A WORD FROM THE EDITORS

We live in interesting times! The sea change within the NHS has thrown up a new set of challenges for our specialty. Recent developments will undoubtedly have a massive impact on all our services over the coming year. Margaret Oates’ informative piece in this newsletter sheds light on the changing face of commissioning. The contents also include the results of a survey of perinatal training across England, reflections of a trainee and a paper on infanticide. We hope that you find these and the other pieces in this issue, interesting and informative. We’d like to thank all those who sent us their contributions. Hopefully, they will inspire and encourage others to submit articles, ideas and suggestions for the next newsletter. If we get an enthusiastic response and can gather enough material, we will have the next issue out in summer 2013.

The Section has made huge strides in promoting the specialty and raising clinical standards over the last year. We extend a warm (albeit belated) welcome to Liz Macdonald and wish her success in her role as Section chair.

Finally, as the year draws to a close, here’s wishing everyone a Merry Christmas and a Happy New Year!

Renuka Lazarus
(On behalf of the editors)
On 1st April 2013 the New NHS comes into being. The changes are radical and complex, not just old structures and staff renamed.

The NHS Commissioning Board will effectively run the NHS, managing its budget exerting quality control and outcomes, developing and assisting the Clinical Commissioning Groups. In addition it will directly commission Primary Care, Military and Offender Health and Specialised (prescribed) Services. These latter services, which include Perinatal Mother and Baby Units and their Community Teams are defined and described by the National Definition Set and can be seen in the recently published Manual web link:


The NHS Commissioning Board will operate through 27 Area Teams, 10 of which have additional resources to act as Commissioning Hubs. (See Section Website for details)

These Commissioning Hubs will also host Clinical Senates and Strategic Clinical Networks.

From 1st April 2013 Specialised Perinatal Psychiatric Services (as defined) will therefore be nationally commissioned—one contract, one price, one Service Specification, one set of CQUINs.

The contracts and monitoring will be managed by the Area Team.

The philosophy and practice of the New NHS is do once and once only, single operating policy, unitary contracts etc. etc. - aiming to eliminate variation from one area to another and promote equity.

Existing mother and baby units will be commissioned i.e. units, not occupied bed days. It will not matter where the patient lives (in theory) although I'm certain the (local) Area Specialised Commissioners will be keeping an eye on this.

It is important that clinicians and providers understand the new arrangements and see the “commissioning products” i.e. Service Specifications and CQUINs so that they can align their services to the New World. The 2013/14 products will be on NHS Commissioning Board very soon.

Web link: http://www.commissioningboard.nhs.uk/

The details of the new NHS are emerging on a daily basis and are changing.

A description of the structure and function of the NHS Commissioning Board and the implications for Perinatal Services can be found on our Section Website, together with links to NHSCB publications as they emerge.

Margaret Oates OBE
Clinical Director
Midlands & East perinatal Mental Health Clinical Network
The importance of specialised training in perinatal psychiatry has been widely recognised. The Section has developed a draft curriculum for training in Perinatal Psychiatry which has the support of The College. It is currently being reviewed by GMC and if approved will lead to the award of Endorsements in higher training for Perinatal Psychiatry.

We conducted a national survey of psychiatry trainees specifically looking at 1) current training provisions and confidence among trainees in assessment and management of perinatal patients; 2) interest in perinatal psychiatry and 3) suggestions from trainees to improve training in this area.

Schools of Psychiatry in all the thirteen deaneries across England were contacted for survey circulation. The study was conducted over a 6 month period using an online questionnaire. Responses were received from trainees across all the deaneries.

Results
A total of 174 trainees completed the survey. Only 22 (12.6%) trainees had received specific training in perinatal psychiatry. Of these, eight had worked full time, seven on a part-time basis and the rest either as special interest or liaison placement. Despite having a mother and baby unit facility in some schemes, trainees were not attached to the service.

108 (62%) trainees were confident in assessing pregnant women with mental illness; however only 56 (32%) felt confident in the treating these patients. 112 (64%) trainees expressed their confidence in assessing post-partum women for mental illness. However, only 71 (41%) were confident with the treatment aspect. 103 (59%) trainees either gave neutral responses or disagreed with their ability to treat this patient group.

104 (60%) trainees felt that they had not received adequate training in assessing and managing perinatal patients in both routine and emergency settings. Given the opportunity, 117 (67%) trainees expressed their interest in undertaking a training post in perinatal psychiatry. 32 (18%) were not sure about this. 60 (35%) trainees were keen to pursue perinatal psychiatry in their future career either full time or part time.

