Newsletter: Section Perinatal Psychiatry

Royal College of Psychiatry
Spring/Summer 2010

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INTRODUCTION FROM THE CHAIR:

ROCH CANTWELL

We certainly live in interesting times - a new government at Westminster and an economic crisis of global proportions. It would be foolish not to expect some tightening of belts, even in the 'protected' world of the NHS. Perinatal mental health services have made huge advances over the past few years – new MBUs and specialised community teams, the development of robust clinical standards, and recognition of the specialty by the College in the form of a draft specialist curriculum. However, specialised services are always vulnerable, particularly when they are seen as expensive add-ons, rather than core essentials to best patient care that should be available in all regions. While not calling for a manning of the barricades, there is a responsibility on all of us to speak up for the protection and enhancement of local and regional service provision. As many colleagues know, the case has to be made persistently and often with mind-numbing repetition! Many section members have lots of experience in honing arguments for service development so, if there are threats to services or even opportunities to develop (!), please don't hesitate to get in touch with local and national colleagues.

The annual meeting is still one of the best places to share experience and meet like-minded colleagues. This year's meeting will be held in London on Friday 26th November. The theme is ethical issues in managing women with perinatal mental illness. Like previous meetings, it should be controversial and challenging. I look forward to seeing members there again. More details will appear on the website and in mailings but please put the date in your diary for now.

UPDATE: QUALITY NETWORK FOR PERINATAL MENTAL HEALTH SERVICES

Following the inquiry into the deaths of Daksha and Freya Emson in October 2003 and the publication of the Confidential Enquiries into Maternal Deaths in 2001 and 2004, the Royal College of Psychiatrists made a commitment to promote perinatal mental health.

The Quality Network for Perinatal Mental Health Services was launched in 2007, as part of this commitment, to develop standards for mother and baby units and encourage service improvement. The network engages with frontline staff and applies a clinical audit method within a peer-support network. The network aims to:

- enable communication and the sharing of best practice between services
- help units to demonstrate their quality and identify challenges through a process of self and peer-review

Reviews are not an inspection or accreditation test, nor a drive to uniformity. It is a supportive network with the emphasis on facilitating change.

Membership and Reviews

The Quality Network is about to complete its third annual cycle of reviews. This year 14 mother and baby units were members representing over 75% of services in the UK. Further information about the quality network can be found at:
http://www.rcpsych.ac.uk/clinicalservicestandards/centreforqualityimprovement/pernatalqualitynetwork.aspx.
At the website you can download the most recent annual report and the network's standards.

Annual Forum

The 2nd annual forum for the Quality Network for Perinatal Mental Health Services was held on 26th November 2009. This was a very successful event with approximately 75 members attending representing 12 mother and baby units across the country. The forum included an update on the network and presentations from members on current topics within Perinatal Mental Health. These included:

- exploring the interface between clinical work and commissioning within the perinatal context.

- family interventions involving mothers and carers

- examining the role of occupational therapy within the perinatal context.

- completing a community review; description of a peer review visit to Southampton perinatal mental health outreach team

All presentations and handouts can be accessed by going to the Perinatal networks web page at: http://www.rcpsych.ac.uk/clinicalservicestandards/centreforqualityimprovement/perinatalqualitynetwork/annualforum.aspx
In Cycle 4, the network will be piloting a model of accreditation. Mother and baby units that are considered to meet a sufficient number of standards will be accredited by the Royal College of Psychiatrists. The project team is currently working on developing the accreditation pilot in liaison with members. We also hope in 2011 to develop standards to work with community Perinatal services.

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TRAINEE PERSPECTIVES

Trainee Opportunities by Andrew Cairns

At this year's Annual Scientific Meeting I outlined what I had done during my first year as Trainee Rep for the Perinatal Section. This has focussed largely on training opportunities in advance of PMetB's decision on subspeciality status for Perinatal Psychiatry.

