

Section of Perinatal Psychiatry Newsletter

Royal College of Psychiatrists
June 2011

Editors : Neelam Sisodia
Nusrat Mir
Renuka Lazarus

On behalf of the Editors:

This newsletter was meant to be the 'Spring' edition, in the hope that this year, we might be able to produce an 'Autumn' one too, and yet here we are, with midsummer just around the corner! It has clearly been a busy year, so far, for everyone. There are many changes planned for the NHS, but those working in Perinatal Psychiatry across the UK have continued to promote the sub-speciality in various ways. You will be aware of this from the Perinatal Psychiatry meetings and events that have already taken place this year, and there are contributions below (gratefully received!) which provide more details in some key areas of developing national policy. Several trainees plucked up courage to write about their experiences of working with women and their families in different settings - I hope that this will encourage others to submit pieces in future. On behalf of the Editors, I would like to thank everyone who sent us an article this time and to encourage Section members to send ideas/pieces for the next newsletter. If we get enough submissions, we might manage to get next year's first newsletter out by late January 2012, perhaps followed by another in June 2012. And if you don't like what we've put together this time then tell us what you want to read about next time! The newsletter is for you to use as a means of spreading information/ideas within the Section and sub-speciality. So even though this edition is a little late, we hope the contents will provide food for thought in the coming months.....

Neelam Sisodia
Nottingham

A word from The Section Chair:

It's a rare sunny morning in Edinburgh. Not a bad time to sit with a cup of tea, looking out over some straggly window boxes, and think about the last year for the Section. As usual, my contribution to the newsletter is arriving at the last minute (apologies to the Editors), but at least that's allowed me to report some positive news. Our argument for sub-specialty recognition for Perinatal Psychiatry has finally been submitted to the GMC. We have had a specialty curriculum waiting in the wings for the past six years, but the tortuous process of gaining approval for the General Adult Curriculum, then changeover from PMETB to GMC, has meant snail's pace progress. The GMC puts a great emphasis on support from trainees and service users, and I'd like to thank all those patients and trainees who provided supporting statements, many of which were deeply heartfelt. In particular, Nicola Muckelroy and Andrew Cairns, service user and trainee executive committee members respectively, did a huge amount of work to collate the supportive statements in time for submission. Now, its fingers crossed and, yes, wait. But while we wait, there's still a job to be done on incorporating perinatal competencies into the core curriculum and providing guidance for consultant appointment panels.

You may be aware about the trials of the Confidential Enquiry into Maternal Deaths. A review process that has scrutinized, reported on and improved maternity care, and which has become the envy of, and template for,

nations worldwide, came close to vanishing overnight. This is something we should all worry about. The Enquiry has been one of the greatest drivers in promoting good maternal mental health and the role that psychiatric services have in reducing maternal mortality. There is hope however. A review panel, with a deadline of producing recommendations for the Enquiry's continuation of July 2011, has already met. You can see more details at www.npsa.nhs.uk/corporate/news/maternal-and-newborn-clinical-outcome-review-expert-panel/. We have already expressed our views on the importance of the Enquiry, including those core methodologies that should be retained in any new incarnation.

2011 has also transformed the Perinatal Quality Network from cosy peer review to sometimes intimidating accreditation inspection. This is the latest step in our 'growing-up' as a specialty. It's been a difficult process for many of us, but putting our services up for independent scrutiny is an important step toward better care for patients – ultimately the common aim for all of us.

And lastly, a word of appreciation and thanks to Dinesh Bhugra, as he comes to the end of his period as the College President. He has been a supporter and advisor to the Section throughout his tenure and I will miss his wise words and wicked sense of humour.

Roch Cantwell
Edinburgh

NHS Reforms - what next?

It may be that things will slow down a bit now but it is difficult to imagine how the juggernaut of change (aka reform) can be stopped. Staff of the SHAs and PCTs are leaving in droves and probably millions have already been spent in redundancy and setting up Consortia. Private Sector Health Management Groups are licking their lips and ready to pounce. Whoever thought that GPs would have the skills to commission, never mind the infrastructure? They barely have time to do their day jobs.