Trainees with experience of working in perinatal psychiatry services were very appreciative of the opportunity and found it invaluable and rewarding. The majority of the trainees said that they would extrapolate their clinical skills of assessing general adult psychiatry patients to the pregnant women. Some highlighted gaining this experience while working in general adult clinics. Others had to deal with this patient group in emergency settings. Trainees emphasised the need for specific training in pharmacological management of perinatal patients. However, a recurrent theme in the trainee’s feedback was about the scarcity of mother and baby units and training opportunities in perinatal psychiatry.
Discussion
The Royal College of Psychiatrists' perinatal section has been improving and promoting the specialty over the years and has prepared a draft curriculum for training in perinatal psychiatry.
Our survey, in summary, showed that trainees would like further training opportunities in perinatal psychiatry and that currently available opportunities are inadequate. Providing better training opportunities will help to expand the pool of perinatal consultants in the future. Consultants in general psychiatry and other specialties will also be better equipped to manage women with perinatal mental health problems.

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Fabida Noushad
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Consultant Psychiatrists
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Lincoln

NICE UPDATE

The NICE/NCCMH CG45 guideline on Antenatal and Postnatal Mental Health is being updated in 2013-14. NICE advertised for the Guideline Development Group (GDG) chair earlier this year and I was interviewed and appointed in the summer.

The draft scope of the update, and the advert for applications for the GDG membership have been posted on the website for comments by stakeholders and will be finalised in the coming weeks. I feel privileged to have this opportunity to help draw up such an important guideline while also feeling somewhat daunted (!) and know the expertise of the GDG members will be key. A broad representation of relevant professionals will be recruited – including, of course, perinatal psychiatrists. Prof Steve Pilling, the NCCMH co-director, is the GDG facilitator again.

As with all updates, there has already been scoping of the literature since the last guideline, to see where there is (and is not) new evidence to inform the update. So where there has been little new research, an update is not appropriate and previous recommendations will remain. The other issue is of course implementation (as it is one thing to recommend good practice and another thing for it to happen, particularly in the current confusing new NHS world) but that is for the future...for now, I look forward to hearing comments from the Section on the scope and draft guideline when it is ready.

Louise Howard
Professor in Women's Mental Health
Institute of Psychiatry
London

http://www.kcl.ac.uk/medicine/research/divisions/wh/groups/mental/index.aspx
www.kcl.ac.uk/hspr
http://www.iop.kcl.ac.uk/departments/?locator=4&context=892
WHY DO WOMEN KILL? Can we identify the risk and prevent it?

The recent tragic case of Felicia Boots who killed her two children aged fourteen months and ten weeks has highlighted for professionals and the public that the perinatal period is a time of increased risk for babies. This is a worldwide phenomenon, well known for centuries and enshrined in our, now little used, Infanticide Act 1938.

Parents who kill fall into three main groups:

1. They are chaotic, may be incompetent, prioritise their own needs above those of their children, which may include their drinking, drug taking or being with a violent partner. Their children die of lack of care and neglect.

2. They are sadistic, cruel and gain pleasure from having power over another human being or from gratifying their own needs, e.g. sexual, without any regard to the welfare of the child. These parents are a tiny minority, though they receive a lot of media coverage when it happens. They would normally be parents who have suffered from oppression and abuse themselves.

3. Parents who are mentally ill. Research by Adrian Falkov in 1995 first highlighted that a third of parents who killed their children (of all ages) were mentally ill. This research was replicated in Sheffield (Trevor Owen 1996) with similar findings, and a report on serious case reviews 2003–2005 (Brandon et al, 2008) also found mental health to be a factor in a third of cases.

Numbers of children killed by their parents are small but proportionately larger in the perinatal period. Babies under one year are eight times more likely to be killed by their parents than children over the age of one.

These deaths are so shocking because they challenge our notions of maternal instinct – our view that caring for one’s own baby is just that – an instinct, a core facet of human and animal behaviour, akin to say hunger. But workers with animals, for example farmers, have always known that a proportion of animal mothers will not care for their young, in fact may reject them aggressively and they watch out for this and separate the mothers and their young as soon as they see it.

So what drives a mother to go against her maternal instinct, why would she kill her own child and, more importantly, can we identify which babies are at risk?

Research identifies that the women who kill their babies are not those with the most severe mental illness or psychosis; they are most likely to be suffering from depression. The typical clinical picture is early onset following childbirth, irrational but not psychotic thoughts, extreme anxiety and fears of losing control and going insane. They are likely to have been seen by their GP, possibly referred to mental health services, they may not have reached the magic threshold for being taken on.

It is doubtful whether any of these mothers would have revealed to their GPs, health professionals or even family members thoughts of wanting to kill their baby, because of a fear that their baby would be removed by Social Services. These fears of statutory intervention are in all mothers regardless of class, race or age.

