Faculty of Medical Psychotherapy and Perinatal Psychiatry Joint Conference

Working psychotherapeutically with families in the perinatal period

11 October 2019
RCPsych, London

Conference booklet

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Welcome

Welcome to the first joint event organised by the two faculties. Perinatal and psychotherapy have intuitive and significant overlaps due to the impact of psychotherapeutic/psychological interventions especially in the perinatal period and the fact that we both are greatly invested in the meaning and importance of early relationships - indeed the perinatal frame of mind is also centred on the notion that the parent infant relationship is a "perinatal patient" in its own right. With the five years forward plan psychological therapy has been recognised as a key element of every perinatal service and with the long-term plan parent infant psychotherapy will similarly be integrated. We therefore feel that joint events and sharing knowledge will help us in thinking of the care we provide to our population.

Dr Maria Eyres, Dr Livia Martucci, Dr Mary Murphy-Ford, Dr Steve Pearce, Dr Gertrude Seneviratne, Dr Anne Ward

General Information

Accreditation

This conference is eligible for up to 6 CPD hours on Friday 11 October, subject to peer group approval.

Certificates

Certificates of attendance will be emailed to delegates after the conference.

Cloakroom

The cloakroom can be found on the 1st floor.

Exhibition

An exhibition is available throughout the day

- Association for Video Interaction Guidance

The presence of an exhibitor is not an endorsement of its products and exhibitors do not influence the content of the meeting.

Feedback

A detailed online feedback form will be emailed to all delegates. All comments received remain confidential and are viewed in an effort to improve future meetings.

Social Media

If you wish to tweet about the conference please use **@RCPsych #medperi19**

Lunch and refreshment breaks

Lunch and tea and coffee breaks will be served in Room 1.6, first floor.

Posters

Poster viewing is available throughout the conference.

Queries

Please come to the Conference Registration Desk on the ground floor if you require any assistance.

Registration desk

The registration desk will be located in reception area, ground floor.

Wifi

Network: RCPsych-Wifi   Password: RCP19@w1f1

Programme

All sessions and workshops take place on the first floor.

Time	Session		
09:00	**Registration and Refreshments**		
09:30 **09:45**	**Welcome and Introduction** Dr Mary Murphy-Ford **The Early Years Parenting Unit** Dr Duncan McLean, Consultant Psychiatrist in Psychotherapy and Psychoanalyst, and Ms Minna Daum, Consultant Family Therapist, Co-Project Leads, Early Years Parenting Unit, Anna Freud Centre		
10:35	**Morning Refreshments and Poster Viewing**		
11:00 **11:35** **12:10**	**Working with mothers with a personality disorder** Dr Anna Motz, Consultant Forensic and Clinical Psychologist Discussant: Dr Ashlesha Bagadia, Consultant Psychiatrist in Perinatal Psychiatry, Bangalore **Working together in the perinatal period** Dr Anne Ward, Consultant Psychiatrist in Psychotherapy and Psychoanalyst **Panel Discussion**		
12:30	**Lunch and Poster Viewing**		
1:45	*A choice of 3 workshops*		
	Therapy in the perinatal period: A systemic approach Isabelle Ekdawi and Belen Duran	**Issues of capacity and advance care planning in the perinatal period** Livia Martucci and Lucy Stephenson	**Perinatal Video Interaction Guidance (VIG) – does it work? Gathering evidence for commissioners on a shoestring budget** Dr Natasha Gray and Emma Custance
2:45	**Afternoon Refreshments and Poster Viewing**		

<table>
<tr><td rowspan="2">3:05</td><td colspan="3">A choice of 3 workshops (repeated from earlier session)</td></tr>
<tr><td>Therapy in the perinatal period: A systemic approach
Isabelle Ekdawi and Belen Duran</td><td>Issues of capacity and advance care planning in the perinatal period
Livia Martucci and Lucy Stephenson</td><td>Perinatal Video Interaction Guidance (VIG) – does it work? Gathering evidence for commissioners on a shoestring budget
Dr Natasha Gray and Emma Custance</td></tr>
<tr><td>4:05</td><td colspan="3">Short Posters Presentations