This moan is not about saving money or being more clinically effective. Everyone one of us could have given Andrew Lansley a hit list for doing this. It's about the apparent passivity of medicine in general and our profession in particular. Apart from a weak protest from the BMA, there have been no statements from the Colleges, no public asking of questions or seeking further detail. We appear to just roll over and cooperate.

Even if the underlying theory was sound and there were good reasons to want to change things, we know that change in itself is de-stabilizing and costs millions of pounds. Just think of all the changed letterheads and the glossy offices on industrial estates and the proliferation of endless layers of management with indecipherable job titles.

The reason why we don't know what is going to happen about commissioning services for populations of over a million (most mental health trusts) or about the future of specialized services such as Perinatal Psychiatry is that they don't know either (yet). If you ask questions of people who should be in the know, their answers are prefixed with "it is likely". So what do we know? At the moment, despite a recent review, Perinatal Psychiatry (interestingly both psychiatric mother and baby units and community Perinatal Psychiatry "outreach teams") remain on the National Definition Set for specialized commissioning. At the moment, psychiatric mother and baby units will be commissioned by Specialized Commissioning Groups, not PCTs. However, at the moment, the intention is that Community Perinatal Psychiatry Teams will continue to be commissioned by PCTs. But what will happen in 2013? Will the Sags remain? "It is likely" they will not or at least they will be reduced in numbers. Will the commissioning pass to the Consortia? Nobody knows.

Rational, epidemiologically based planning with central monitoring of Standards for large populations is the apotheosis of "free-market" and "any will provider" and of Consortia commissioning for small populations. It is ideologically apposed to current health policy. Not just Perinatal Psychiatry but Cancer, Neonatal, Pediatric surgery, Renal Networks are all nervous and concerned. Entrepreneurial Foundation Trusts are rubbing their

hands with glee, no longer restrained by the prohibition not to destabilize another Trusts activities. For clinicians running services, it is a potential nightmare negotiating contracts with multiple Consortia (at least double the current number of PCTs). Clinicians will have to know the Consortia responsible for each individual patient before they know whether they are allowed to see Mrs. Smith once, twice or three more times after her assessment.

Perinatal Psychiatry Services that currently provide an integrated mother and baby unit and community service will find themselves with beds commissioned centrally but community teams commissioned by numerous Consortia, each theoretically with individual contracts, health management systems and thresholds for referral.

We really should say something. As a Section, as a College, we ought to publically express our concerns, ask questions and seek further details. If we do nothing, we may well find ourselves, in two years time, only being able to see or admit a woman after the approval of a Consortia Health Management System, unable to take referrals from midwives and obstetricians and all our carefully worked out clinical pathways will have come to nought.

However, if you prefer the ostrich method, then you may be right. Just like the Trusts IT plans, it may never happen.

Margaret Oates
Clinical Director
East Midlands MCN in Perinatal Psychiatry

Examining the evidence base: Should we stop using tricyclic antidepressants in pregnancy?

In a recent editorial in *Psychological Medicine*, Pariante et al. (2011) challenge the conventional view that tricyclic antidepressants, because they have been around for much longer than novel SSRI's or other antidepressants, are the safest choice in pregnancy.

It is true that during their many decades of use, no major teratogenic effects have been observed with tricyclics. In contrast, SSRI's have been used for a much shorter time, and so less might be known about their effects. However, in light of new evidence from a Swedish study by Reis & Källén (2010), the editorial asks whether the idea that tricyclics are safer in pregnancy is based on evidence or is just a perinatal myth.

Reis & Källén (2010) describe approximately 15000 women (and their babies) who, between 1995 and 2007, reported the use of antidepressants, or were prescribed such drugs, during pregnancy. These women were compared with all other women who gave birth in the same period: approximately 1 million women.

Most women took SSRI's ($n = 10170$) but a reasonable number took tricyclics (1662 women which for 1208 was clomipramine); 1351 took other antidepressants, mostly venlafaxine ($n = 859$).