“If told these thoughts my daughter would be taken away by police and I would be locked up”

Is this a paradox then, that these mothers are fearful of their baby being removed from their care when they want their babies dead anyway?
There is no paradox because, unlike fathers who mainly kill their children for retribution towards the children’s mother, mothers who kill in the perinatal period do so for altruistic reasons. As the comments of women who have killed show, they acted to protect their babies, not because they wanted to get rid of them:

“I've given her peace – I loved her more than anything else in the world” McGrath 1992

She needs me
I'm going to be there for her, whatever it takes. Daksha Emson

Unpublished research that I conducted whilst at Sheffield University, found that thoughts of death were common amongst women with mental health problems and thoughts of infanticide were not uncommon. 175 questionnaires were sent out to all postnatal women referred to a community mental health team over a five year period. 90 were returned (51.4%). Out of the questionnaires returned, 42 revealed that they had had recurrent troubling thoughts, half of whom had experienced thoughts of death and dying, including thoughts of harming their baby:

“I always thought the baby was going to die. These thoughts progressed to me wanting to kill my baby. Firstly to make it look like a cot death. I concluded that if I killed myself and the baby I wouldn’t have to face anyone.”

None of these mothers had been referred to Social Services and none had revealed these thoughts to a health professional, though several had confided in family members. As none of these mothers had actually harmed their baby, they were asked what had helped them and what had prevented them from acting on their thoughts. The top response for what stopped them acting on their thoughts was their husband/partner, followed by a perinatal mental health support group. The group scored highest as helping them manage their distress and also as the service that helped them most; ahead of their GP, health visitor and CPN. However, the mothers acknowledged that it was medication that helped stop their thoughts. The actual comments of the mothers in the research sample, none of whom had done any harm to their babies, for example:

“...I felt that by myself and my son being dead, then we would be safe and together and nothing in the ugly world could harm us.”

were remarkably similar to a comment made by a mother who had killed her baby, “I decided that [the baby] would be better off dead and the rest of the family should go with it.”

However, there was a difference in the amount of support that they felt that they had received.

All the mothers in my sample received some support, mainly from family and sometimes from professionals. Although the mothers described medication and professional counselling to be important in helping them to recover in the long term, they cited family support, particularly from a partner, as the reason stopping them from acting on their thoughts. All, except three of the mothers in my sample had talked to a family member about their thoughts.

“The main conflict of interests was leaving my husband without me and the baby, as I thought that the best option was to kill both myself and the baby”

“I couldn't hurt him and put my family though all the hurt and pain”
This level of support is in contrast to studies on mothers who have committed infanticide, where more than half did not have a partner or had an unsupportive one and nearly two thirds had poor social support.

My experience is that severely depressed women experiencing infanticidal thoughts in the perinatal period feel unable to share their thoughts because of their fears of Social Services and their thoughts become real in their minds.

“Even how awful these thoughts were, they seemed normal reactions to me. They weren’t bizarre or unreasonable to me, they made sense”

The biggest fears in accepting services were cited to be their fear of being a failure and fear of being ‘mad’. The mothers need reassurance that they are not going mad and will be sectioned or bad and have their baby removed. They do need treatment for their depression and most of all, they need support. Support within a perinatal mental health group, such as the one to which the women referred in their questionnaires, is reassuring, as mothers can share their unthinkable thoughts without being judged, a mother can realise that she is not the first mother to experience this and, most importantly of all, that she is thinking these things because she is ill and not because she is a bad mother.

The mothers cited “verbalising their thoughts” as being an important factor in preventing them from acting on them.

As one mother said:

“When I spoke out loud what I was thinking, I thought ‘Did I really say that? Am I really that bad?’ which pulled me back to reality. You haven’t got the same control when it is in your head.”

The group can provide role models of other mothers to show her that she will get better, she will love her baby and she will be a good mother.

“I felt like I wasn’t alone and whilst I was in the group I felt safe”

I have run two perinatal mental health groups as treatment for severe postnatal depression, the first for six years and my current group has been running since 2010. The groups are small, only four to five mothers with their babies. Mothers who have been assessed in the service and are thought to be suitable are invited to attend. Their commitment to the group is open ended in terms of attendance; they can come if and when they want to and for as long as they want to. The group is non-structured, mothers are invited to share their experiences without any pressure to do so and the intervention uses a behavioural approach; anxiety / stress management together with a cognitive behavioural approach. There is on-going assessment of the mothers’ mental health needs and all the mothers in the group also receive medical treatment which we try and arrange so that appointments with our psychiatrist are offered on the same day as the group. Some of the mothers also receive psychological treatment from IAPT workers, a special arrangement as people under secondary services are not normally offered IAPT services simultaneously.