From ABC to DBT: A New Dialectical Behavioural Therapy Skills Group within a Perinatal Mental Health Community Team
Helen Hutchings and Jayne Herriott
The diagnostic dynamic formulation: a plea to be taken forward- fast
Dr Ruth Brand Flu
Audit to establish whether routine pregnancy testing is performed in women of childbearing age admitted to acute psychiatric female wards in Birmingham, UK
Marianne Cobham
Sodium Valproate - Risk minimization audit in women of child bearing age
Dr Azhar Aswad
Using Non-Violent Resistance (NVR) psychological approach in family therapy
Dr Haroon Yaqub</td></tr>
<tr><td>4:30</td><td colspan="3">Close of conference</td></tr>
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Presentation abstracts and biographies

The Early Years Parenting Unit

Dr Duncan McLean and Ms Minna Daum

Duncan McLean will present together with Minna Daum an outline of the Early Years Parenting Unit. This is a mentalization based intervention for under 5 children and their parents where the children are on the edge of care due to personality difficulties in the parents.

Duncan McLean is a retired consultant psychiatrist in psychotherapy. He is also an adult and child and adolescent psychoanalyst. In the NHS he was consultant for a personality disorder service. He has also worked for the Anna Freud Centre for 33years as a psychiatrist working with children and families.

Minna Daum BA, BSc (Hons) has been practising as a Systemic Family Therapist since 1992. For most of that time she has specialised in carrying out and supervising multi-disciplinary court assessments and providing expert opinion on the risk of rehabilitation following abuse. Her particular area of interest lies in child maltreatment and the family justice system, and specifically in adult personality disorder and its impact on children's emotional development. At the Anna Freud Centre and in conjunction with Dr Duncan McLean she developed the Complex Cases court assessment service, specialising in working with families involving parents with personality disorders. In 2011 she and Dr McLean set up the Early Years Parenting Unit, a pioneering mentalization-based assessment and treatment service for parents with personality difficulties and their under-5 children on the edge of care.

Dr Anna Motz, Consultant Forensic and Clinical Psychologist, on working with parents / families where severe personality disorder is an issue**.**

Discussant: **Dr Ashlesha Bagadia,** Consultant Psychiatrist in Perinatal Psychiatry, Bangalore

In this presentation Anna Motz describes the intergenerational transmission of highly disturbed parenting, using illustrative clinical material to describe a case of infanticide, in a woman who had herself experienced severe trauma in early life. She presents a psychoanalytic account of female violence and describes approaches to working with women in states of severe distress who have enacted violent impulses on their children. She describes the model of forensic psychotherapy and also outlines an MBT based parenting programme designed for parents whose children are at high risk of harm.

Anna Motz is a Consultant Clinical and Forensic Psychologist and psychoanalytic psychotherapist with over twenty-eight years of experience of working with people with severe personality disorders, who have committed acts of violence against themselves and others, including intimate partners and

children. She is also an MBT Supervisor for the Anna Freud Centre, a forensic psychotherapist and the author of The Psychology of Female Violence, Toxic Couples: The Psychology of Domestic Violence, co author of Invisible Trauma: Women, Difference and the Criminal Justice System and editor of Managing Self Harm. Anna has a private psychotherapy practice and works within the Offender Care Pathway of CNWL Trust.

Dr Anne Ward, Consultant Psychiatrist in Psychotherapy and Psychoanalyst on parent-infant psychotherapy / psychotherapy in the perinatal period

Dr Ward will present a psychoanalytic framework for understanding and treating perinatal disturbance, including a model for parent-infant therapy suited to secondary care services.