Interestingly, the study revealed that outcomes after exposure to tricyclics are, for most measures, equal or worse than after exposure to SSRI's or other antidepressants. For example, there is a tendency for a higher risk of preterm birth and low birth weight after tricyclics than after SSRI's. Moreover, the risks for hypoglycaemia, respiratory diagnoses and low Apgar scores are significantly increased primarily after the use of tricyclics, but also of SSRI's; and an increased risk of jaundice is present after exposure to tricyclics and other antidepressants, but not SSRI's. Even more important, the risks for a relatively severe malformation, for any cardiovascular defects, for ventricular septum defects, or for atrial septum defects, are all significantly increased only for tricyclics and for one SSRI, paroxetine.

Limitations of their study are acknowledged by Reis & Källén. The findings could be confounded by 'indication', that is, that women prescribed tricyclics could be clinically different from those prescribed SSRI's. Moreover, most women receiving tricyclics were, in fact, receiving clomipramine, a tricyclic with a strong serotonergic component and, anecdotally, not widely prescribed in the UK. The study is based on a relatively small number of women, and therefore the data on which to base conclusions is limited.

Pariante et al. (2011) believe that these findings challenge the notion of a 'superiority' of tricyclics, and cannot be ignored in clinical practice. In view of the lack of evidence indicating the superiority of tricyclics for pregnancy or teratogenic outcomes, they conclude that this class of drugs can no longer be considered to be the safest choice in pregnancy.

References:

Reis M & Källén B (2010) Delivery outcome after maternal use of antidepressant drugs in pregnancy: an update using Swedish data. *Psychological Medicine*. Published online: 5 January 2010. doi: 10.1017/S0033291709992194.

Pariante CM, Senevirante G, Howard L (2011) Should we stop using tricyclic antidepressants in pregnancy? *Psychological Medicine*. 41 (1), 15-17.

Nusrat Mir
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Sheffield

Trainee Perspectives

An insight into the Cassell Family Unit in a time of austerity

The Cassell Hospital Family Unit, based in Richmond, is a national service. The families assessed and treated here are referred from various sources, including the Courts, Social Services and Community Mental Health Teams. The cases seen are complex, often complicated by abuse, neglect, personality disorder and significant forensic histories; an inpatient assessment helps decision making around whether children should be removed from a family or not.

Working at the Cassel trains you to manage the constant flux that exists as a result of movement between circumstances and people, whilst allowing you to maintain boundaries and responsibility at all times. This is something in common with other medical and psychiatric placements I have worked in. However, there is possibly a difference in the amount of thinking space that is allowed for in your daily work, something that is clearly important to being a psychotherapist. The Cassel widens the role further by not allowing you to stay in the frame of your room, but encourages you to move through the hospital, facing your patient, their family and community in different environments; in this way, the whole hospital becomes your frame. As you move from being an individual therapist, working with the dynamics of the patients' shattered childhoods, their broken parental objects, to a group therapist, transferring into the role of the discarding parent, you rest assured that the system will hold you.

With the changes in the economy, the system is dissolving and both you and the patient are trying to hold the strength as the 'home' is again under threat. The current climate and the effects of this are present in the room, unconsciously bringing up the gaps and adding a little more. We try and sort through it, think about what could be used, where it should be communicated and by whom. The staff move past each other, working, thinking and feeling, passing their patients, their thoughts and their own back grounds in complex shards, trying to hold it all together to continue the work at hand. It makes me wonder, of how other hospitals/units and their patients are coping with these added stressors, without the support of staff reflection practices.

The Cassel is different from any other environment I have experienced in my medical and psychiatric training. The tasks facing mental health workers seem the same; staff work in constant dynamics facing parts of themselves in their work, holding onto boundaries, moving into their thinking space. These spaces are amplified where children are involved. Every staff member on the Family Unit is aware that when the decision is made to accept a parent and their children, it is a time for increased awareness, to ensure that the children are protected, and that no further damage is done during the stay on the Unit. Often the families admitted will be

involved in Family Court/Care proceedings, an indication that there is already a high level of concern about what has happened in the family home. The staff work with the knowledge that their experience and therapeutic involvement will not only keep further damage from occurring, but may also give a some hope that further work can be done. To see movement in an interaction, where a mother is able to hold her child, and 'just listen', to see those small glimpses of a child being able to express their internal world to the person most important to them in a continuous way, is what makes the work notable.