There are several mothers whose lives have been turned round by the group:

- mothers who now care for and more importantly enjoy caring for their baby when previously they had no hope of looking after their baby without hospital or Social Services care
- mothers who were suicidal and now support other mothers
- mothers now enjoying their babies when previously they had not wanted or been attached to their baby
- mothers whose anxiety was overwhelming in pregnancy able to experience a calm birth, even in the face of birth complications

The group has not been formally evaluated and it is not easy to isolate the group work outcomes from outcomes resulting from other interventions, such as medication. The
mothers are encouraged to give feedback on anonymous post it notes and these are overwhelmingly positive.

“From that group meeting I got better and better, I met women that had felt exactly the same as I did and had come out the other side. It was such a relief to realise that ‘I wasn’t the only one’ and that I was going to get better and love my baby”

The group meets for two hours each Thursday morning and it is a huge commitment for me, to which I honestly do not look forward when I have a lot of other work to do, but every week when I am at the group and hear the women talking and supporting each other, I am very proud of their dedication and determination to feel better for themselves and for their babies. As the mothers are at different stages of recovery, they provide role models for each other.

A recent editorial in the Lancet (Vol 380 November 10, 2012) about the case of Felicia Boots commented that “The day in which women can talk to other new mothers at mother and baby groups or to others antenatally, honestly and frankly about how they feel is still some way off.”

Mothers who attend the group are able to talk honestly and frankly about how they feel with no fear of being judged. I work openly with Social Services and the group provides two hours of supervised parenting on which I can report to Social Services if they are involved. This is a unique opportunity and far from being a threat to mothers, it is their opportunity for their parenting to be seen in a relaxed and supportive setting, reported back within the context of their mental illness, so often misunderstood by Children’s social workers.

Of course, not every mother wants to or can attend a group and so individual peer support is offered to mothers suffering postnatal depression by a local voluntary organisation, called SheffieldLight www.sheffieldlight.co.uk

This voluntary organisation was set up by two of the mothers who had been through our service, together with one of our volunteers. It is now a charity offering peer support through email, phone, text and face to face meetings.

Funding for perinatal mental health is scarce. We only have a specialist service in our city because of a dedicated group of health and social care professionals pressing for this over several years. I run the support group in partnership with volunteers and it takes just two hours a week of my time and receives no other funding. SheffieldLight is supported by our Trust in that they provide office space, but otherwise Light has to fund raise to keep afloat.

One family of a mother who had suffered from severe postnatal illness provided several pages of articulate narrative feedback, summed up by the mother quite simply: “Light saved my life”

Every death and serious incident involves a great deal of meetings with a great number of professionals and costs a great deal of money. I look forward to a day when preventative work is supported with the same funding as investigations.

Jan Cubison
Clinical Service Manager
Sheffield Perinatal Mental Health Service
On many occasions over the last 30 years, I have had cause to regret the decision to call our speciality Perinatal Mental Health/Psychiatry, none more than now. It didn’t exist prior to the 1980s and is not used widely except in the United Kingdom. We know what it means, it is defined by our Section and Specialised Perinatal Services are defined in the National Definition Set.

The problem is that the term perinatal is used quite differently by others and the term Perinatal Mental Health Services is also used as a descriptor of at least two different types of Service. Confusion therefore exists from the very top, The Department of Health, The National Mental Health and Children’s Leads through to Commissioners, Service Leads and individual practitioners.

Perinatal strictly refers to events affecting the child shortly before and after its birth; hence the word perinatal has its widest use in paediatrics as in perinatal mortality rates, which refers to the deaths of infants not of mothers (maternal mortality). It is also used in this sense by colleagues in Infant Mental Health and CAMHS Services, although they adopted this term long after it was used by us. They focus on parenting and the future mental health of the infant, albeit often within the context of maternal mental illness. Although a few of these Services are closely integrated with Perinatal Mental Health Services as defined, the majority are not. In general they will see a different population and manage maternal mental health difficulties with psychological and psychosocial interventions.

Our Services might be more properly called Peripartum Services emphasising the disorders in the mother before and after childbirth, although we too have a primary concern about the effects of the illness and its treatments on the infant as well. One of our most important roles is the promotion of the new developing relationship between mother and infant and ensuring the infant’s wellbeing.

