your diary

Royal College of Psychiatrists: Faculty of General & Community Psychiatry Annual Residential Conference

Date: 13 & 14th October 2011

Venue: Hilton Hotel, Newcastle.

Contact: The Royal College of Psychiatrists Conference Office

Tel: 020 7235 2351 ext 6145

Email: dgoka@rcpsych.ac.uk

Liaison Psychiatry Forum meeting

Dates: 26 July, 27 September and 29 November 2011.

Time: 1 - 5 PM

Venue: Orsborn House, DRR Meeting Room 1st Floor, 55 Terrace Road, Handsworth, Birmingham B19 1BP

Contact: Dr Mahnaz Hashmi

Email: mahnaz.hashmi@nhs.net

Upcoming events

BIPA'S Young Scientists Forum (YSF)

Date: 3 September 2011

Venue: Clarendon Suites, 2 Stirling Road, Edgbaston, Birmingham, B16 9SB.

YSF welcomes all psychiatry trainees, young investigators, PhD students, post-docs, and academics interested in psychiatry, neuroscience, mental health, and neurology.

Main Highlights of the programme:

Keynote Lectures by eminent psychiatrists - Professor Veena Kumari & Professor Stephen J. Wood.

“**Crack the CASC**” by well known CASC organizer Dr SPM Murthy ,

Dedicated Workshops on “**research**” for SHOs ,SpRs and SAS doctors.

“**CESR Pathways**” - current trends and expectations.

“What to expect and how to prepare for **consultant interview**”.

“**Ask the Panel**”- chance to interact with successful professionals.

This event is **free**, but space is limited, and available on a first-come first-serve basis.

Download registration form and programme online (www.bipa.org.uk/ysf.php)

Apply for the BIPA Trainees Research Awards and the Medical Students Award.

Contact: Dr Venkatesh Muthukrishnan (drvenka@gmail.com). Dr Nora Vyas (drnsvyas@gmail.com).

BMI meetings

Venue: Birmingham medical Institute, 36 Harborne Road, Edgbaston B15 3AF.

Email address: info@bmedi.org.uk

Dates and topics:

6th Sept “**The future of dementia care**” Dr Bernie Coope, Consultant in Old Age Psychiatry. Worcestershire Mental Health Partnership NHS Trust.

4th October “**Brainless psychiatry, mindless neurology**” Dr Andrea Eugenio Cavanna, Consultant in Behavioural Neurology, Birmingham and Solihull Mental Health NHS Foundation Trust.

West Midlands Regional Perinatal Mental Health Conference

Date: 8 July 2011

Venue: Birmingham Medical Institute

The conference is aimed at midwives, health visitors, psychiatrists, mental health teams, social workers, obstetricians, CPNs, GPs, academics and service users. All welcome!

Speakers include:

Professor John Cox - “identifying postnatal depression”, Dr Margaret Oates - “report on the most recent Confidential Enquiry into Maternal Deaths”.

Dr Ian Jones - “postpartum psychosis”. Dr Carol Henshaw - “normal emotional changes following pregnancy”.

Dr Dawn Edge - “considering BME issues”. Dr Amanda Daley - “exercise and PND”.

Dr Jo McCleery - infant health. Sukhi Sembi - peer support and many more.

Contact details : Shazia Hussain (Shazia.hussain@bsmhft.nhs.uk)

The views expressed in the articles are the views of the authors and do not necessarily reflect those of the editors of the newsletter. This newsletter is intended to inform and promote the positive work of the West Midlands General Adult Psychiatry higher trainees. It is also hoped that it provides a platform for junior trainees, trainees in other specialties, SAS doctors and Consultants. We aim to publish this newsletter twice a year. Portfolio certificates are provided.

Contributions should be sent to the editors:

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