The ability to trust the other, the parent, is something that all the staff members working here carry inside themselves. The Cassel is a 'Family' Unit and the staff members are all part of the 'family', imperfect, with flaws and full of emotion. The difference to a usual family is that each member brings their own family experience to the mix, so initially it can seem like a terrifying place. We come to realize what it is like for the patient again and again. And as one settles in, one recognizes the hierarchy, the sibs, the aunties and uncles and particularly the father.

Dr Roger Kennedy provides a satisfying and strong leadership role that works to keep the minds of all staff free to centre on their patients, in the knowledge that they have a place to come to, to reflect and digest the risk they carry. It comes as an undeniable disturbance that Dr Kennedy's post has not been extended and he will leave in March 2011. The Family Unit, however, will battle despite the threat of closure until at least September 2011, after public and staff consultations have been completed. As the message spreads of Dr Kennedy impending absence, the Family Unit is starting to understand the added pressures that will befall us. The space to think sadly is shrinking, the space to feel is gradually exploding and throughout it all the need to continue the work remains static. Something that we can only imagine is mirrored in other mental health services in the rest of the country.

As the patients of the Family Unit gradually adjust to the apparent breakdown of their unit, a repeat often of their own family lives, the therapists and nurses continue to hold the frame, working with all that is being shown to them in a hopefully therapeutic manner. They work to somehow bring about the belief that not all 'breakdowns' cannot be overcome. The continued ebb and flow of passing each other does not end, we do not stay in our rooms, hoping to ignore the outside, but that we go head-on, thinking of what needs to be done and how to face it responsibly with all the capabilities our training has given us. I hope that this strength and work can be preserved in the NHS and that the ideas that the Cassel builds are present and continue to influence other systems in their interaction with families who are in a state of breakdown.

Leah B Henen
ST4 in Psychotherapy
Family Unit, Cassell Hospital
Richmond

A Trainee's Introduction to Perinatal Psychiatry

General Adult Psychiatry has always appealed to me due to the diversity of disorders and patients found in this broad specialty. One area within General Adult Psychiatry, in which I was fortunate enough to spend six-months during the third year of my core training, was Perinatal Psychiatry. Having had no experience in an obstetric post during my foundation years, I wondered whether this might prove challenging due to the extent of overlap between psychiatry and this medical specialty, however I was excited about working in my local Mother and Baby Unit, as it is a specialized tertiary unit, and one of only 22 in the country. As the junior doctor in a team that provided a service to a busy urban centre and the surrounding county areas, I was able to experience working with patients in many settings as I was involved with assessments and follow-up in the community, out-patient clinics, and in hospital (both inpatients on the Mother and Baby Unit and regular urgent referrals from the obstetric wards on two city sites).

I needn't have worried. I found the job varied, rewarding and even challenging at times, but learnt a great deal. My favourite part of the job was spending time with the women who were inpatients on our unit. In this specialty

I met the most unwell patients that I have ever come across in my three years of psychiatry training, and witnessed the most incredible transformations as they started to recover. The most rewarding part for me was to see the change in the relationship between a mother and her baby as the mother's mental state began to improve; the pure delight that the mother experienced from her baby in contrast to the anxiety, fear or disinterest that she might have felt towards the child previously.

Working in this specialty also made me realize that mental illness in pregnancy and postpartum can affect anyone, as I followed the experiences of women who had previously been psychiatrically well, some of whom were pre-morbidly highly functioning in jobs similar to my own. I was also fascinated by our patients' differing social and cultural circumstances, although I sadly saw how unsupportive relationships had in some cases had a catastrophic impact on patients' mental wellbeing.