All of this might seem a semantic nicety if it were not for the fact that it is becoming increasingly clear that many important people, both policy makers and commissioners seem not to understand the difference between the two kinds of Service. If this problem exists at higher strategic levels, then it is inevitable that it will be compounded and much worse when the Clinical Commissioning Groups take over the commissioning of all Maternal Mental Health Services with the exception of Mother and Baby Units and a small part of the function of Specialised Perinatal Mental Health Teams.

The Clinical Commissioning Groups (CCGs) will be more numerous than the current PCTs. In 2013 they will be taking on the onerous responsibility of commissioning a wide variety of Services with a restricted budget. If both types of Service have the same name how will they know what they are commissioning? How will they know that one Service aims to provide comprehensive care for seriously mentally ill mothers (and their infants) whilst the other aims to promote infant mental health through parenting interventions? There will inevitably be some overlap in the women seen but at core their remits are different. It is of concern that one type of Service only may be commissioned to the exclusion of the other.

This is not a turf war between two different Services and two different types of approach. Both types of Service are complementary and both are important components of an overall Maternal Mental Health Strategy. It is rather a plea that within both of our Services, colleagues recognise the strengths and limitations of the other and the potential for integrated working. The Joint Commissioning Panel (RCPsych & RCPGP & other Stakeholders) has produced Guidance for Commissioners of Perinatal Mental Health Services (published in October). In this document, the contributions of both Services are
made clear. The term Perinatal Mental Health Service is used as defined by our Section and the National Definition Set and the term Parenting Service or Mother-Infant Service is used to describe the other. However, in the future perhaps we should consider changing our name to a more semantically correct one of Peripartum Mental Health Services.

Margaret Oates OBE
Clinical Director
Midlands & East Perinatal Mental Health Clinical Network

NEW RESEARCH

Frequency of Infant Stroking Reported by Mothers Moderates the Effect of Prenatal Depression on Infant Behavioural and Physiological Outcomes

Sharp et al 2012; Public Library of Science (PLOS) ONE 7(10) : e45446.
doi: 10.1371
Published in PLOS ONE, a peer reviewed open access journal on 16 October 2012

Summary
Consistent with the animal literature, human studies have found that indices of prenatal stress such as maternal depression or anxiety in pregnancy also predict altered hypothalamo-pituitary axis (HPA) reactivity, cardiovascular regulation, and negative emotionality in infants, as well as conduct disorders and emotional problems in children.

Postnatal behaviours in rats, notably licking and grooming, has been shown to cause decreased behavioural indices of fear and reduced HPA axis reactivity mediated via increased glucocorticoid receptor (GR) gene expression. In this study, Sharp et al. examined whether, according to self-report, maternal stroking over the first weeks of life modified associations between prenatal depression and physiological and behavioural outcomes in infancy, thus mimicking the effects of rodent licking and grooming.

From a general population sample of 1233 first-time mothers recruited at 20 weeks gestation, a random stratified sample of 316 were drawn for assessment at 32 weeks based on reported inter-partner psychological abuse, a risk to child development. Of these 271 provided data at 5, 9 and 29 weeks postnatally. Mothers reported how often they stroked their babies at 5 and 9 weeks. At 29 weeks, vagal withdrawal to a stressor, a measure of physiological adaptability, and maternal reported negative emotionality were assessed.

There was a significant interaction between prenatal depression and maternal stroking in the prediction of vagal reactivity to a stressor, and maternal reports of infant anger proneness and fear. Increasing maternal depression was associated with decreasing physiological adaptability with increasing negative emotionality, only in the presence of low maternal stroking.

These initial findings in humans indicate for the first time, that maternal stroking in infancy, as reported by mothers, has effects strongly resembling the effects of observed maternal behaviour in animals, pointing to future studies of the epigenetic, physiological and behavioural effects of maternal stroking.

Nusrat Mir
Consultant Perinatal Psychiatrist
Sheffield
FROM OBSTETRICS TO PERINATAL PSYCHIATRY: 
Reflections of a Trainee Psychiatrist

My current post – ST4 in a General Adult Psychiatry training scheme is a bit of a change from what I imagined I would be doing, as a student and later, as a trainee working in obstetrics. I graduated from the University of Edinburgh Medical School in 2002, with no real idea of where my career might go. I knew a couple of things I definitely wasn’t interested in but really the future was a blank page. House jobs helped to narrow down slightly the vast array of options in BMJ Careers, but only a bit. Being still pretty unsure of myself when all my pre-registration colleagues seemed to have their careers planned down to the last detail worried me a little and therefore I took the plunge and sent off some applications for an Accident and Emergency post for the next six months.