Firstly, I have mapped all Psychiatric Mother & Baby Units (including specialist Mother & Baby beds attached to General Adult Wards) in the UK. The result was a map of 22 units which can be viewed on googlemaps at **http://tinyurl.com/yghyuz9**. Secondly I surveyed Consultant Perinatal Psychiatrists to identify training posts and special interest sessions throughout the UK. This found 47 current consultant posts with a mean average of 6 PAs (range 1-11). There are 18 Core Trainee posts and 13 Specialty Trainee (4-6) posts. 7 consultants have both CT and ST doctors. 30 consultants are happy to supervise special interest sessions. For a map of Perinatal Consultants (by location) and trainee posts, see **http://tinyurl.com/ygnbr2c**. If anyone has any questions or would like contact details for Perinatal Consultants in their region, please contact me: andrew.cairns@doctors.org.uk.

Musings of a Perinatal Higher Trainee by Kathryn Bundle

I am approaching the end of my Higher Specialist Training and this seems an opportune moment to reflect on the time I have spent as an SpR (a dying breed, it's true – I'm only still going in this capacity as I have trained flexibly), and in particular my time in perinatal psychiatry. I consider myself extremely fortunate to have had a perinatal placement, as such posts are not always easy to come by; most training schemes will have only one perinatal post, maybe none at all. My interest in perinatal psychiatry began as a medical student at Nottingham University, where I did a "Special Study Module" in Motherhood and Mental Health, with Margaret Oates. The clear interplay of biology, psychology and social factors in the patients I saw and read about fascinated me and stimulated a desire to learn more. As often happens in medicine, personal experience also influenced the direction my training took, with the births of my two children and the delight of seeing them grow and develop prompting me to request the perinatal placement on my training scheme.

What should a higher trainee aim to get out of a placement in perinatal mental health? For some, such a placement will provide useful experience for working as a general adult psychiatrist, whilst for others it will be essential training for a future career in this subspecialty. For the former group, my feeling is that the training should provide knowledge of the way in which pregnancy, delivery and the puerperium can impact on pre-existing mental illness, influence the management of new onset disorders during this time, and act as a specific trigger for certain conditions. General psychiatrists need to know who and how to refer to specialist services, and have some understanding of how to manage their patients who become pregnant if such services are not readily available. An understanding of the issues involved in making decisions about prescribing in pregnancy and breastfeeding is also very important, as is an appreciation of the potential impact of perinatal and parental mental illness on an individual's capacity to parent their child(ren). Linked to this is the importance of safeguarding and any training in perinatal psychiatry should equip the trainee with a sound knowledge of child protection issues.

For those trainees who hope to go on to become perinatal psychiatrists all of the above competencies are obviously essential, but there is the added necessity of learning precisely how to manage this patient group and what advice to give to women and professionals in

different scenarios. To gain the best training I think it is important to have experience of the different settings in which perinatal services are provided, i.e. community / outpatients, obstetric liaison and inpatient Mother and Baby Unit if possible. This may not be automatically available in a given placement and to obtain this range of experience the trainee will require flexibility and motivation, and a supportive consultant! An important aspect of the work of most perinatal services is midwife training and it helps if one is interested in this and keen to take part. I have found this very rewarding and enjoyable. Trainees should be aware of the broader context within which perinatal services are provided and be familiar with the various national guidelines and reports which influence clinical practice. There are also several annual conferences which are well worth attending, including the College Section of Perinatal Psychiatry Annual Scientific Meeting, the annual Perinatal Academic Conference organised by the Institute of Psychiatry, and the Winchester Course which provides a very thorough update on current research and practice.

There are of course many challenges to working within perinatal mental health. A perinatal psychiatrist has a responsibility to two patients, mother and baby, and whilst the interests of the two will usually coincide, there can occasionally be an apparent conflict. Emotions run high where babies are involved, in both patients and staff, and this can be particularly pronounced in cases where Children and Families Social Services are involved. The Mother and Baby Unit where I am based carries out parenting assessments and experience of this has provided a fantastic added dimension to my training. This work can be especially demanding and difficult however, as different members of staff may have their own views as to what constitutes “good enough” parenting, inevitably influenced by their own experiences. Clearly it is not a pre-requisite for working in perinatal psychiatry be a parent oneself, but I have found my understanding of some of the issues which our patients face greatly enhanced through my experience of having children. On the other hand, it requires honesty and self awareness to recognise where this personal experience could potentially get in the way of making objective judgements and to acknowledge the feelings which certain patients inevitably stir up in me.