The job offered much experience in working in a busy multidisciplinary team and with other medical disciplines and agencies such as Social Services. I am now working in Liaison Psychiatry, another sub-specialty where psychiatry interfaces with other areas of medicine. As I commence my Specialist Registrar training in General Adult Psychiatry, I feel that the sub-specialties of Perinatal and Liaison Psychiatry have taught me the importance of taking a holistic view of the patient. I have learnt not to underestimate the significance of personal and social circumstances, or indeed of physical health. I hope to spend another year during my higher training in Perinatal Psychiatry in a few years time, from which I'm sure I will learn much more about this fascinating field.

Katie Williams
CT3 in Liaison Psychiatry
Queens Medical Centre
Nottingham

“CPD but not as we know it Jim”

Last year was so busy at work and home that I found it difficult to carve out the time to attend the annual Royal College of Psychiatrists International Congress in June. The General Adult Psychiatry Faculty's two day meeting in the autumn was so popular that by the time I managed to get an application in, I was too late and all the places were gone. So apart from local CPD and the annual Perinatal Psychiatry events in November (the CCQI and Scientific meetings are always good value for the content of the talks and for networking with other colleagues in the UK), I still had to fulfill the wider general specialty aspects of my PDP programme with only three months to go to the end of my CPD year.

I then fortuitously received an email from a friend in Australia, also a Perinatal Psychiatrist, asking if I planned to attend the 4th World Congress of the International Association for Women's Mental Health, to be held in Madrid in March 2011. I had heard of this organization but never previously attended a meeting and when I checked the programme, it looked as if there was quite a lot that would be interesting and useful for my purposes. Having fitted in a clinics and a ward round at the beginning of the week, I got to the conference by the skin of my teeth, as it started midday on a Wednesday and went on till the Saturday afternoon.

The sessions started early and continued well into the evening each day; the programme was very full but I was impressed with the wide ranging content of each day's plenary sessions, symposia and seminars, relating to almost any aspect of women's mental health that you can think of. You will be glad to read that I don't plan to give you a list of every session I attended. However it was useful to be made to think once again about the importance of basic things which can impact on the psychological well-being of women and their families. Peace, law and order, access to good obstetric care, contraception and sexual health facilities are things we take for granted in the UK but these things are not available to vast numbers of women across the world, and Perinatal Psychiatry Services come very low on the list of health priorities for many poor nations.

Whilst academics from Africa, South America and South Asia described the difficulties of mental health provision in the poorest of their urban and rural populations, speakers from North American and European institutes gave insights into the latest research in psychiatric disorders affecting women across the life-span. I was particularly interested in the sessions relating to the physiological and pathological regulators of mother-infant relationships. The behavioural experiments on sheep, looking at ewe-lamb bonding and descriptions of another series of experiments showing how physical contact with infants can regulate maternal neurochemistry and anxiety seemed to me to open up many therapeutic possibilities. I would recommend the next IAWMH conference to anyone who can manage to get there, but it is not an annual event (for further information go to www.iawmh.org).

So what if one can't get away on study leave? Although there are people who will religiously work through certain journals, most of us mere mortals will need something that is easier and more entertaining to read after a hard day's work than articles full of methods and results tables. To anyone who is interested in reading books that are not journals or textbooks in the truest sense, I would strongly recommend any of the following, for the vivid and personalized descriptions of women's experiences of the kind of illnesses we see in our daily practice.

"Mad, Bad and Sad: a History of Women and Mind Doctors from 1800 to the Present" by Lisa Appignanesi (Virago Books 2008), is as the title indicates, a historical treatise. However, don't be put off by this, as the mixture of a history of psychiatry, particularly as it pertains to the treatment of women, and a number of case studies makes it anything but dry and provokes thought about the way we conceptualize and treat psychiatric disorders in the present.

If you shy away from non-textbook non-fiction, then perhaps a good short story or novel will serve instead. I recently found a paperback copy of the selected writings of Charlotte Perkins Gilman, entitled "The Yellow Wallpaper" (again Virago Books, 2009). In the opening short story of the same title, Gilman gives perhaps the earliest published personalized description of a puerperal depressive psychosis. In her introduction, the novelist Maggie O'Farrell describes Gilman's background in 19th century American intellectual circles and comments that Gilman wrote the story as a way of drawing to the American public's attention how awful and inhumane she felt her treatment had been at the hands of one society doctor.