Despite my ambivalence about it, A&E was a useful time. It allowed me to discover that orthopaedics was not a choice. Neither were anaesthetics, ophthalmology, paediatrics, general medicine or surgery. I had a particular enjoyment of the bread-and-butter A&E, like minor traumas and I was very proud of my suturing results! But all too quickly the pressure started again to sort out where I would be going once February arrived. I had narrowed it down to a choice between the two – as I thought – polar opposites of Psychiatry versus Obstetrics and Gynaecology. Subsequently I started work in a local maternity hospital (mainly because the interviews for that post were earlier than those for the Psychiatry posts)!

Working in obstetrics was a fantastic experience. I loved being able to participate in a huge variety of different work settings, from antenatal clinics, to theatre. Building skills in ultrasound, colposcopy, labour ward management and sexual health – and working with a varied group of patients in each – was an immense privilege. I took my first membership exam and for once I really enjoyed the pressure of studying. Passing first time made me more convinced that this was the right place for me. I was working well, getting good reports from my supervisors and colleagues but slowly I started to notice some cracks in the bubble. It started with theatre. Although I enjoyed the simpler procedures, I couldn’t seem to progress in confidence to undertake the more complex. My colleagues seemed to be far outstripping me and unhappily I had to conclude that, while my knowledge was excellent, I really didn’t have the practical abilities to succeed in the operating theatre. O&G is a specialty that combines a medical and a surgical practice. Continued working in obstetrics demands a high level of surgical competence for dealing with labour ward emergencies and I had to conclude that I wasn’t up to it. That wasn’t an easy admission, but it forced me to think about what it was that I loved about my work.

I discovered that the times I felt most satisfied were around the individual patient contact. Being able to listen to another person’s problems and do something to help them – this may be clichéd, but it remains a fundamental goal of most practitioners. Rather than moaning about being asked to admit overnight the postnatal first-time-mum who “wasn’t coping” at home, I felt useful, and when writing the referral to liaison psychiatry the next morning I wished there was a way to follow these people up. It was these kinds of referrals, I found, that gave the opportunity to practice the kind of history taking and communication skills that we had spent years in medical school learning. How very different to the usual encounter in Accident and Emergency, where bleeps constantly reminded me of the need to be in three other places at the same time; where, by necessity, histories were honed to a brief list of key questions in order to manage the overwhelming flood of referrals; where privacy was an ideal to be aspired to (when I managed to bag the one cubicle in the department with a door rather than a curtain).
The advent of MTAS, and the upheaval in training that it brought with it, forced my career musings into sharp focus as the realisation that we would all have to reapply for posts in the new system hit us SHOs. Having discussed my career with my College Tutor, she was hugely supportive, to the extent of letting me undertake an attachment with one of the local Consultant Psychiatrists. It took very little time for me to realise that working in mental health was a breath of fresh air. Decisions were taken not in a split-second, but with time for consideration and discussion with all parties. New patient clinic slots were an hour, and twenty minutes for follow up, when I was used to seeing multiple patients booking into a single ten minute slot. I felt that I could really make a worthwhile contribution here. There were some elements that I missed about obstetrics. I had worked with one of the consultant obstetricians in a High Risk antenatal clinic and the chance to work with young women with a variety of substance use and mental health problems throughout the pregnancy and postnatally was a great experience. I hoped that I would be able to follow this interest through into a career in psychiatry.

I have now been training in Psychiatry for 5 years. The time has gone by so quickly and I have never regretted making the decision to change career trajectory. But I have never lost my interest in Obstetrics and last year I began to undertake Special Interest sessions with Sheffield Perinatal Mental Health service. This is a community based team, where I have been able to see patients presenting with a variety of mental health concerns pre-conceptually, during pregnancy and after delivery.

The field of Perinatal Psychiatry allows me to combine two of my major areas of interest, and I hope to develop the third, by completing my training with an endorsement in Substance Misuse. My experience of this on the obstetric and postnatal wards reinforced how important it is to work effectively with this group of mothers, both for their benefit and that of their babies and the wider family. Pregnancy gives an opportunity for intervention in a group of women who may otherwise be difficult to engage with. Working with substance misuse in pregnancy will always be a challenging and evolving field but I know that this will be part of my eventual career no matter what else I may do on the way there.

Gayle Smith
ST4 Special Interest Trainee
Sheffield

ROYAL COLLEGE OF PSYCHIATRISTS IS ON THE MOVE

The Royal College of Psychiatrists will be relocating to new, modern premises in Aldgate, East London. The move from the offices in Belgravia is expected to take place in June-August 2013 once necessary refurbishment has been completed.
The Royal College of Psychiatrists’ Section of Perinatal Psychiatry Annual Scientific Meeting took place at the Hallam Conference Centre, London on 29th November 2012. This year’s theme was ‘Current issues in Perinatal Psychiatry: Medication, Parenting Capacity and Ethical issues’. A record number of attendees were treated to a host of highly informative, stimulating presentations and workshops.