This is work which I love and would recommend to all trainees in adult, or indeed, child psychiatry. I have learnt a great deal from all the staff on the unit where I work and am indebted to them. It is arguably not a good time to be completing my Higher Training and I am frequently reminded that the consultant job market looks fairly bleak, but I remain hopeful that at some point I will be able to work as a perinatal psychiatrist and draw on the knowledge and experience which I have been gaining over the last 18 months.

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Northern Travelling Circus event held in Nottingham

On 19.03.10, the Nottingham Perinatal Psychiatry Team hosted the “Northern Travelling Circus” for the first time. In the morning there were three guests speakers: Dr Margaret Ramsay, Consultant in Feto-Maternal Medicine, provided a review of physiological changes in pregnancy and how these might affect medical management by Perinatal Psychiatrists; Dr Charlotte Porter, Consultant in Community Gynaecology updated us on the latest developments in contraception, particularly long acting reversible contraceptives (LARCs) and Dr Margaret Oates, Clinical Director of the East Midlands MCN in Perinatal Psychiatry gave an overview of the work of the E. Midlands MCN to date, with some predictions for the future. Dr di Mambro presented the computerised teaching package for community midwives that he has developed from the original teaching package put together by Dr Oates a number of years ago (we are currently comparing the face to face teaching with the computerised programme in a pilot across the county) and Mrs Gardiner, Manager of the MBU, and I shared the difficulties we had experienced in managing a complex case. Colleagues in the specialised community nursing team presented data on case loads across the county and ran workshops on clinical scenarios that commonly occur in Perinatal Psychiatry but which can give other health professionals working with pregnant women cause for concern. The talks and workshops were well received and the feedback from the 30 or so delegates who attended from around the country was very positive.

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NEW INFORMATION:

A new "Mental health in pregnancy" leaflet is available on the Mental Health Information section of the college website. Printed copies are also available. Please ask women to give feedback through the website.

If anyone is interested in developing further leaflets for pregnant and postnatal women please contact Lucinda Green Lucinda.Green@slam.nhs.uk

DEPRESSION DURING PREGNANCY: FINDING THE BIOLOGICAL LINK BETWEEN MENTAL AND PHYSICAL HEALTH

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Depression during pregnancy is common, with prevalence rates between 7-15% in developed countries. In addition to the untoward effects of depression on the sufferer and her family, the development of depression in pregnancy increases the likelihood of poor obstetric outcome: for example, of preterm birth and low birth-weight babies. We know a lot about the biology of major depression, but not enough during pregnancy. Can some of the knowledge from general psychiatry help us in understanding why depression during pregnancy worsens obstetric outcome?

Hyperactivity of the main hormonal stress system, the hypothalamic-pituitary-adrenal (HPA) axis, is one of the most consistent biological findings in major depression; data include increased production of the hypothalamic peptide, corticotrophic releasing hormone (CRH), increased levels of the glucocorticoid, cortisol, and impaired glucocorticoid-mediated negative feedback regulation. Furthermore, increasing evidence suggests that inflammatory responses have an important role in the pathophysiology of depression; for example, depressed patients have been found to have higher levels of proinflammatory measures, most frequently interleukin (IL)-6 and C-reactive protein (CRP), but also IL-1β and tumour necrosis factor (TNF). This seems to occur despite the high levels of circulating cortisol (a hormone with immunosuppressive properties), possibly because of an impairment in the anti-inflammatory action of glucocorticoids.

Interestingly, normal pregnancy heralds profound changes in the HPA axis. As pregnancy advances, CRH, usually considered exclusively an HPA axis hormone, is produced by the placenta in progressively increasing amounts; this is fuelled by the *positive* feedback of cortisol on placental CRH, which is in contrast to the negative feedback of cortisol at the hypothalamus in the non-pregnant condition. When at a critically high level, CRH is an important trigger for the onset of parturition. Further evidence of alteration in HPA axis function in pregnancy is the finding of non-suppression of cortisol by dexamethasone, which suggests reduced glucocorticoid-mediated negative feedback, as also demonstrated in depression. Interestingly, studies have shown that, compared with women delivering at term, women delivering preterm had significantly elevated CRH levels as well as a significantly accelerated rate of CRH increase over the course of their gestation. Therefore, links have been postulated between chronic psychosocial stress in pregnancy, elevated levels of CRH, and preterm birth, but this model has never been tested in women with operationally defined clinical depression. If depression in pregnancy is characterized by hypercortisolaemia – as it is in depression outside pregnancy – then as a result of the positive feedback of cortisol at the placenta, depression in pregnancy is likely to further increase CRH, which in turn may anticipate timing of delivery.