Anne Ward is a Consultant Psychiatrist in Psychotherapy and Clinical Manager of the Integrated Psychological Therapies Perinatal Psychotherapy Service at the South London and Maudsley NSH Foundation Trust. This service offers psychodynamically based assessment and treatment as well as referral on for specialist / longer-term treatment in other modalities. Dr Ward is also a Fellow of the British Psychoanalytic Society and a member of the international Psychoanalytic Parent-Infant Therapy network.

Workshops

Therapy in the perinatal period: A systemic approach
Isabelle Ekdawi and Belen Duran

This workshop will introduce some Systemic principles, with particular reference to working with couples in the perinatal period. The facilitators will address common themes in this work, and some of the methods and techniques they typically use.

Isabelle Ekdawi is a Consultant Systemic Psychotherapist and Clinical Psychologist, and has worked within the NHS for over 30 years. She is Trust Advisor for Family Therapy within South London and Maudsley NHS Foundation Trust (SLaM), where she also provides Systemic Family and Couple Therapy and Systemic network meetings in an Adult Mental Health setting. As part of her role, Isabelle has worked with teams to develop their Systemic thinking and practice, providing training, workshops, consultations, supervision groups and individual supervision. She has worked in a number of contexts including inpatient, outpatient and community settings, and within a number of specialties including Adult Mental Health and Older Adults.

Belen Duran has been systemic family psychotherapist since 2012. She has worked for the NHS since 1997 in a variety of mental health in-patient and community clinical settings setting including older adults, early interventions for psychosis, adult community mental health.
She is currently based at the Lewisham Integrated Psychological Therapies Team delivering systemic family and couples therapies to adults struggling with depression, anxiety and personality difficulties.

Issues of capacity and advance care planning in the perinatal period
Livia Martucci and Lucy Stephenson

This workshop will cover basic points of law in the mental capacity act, developments in advance care planning, and include case based discussions.

Livia Martucci is a Consultant in Perinatal Psychiatry, South London and Maudsley NHS Foundation Trust (SLaM), Lambeth Community Perinatal Mental Health Service (formerly MAPPIM) at St Thomas' Hospital, London.
Lucy Stephenson is an ST6 dual trainee in Medical Psychotherapy and General Adult Psychiatry at South London and Maudsley NHS Foundation Trust. She is currently doing a PhD at the Institute of Psychiatry, Psychology and Neuroscience with the Mental Health and Justice Project. Her work focuses on developing a model of advance decision making for people with Bipolar.

Perinatal Video Interaction Guidance (VIG) – does it work? Gathering evidence for commissioners on a shoestring budget
Dr Natasha Gray and Emma Custance

Natasha Gray and Emma Custance will provide a brief introduction to Video interaction Guidance as an intervention to support the developing parent infant relationship. They will describe their experience of setting up and running a pilot to evaluate the effectiveness of this intervention. Qualitative and quantitative evidence gathered will be presented along with video footage from work with women and their babies.

Natasha Gray qualified as a Clinical Psychologist in 1996. Post qualification she worked in Child and Adolescent Mental Health Services(CAMHS) in Brent and then Southwark. She developed an interest in Early Intervention with young children and worked on a trailblazing surestart initiative. Following a move to Hertfordshire she worked in the Early Intervention CAMHS and set up the under 5s provision within this service. She began training in Video Interaction Guidance(VIG) in 2011 and is now an advanced supervisor in this intervention. In 2017 she set up and ran a pilot to evaluate the effectiveness of VIG with parent and babies to highlight the need to commissioners for interventions

supporting the parent infant relationship. She now works in the Hertfordshire Community Perinatal Team as a Parent Infant Psychologist.

Emma Custance is a registered mental health nurse and since qualifying in 1997, has worked in various clinical nurse specialist roles across East London and Hertfordshire, in inpatient and community CAMHS, adult services and as a named nurse for safeguarding in Tower Hamlets. Since 2015 Emma began working in an early intervention CAMHS service in Hertfordshire and began training in video interaction guidance, working with children under 5. Emma joined Dr Natasha Gray on the VIG pilot. She is currently an accredited VIG practitioner and trainee supervisor and works in 'Together with baby' a parent infant mental health service in Essex.