Here is a summary of 10 points picked out from the meeting:

1. Studies with subjects of over 30,000 have indicated that whilst the use of Selective serotonin reuptake inhibitors (SSRI’s) in pregnancy is associated with an increased risk of birth defects, the absolute risk is small.

2. The first study demonstrating an association between SSRI use in pregnancy and persistent pulmonary hypertension of the new-born overestimated the risk as evidenced by data from subsequent larger studies.

3. If antipsychotics do carry any teratogenic risk, it is likely to be very small.

4. Antipsychotics do raise the risk gestational diabetes and this should be screened for.

5. Promethazine, which has been in use for 50 years with no evidence of teratogenicity, should be considered as an alternative to benzodiazepine hypnotics which have known association with birth defects.

6. Early intervention and referral to Children & Families services is of paramount importance in cases of infants suffering or likely to suffer significant harm.

7. When thinking about a safeguarding case, do not forget to consider the potential ‘double jeopardy’ of removal of a child from its mother followed by removal from foster care and into adoption.

8. When making pharmacological treatment decisions, take an individual approach, taking into account the woman’s illness history, history of response to treatment, side effects and individual preferences.

9. There will be a new dawn for the NHS on 1st April 2013 when its running will be taken over by the NHS Commissioning Board (NHSCB).

10. Community Perinatal Psychiatry services which are not already formally linked to a Mother & Baby Unit will need to set this up or will become very vulnerable in the brave new world.

Nusrat Mir
Consultant Perinatal Psychiatrist
Sheffield
I wonder if it was the thought of seeing Paris in the autumn, or the topics in the programme, that first sparked my interest in the Marcé Society International Congress, 2012. A short train journey later, I discovered that there were at least a couple of hundred people from all around the globe who were there on a similar quest. I was surprised at the wide range of professions and allied specialties that were represented. The common thread was that they were all dyed-in-the-wool perinatal enthusiasts.

The programme opened with the ‘Channi Kumar lecture’ by Prabha Chandra, which I thought was excellent. Dr Chandra described the challenges she faced while setting up the first mother and baby unit in India and highlighted the importance of culturally relevant care.

There was a wide selection of biological and psycho-social topics in all the sessions. Carmine Pariante’s talk on the biological effects of stress in pregnancy and Ian Jones’ update on the genetics of postpartum mood disorders were interesting. Katherine Wisner’s lecture on screening for postpartum depression and Paul Ramchandani’s work on antenatal depression were also noteworthy. There were several thought-provoking sessions on the prevention, detection and management of pregnant and postnatal women in various settings. The biological talks were unfortunately over-subscribed, which resulted in people being forced to opt for their second choice, once the auditorium was full. The organisers seemed overwhelmed by the unprecedented number of delegates.

I was impressed with the standard of most of the sessions that I attended. The conference also provided a good opportunity to network with delegates from diverse specialties and nationalities, working in a wide range of settings.

Paris of course, is a magical city and provided the perfect backdrop for the conference in 2012. The next international congress in 2014 is in Swansea, Wales. Based on my impressions of the last congress, would I recommend it? Most certainly- Oui!

www.marcesociety.com

Renuka Lazarus
Consultant Perinatal Psychiatrist
Leicester

RECENT COLLEGE PUBLICATIONS

1. Postpartum Psychosis leaflet: Authors: Lucinda Green, Ian Jones, Nicola Muckelroy
   leaflets@rcpsych.ac.uk.

   College Seminars Series
FORTHCOMING EVENTS

The Royal College of Psychiatrists' International Congress: 2-5 July 2013 - Edinburgh

Travistock Centre, London

3rd Annual meeting SMFM – Society for Maternal and Fetal Medicine
6-11 February 2013 - San Francisco, USA

21st European Psychiatric Association congress
6-9 April 2013 - Nice, France
Link

European Psychiatric Association (EPA)
April 2013 - Nice, France

5th World Congress on Women's Mental Health (International Association For Women's Mental Health)
4-7 March 2013 - Lima, Peru
Link

International Attachment Conference – IAC
30 September 2013 - Pavia, Italy
Attachment and Human Development
Link

European Psychiatric Association Congresses
2014 - Munich, Germany
2015 - Vienna, Austria
Link

POSTNATAL DEPRESSION: NHS pledges more support

In May this year the then Health Secretary, Andrew Lansley pledged more NHS support for women with postnatal depression or who have suffered a miscarriage, stillbirth or neonatal death.