Maggie O'Farrell herself has written two novels that I think are an excellent way into thinking about what it can be like to be a woman with mental health problems around the time of child birth. In "The Vanishing Act of Esme Lennox" perhaps the protagonist was not mentally ill when she was incarcerated in a Scottish asylum in the 1930s, but her family and the authorities nevertheless colluded to deprive her of her liberty and her child (and this happened to many other women like her in the early decades of the 20th century).

In her latest novel "The Hand That First Held Mine", Maggie O'Farrell returns to the themes of pregnancy outside marriage, the dangers inherent in the process of childbirth, so often forgotten these days by those of us fortunate enough to live where we can access high quality obstetric care, and parental loss. Along the way, O'Farrell's heroine gives us a way of experiencing what it must be like to be traumatized by coming close to death from a post-partum haemorrhage; the lack of understanding from those treating her, as she slides into an illness which could be understood as a combination of severe post-traumatic stress and sleep deprivation or the lived experience of a polymorphic psychotic illness in the early days post-partum. In this particular novel, O'Farrell's storyline also draws our attention to the difficulties that first time fathers may suffer; it is not just mothers whose childhood memories are re-evoked by the experience of becoming a parent; the father in this story is almost lost to his family because he is remembering an experiencing the loss of a parent himself. I would love to know who O'Farrell spoke to whilst researching her books; she writes as if she or someone close to her has experienced what she describes, and her novels have the hallmarks of all the best books, simple elegant prose that does not distract from the characters and plots developed, and yet totally believable.

I am sure we could all think of books we have read that would be useful as learning and teaching aides. I have a list that I keep in my office and I often make recommendations, particularly to trainees and undergraduates. And yes, I do still make myself read the odd journal article.....

Neelam Sisodia
Nottingham

Information from our College

The Joint Commissioning Panel for Mental Health will be launched on Monday 28th March 2011. To accompany this, the document *Practical Mental Health Commissioning Volume One: setting the scene* will be published.

I have attached for you the final press release and the Volume one document. These will also be available on the website www.jcpmh.info.

Claire Churchill,
Policy Administrator/Researcher
Royal College of Psychiatrists
Tel: 020 7235 2351 ext 6293

New from RCPsych Publications

The College has recently published the following two books that will be useful to all psychiatrists.

‘101 Recipes for Audit in Psychiatry’ - edited by Clare Oakley *et al*

Audit is an essential activity for all psychiatrists and this book will help ease the audit process and save you time by offering tried and tested recipes for conducting audits in clinical services. All the audits have been undertaken by the authors who give practical advice for carrying them out in day to day practice. This book is invaluable for both consultants undertaking revalidation and for trainees doing their Annual Review of Competence Progression (ARCP). (March 2011, 256 pages, ISBN 9781908020017, £20)

Buy online: <http://www.rcpsych.ac.uk/publications/books/rcpp/9781908020017.aspx>

‘A Clinician’s Brief Guide to the Mental Health Act’ – by Tony Zigmond

This is a ‘how to’ book guiding clinicians through the mental health legislation that they need in their daily practice. It includes practical advice on detaining and treating patients, civil and court detentions, community treatment orders, consent to treatment and giving written and oral evidence for Mental Health Tribunals. In addition to the Mental Health Act 1983 and its more recent amendments from 2007, the book also includes useful aspects of other relevant Acts. (March 2011, 126 pages, ISBN 9781908020024, £18)

- Gives you practical advice and answers to real-life clinical questions.

- Written for clinicians – not lawyers!

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Forthcoming Events

1) Perinatal Mental Health 2011:

'Quality, Innovation, Productivity and Prevention in Treatments and Services'

Thursday 16 June and Friday 17 June 2011
Paul Woodhouse Suite, Winchester Cathedral Visitors' Centre

The annual two day update on clinical research, service and policy developments and good clinical practice in the field of antenatal and postnatal maternal mental health, hosted by the Hampshire Perinatal Mental Health Services. National expert speakers include Dr Roch Cantwell, Dr Alain Gregoire, Dr Ian Jones, Dr Liz McDonald, Dr Margaret Oates OBE, Dr Susan Pawlby, Professor Louise Howard, Professor Gwyneth Lewis, Professor Vivette Glover and Dr Carmine Pariante.