Normal pregnancy is also characterized by a physiological activation of the systemic inflammatory response. A solid body of evidence indicates that cytokines play a central role in the mechanisms of inflammation/infection-induced preterm parturition, and strong evidence suggests that cytokines can stimulate production of prostaglandins E2 and F2α which are involved in initiation and maintenance of human parturition. Animal models indicate that preterm labour can be stimulated by proinflammatory cytokines such as IL-1 and TNF. In humans, associations have been found between enhanced expression of the proinflammatory cytokines, IL-1, IL-6 and TNF-α, and preterm delivery. Interestingly, these are the three cytokines more consistently increased in major depressive disorder. Again, if these cytokines are elevated in depression during pregnancy – as they are in depression outside pregnancy – they may contribute to pathways to preterm birth.

These hypotheses are currently under investigation in the newly linked Section of Perinatal Psychiatry and Section of Stress, Psychiatry and Immunology at the Institute of Psychiatry, following the appointment of Dr. Pariante as the Head of Perinatal Psychiatry. Improved understanding of the links between depression in

pregnancy, abnormal biological factors and adverse obstetric outcomes, will facilitate clinical decision-making aimed at reducing harm to both mother and baby, and will be an important consideration in the on-going debate on the risks and benefits of the use of antidepressant medication during pregnancy. Ultimately, finding the "biological link" will deepen our understanding of depression occurring during pregnancy and its consequences.

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FORTHCOMING EVENTS!!!!!!!!!!!!

1. THE MARCÉ SOCIETY :INTERNATIONAL SOCIETY FOR PSYCHIATRIC DISORDERS OF CHILDBEARING UK AND IRELAND MARCÉ SOCIETY ANNUAL SCIENTIFIC MEETING

Thursday 16th September 2010
Perinatal mental illness, and effects on the child; causes, mechanisms and interventions @IRDB, Hammersmith Hospital site, Du Cane Road, London W12 ONN
Fee £20.00, including lunch, payable on the door (Please pre- register)
We welcome 15 minute presentations on your research, even if it is in the early stages. Please send the title, together with your email address to: Prof Vivette Glover v.glover@imperial.ac.uk
The UKIMS Annual General Meeting will take place at 17.00 hrs.

2. PERINATAL SECTION ANNUAL MEETING, 26 NOVEMBER 2010
Overarching themes included sharing experiences; perinatal mental health in the NHS; equity in the NHS, ethics, the effectiveness and cost implications of specialised care; children as priority; and involving families. Speakers to be confirmed.

3. TRAVELLING CIRCUSES

28th September 2010 Winchester : Venue TBC

4. THE SCHOOL OF INFANT MENTAL HEALTH Workshops
1. Baby Brains: Research on the effects of trauma, music, movement and temperament on the developing brain and mind in the first year of life
The Langorf Hotel, 20 Frognal, London NW3 6AG,UK
Saturday/Sunday, 12th-13th June 2010
COST: £190 per delegate
12 CPD Credits

2. Infant Psychiatry : Diagnostic Classification: 0-3-R

The aim of this workshop is:
to explore the diagnostic classifications in the 0-3 years age group and look at the basic aspects of normal behaviour in these infants. There will be ample opportunity for discussion and debate in what promises to be an exciting and stimulating workshop of special interest to paediatricians, general practitioners, health visitors and anyone working with young children.

Sunday/Monday, 12th-13th September 2010

£190 per delegate 12 CPD Credits (TBC) Please see website for speakers for both workshops. [mailto:IMH@adsmart360.com]

Please send any articles for future newsletters to:
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