The Government is to recruit an extra 4,200 health visitors and provide them with enhanced training so that they will be better placed to spot the early signs of postnatal depression.
Where extra help is needed they will be able to refer them to counselling in primary care, thanks to the Government's £400 million investment in psychological therapies (IAPT).

For the first time, the NHS will be measured against how well it looks after parents who have miscarried, suffered a stillbirth or cot death. Patients will be asked to rate their care which will form part of the Prime Minister’s ‘Friends and family’ test which was announced earlier this year.

There is also a pledge to improve maternity care to ensure one named midwife to oversee the care during pregnancy as well as guaranteeing one-to-one midwife care during labour and childbirth. Parents-to-be are to be given more choice about where and how they give birth with an aim to provide a more integrated, flexible service.

Andrew Lansley said: “No woman should have to cope with postnatal depression without help and support. The changes we are putting in place today will mean that the NHS is providing even more support to women with this serious condition.”

“We have listened to the concerns of women about their experiences of maternity care, which is why we are putting in place a ‘named midwife’ policy to ensure consistency of care. Not least, we will focus on the quality of care given to mothers-to-be and measure women’s experience of their maternity care for the first time.”

Department of Health Press Release 16 May 2012
Summarised by
Nusrat Mir
Consultant Perinatal Psychiatrist
Sheffield

COLLEGE: Support when facing threats to your job

The College is very aware that the NHS changes and current financial climate are leading to many and varied changes in services, and that there are many of you facing difficult and uncertain times. Service changes, tendering processes and drive for efficiencies are leading to threats of redundancies, actual redundancies, loss of posts and decrease in paid Programmed Activities. There are also Psychiatrists facing a potential loss of earnings as a result of changes in the legal system. As a result many feel under considerable stress due to the uncertainty and possible changes in lifestyle.
It can be difficult to know where to turn at such times. There are no clear answers, but here are some thoughts on what might help:

1. The British Medical Association provides assistance with employment and contractual issues. This is an important avenue of support when faced with service or contractual changes or the possibility of redundancy.
To contact the BMA for employment and general information queries, telephone 0300 123 12333. Lines are open Monday-Friday, 8.30-6.00pm. Alternatively, visit their website at: http://www.bma.org.uk/_top/contact_us/index.isp and use the feedback form to contact an adviser.
2. Consider what procedures are available to you within your organisation to review your position or offer advice. This could include discussion at a Medical Staff Committee meeting, Local Negotiating Committee meeting or discussion with Human Resources.

3. The Psychiatrists Support Service is a confidential telephone advice service providing support and signposting for members of the Royal College of Psychiatrists. Contact can be made on telephone 0207 2450 412. The Support Service Manager will listen to the details of your situation and review them with the Specialist Adviser who leads the service. You will then be directed to an appropriate organisation to provide the necessary support or referred to a College member for focused advice.

4. Informal discussion with your colleagues. You may be surprised to learn that others may be experiencing similar anxieties. Your colleagues may have helpful ideas about what you could consider doing and help you to explore your options.

5. The British Medical Association Counselling Service and Doctors for Doctors service provide a confidential service where doctors can discuss problems and get support. You can either speak to a counsellor or a doctor-advisor. To make contact telephone 08459 200 169.

6. Support for Doctors is a website developed by the Royal Medical Benevolent Fund and provides a lot of useful information (www.support4doctors.org). The Royal Medical Benevolent Fund can also provide support for doctors and their families facing financial problems.

7. The BMA can direct you towards financial advisors, or you may wish to make contact with an advisor independently.

8. You may want to consider avenues of alternative income or a portfolio career. Information and contacts for the College ‘Private and Independent Practice Special Interest Group’ is available on the College website, Members Section, and an information guide ‘On planning a portfolio career’ is on the Psychiatrists Support Service website (available at: www.rcpsych.ac.uk/pss). The British Medical Association also provides information and seminars on setting up a private practice.

9. You may want to consider an alternative career or specialty. Talking to colleagues may generate ideas. The Medical Forum offers career planning support (see http://medicalforum.com. The British Medical Association also provides careers counselling, and your local Deanery may have a careers advisory service.

Above all it is important to look after yourself. Talk to your family, friends and colleagues. Maintain a healthy lifestyle and work life balance. You might find the information guides available on the Psychiatrists Support Service website helpful, in particular advice on dealing with stress (available at: www.rcpsych.ac.uk/pss)

The College is keen to hear from you and to understand what is happening to jobs and services. Please do contact Charlotte Collins, Workforce Manager, on ccollins@rcpsyh.ac.uk with any news or updates.

Royal College of Psychiatrists
London

SUBMISSIONS

Please send your articles, musings, suggestions etc. for the next newsletter to:

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