Contact: Sue Wallis, Perinatal Mental Health Service, The Lodge, Tatchbury Mount, Calmore, Southampton SO40 2RZ. Tel: 023 8087 4348 Fax: 023 8087 4360
Email: sue.wallis@hantspt-sw.nhs.uk <<mailto:sue.wallis@hantspt-sw.nhs.uk>>

2) The Manchester Women's Conference

Seminar series Thursday 23rd June 2011

'Evidence into practice: Promoting mental health and wellbeing for mothers and families'

Workshops, Friday 24th June 2011

'Demonstrating how to get evidence into practice'

Hulme Hall, Oxford Place, Victoria Park, Manchester M14 5RR

Booking form and enquiries to: carol.rayegan@manchester.ac.uk
Tel: 0161 275 0714

3) Royal College of Psychiatrists International Congress 2011

Tuesday 28th June to Friday 1st of July 2011
Hilton Metropole, Brighton

Details of the whole programme, which looks very interesting, are available as usual on the College website. Although there is no longer a whole day for Perinatal Psychiatry, Alain Gregoire and Ian Jones will lead a workshop (W5) on Wednesday 29th June, from 14.30 to 15.45 hrs, entitled ***'Improving care of our patients in pregnancy and post-natally'***.

There will also be half a day of talks (S40) on Friday 1st July, from 09.45 to 11.00 hrs, on ***'New Findings in Post-natal Mood Disorders'***. Speakers will include Roch Cantwell, Ian Jones and Trine Munk-Olsen.

4) 'Motherhood and Mental Health Day' 6th Annual Conference

Friday 1st July 2011 9am – 4.40pm

The Cooke Lecture Theatre, Learning Centre, St George's Hospital Stafford ST16 3AG

A one day multidisciplinary conference on Perinatal Mental Health to be hosted in South Staffordshire by staff from the Brockington Mother and Baby Unit in Stafford

Application forms and further information available from sheila.murray@sssft.nhs.uk

Tel: 01785 221554

5) Royal College of Psychiatrists Trent Division CPD Event

'Parenting in Adversity'

A series of three talks looking at the impact of mental illness, learning disabilities and substance misuse on families and children

Wednesday 6th July 2011

Radbourne Unit, Royal Derby Hospital, Derby DE22 3WQ

6) West Midlands Regional Perinatal Mental Health Conference

'Improving Perinatal Mental Health Care'

Friday 8th July 2011

Birmingham Medical Institute

The Birmingham and Solihull Mental Health Trust / Marce Society Regional Perinatal Mental Health Conference will take place at the Birmingham Medical Institute. All welcome!

For further information and a booking form contact Shazia.hussain@bsmhft.nhs.uk.

7) The UK and Ireland Marce Society Annual Research Meeting 2011

Thursday 8th September 2011

IRDB, Imperial College, Du Cane Road, London W12 ONN

Free registration for Marce Society members – visit www.marcesociety.com to join

Contact Professor Vivette Glover to request a presentation slot (places limited): v.glover@imperial.ac.uk

8) Northern Travelling Circus

Friday 23rd September 2011

This will be hosted by Leeds Perinatal Psychiatry Service; venue and programme to be confirmed

9) Annual Perinatal Section Scientific Meeting

Friday 25th November 2011

Hallam Conference Centre, London

10) Southern Travelling Circus

The details for this event are yet to be confirmed. Contact Dr Alain Gregoire through Sue Wallis, Perinatal Mental Health Service, The Lodge, Tatchbury Mount, Calmore, Southampton SO40 2RZ. Tel: 023 8087 4348
Fax: 023 8087 4360

Email: sue.wallis@hantspt-sw.nhs.uk <<mailto:sue.wallis@hantspt-sw.nhs.uk>>

Please send any articles for future newsletters to:

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