Poster presentations

1.	**Mindful Mums** Dr Kirsty Alderton, ST6, AWP NHS Trust; Natalie Wilkins, Mental Health Social Worker, AWP NHS Trust; Dr Vaneeta Sadhnani, Clinical Psychologist, Supervisor, AWP NHS Trust **Aims and hypothesis** To provide a mindfulness group for post natal women and their babies in a community perinatal service Background A need was identified in specialist perinatal services for a style of group work that wasn't DBT informed. A style more suitable for those with more 'over-controlled, anxious/perfectionist traits. It was felt that a mindfulness group would best serve this need. It felt really important to create a group setting that differs from other potential therapy available, which included a space for Mum's to engage with their baby. **Methods** We designed an 8 week mindfulness course including baby specific mindful practice and massage. Women were identified by using an internal advert to the specialist community perinatal team. They were interviewed to assess suitability and to attain their goals for the course. At the start of the course they completed questionnaires including GAD-7 PHQ-9 Core 10. **Results/Conclusions** Women felt they had been able to create a space in their lives for mindfulness and self compassion by adding in meditation and mindful awareness practice. Feedback included feeling connected, making relationships, acceptance and awareness of negative self talk and being on auto pilot. The women are keen for the group to continue as they have found the space to be invaluable for not only supporting their mental health but also supporting this stage of being a new mum. They have developed skills which they can take forward as they are discharged from the service.
2.	**The Characteristics of Women Who Self-Harm in Pregnancy and the Postnatal Year: A Psychodynamic Perspective?** Dr K Ayre, NIHR Doctoral Research Fellow, Section of Women's Mental Health, Institute of Psychiatry, Psychology and Neuroscience, Kings College London, London, UK and South London and Maudsley NHS Foundation Trust; Dr H Gordon, Junior Doctor, University of Melbourne, Melbourne, Australia; Dr R Dutta, Clinician Scientist Fellow, Academic Department of Psychological Medicine, Institute of Psychiatry, Psychology and Neuroscience, Kings College London, London, UK and South London and Maudsley NHS Foundation Trust; Professor Howard LM, Professor of Women's Mental Health, Section of Women's Mental Health, Institute of Psychiatry, Psychology and Neuroscience, Kings College London, London, UK and South London and Maudsley NHS Foundation Trust **Aims** To describe the most recent research on the characteristics of women who self-harm in pregnancy and the postnatal year To compare the characteristics of women who self-harm in both periods To discuss the meaning of any differences from a psychodynamic perspective **Hypothesis** The characteristics of women who self-harm in pregnancy are the same as those of women who self-harm in the postnatal year. **Introduction** Self-harm within the perinatal period is an under-researched area, despite the fact suicide remains the leading cause of direct deaths within the postnatal year and is often preceded by perinatal self-harm. The author has recently completed a systematic review into the prevalence and correlates of perinatal self-harm. However, are the characteristics of women who self-harm the same between pregnancy and the postnatal year? What does it mean if they are – or are not? Can a psychodynamic perspective help us understand any differences? **Methods**

	Six databases (EMBASE, Medline, PsycINFO, MIDIRS, CINAHL, CENTRAL) were searched from inception - 31/10/18. Only peer-reviewed papers with data available for estimating prevalence/correlates were included. Exclusion criteria were: (1) studies of women seeking abortion (2) letters, editorials, case reports/series. Two reviewers independently screened all papers, extracted data and appraised quality. The author considered the results from a psychodynamic perspective. **Results** The characteristics of self-harm in pregnancy and the postnatal year appear to be very similar across studies of women from the general population. However, there is some evidence that for women with existing serious mental illness (SMI), the characteristics may differ between pregnancy and the postnatal year. The possible psychodynamic meaning of such differences is discussed. **Conclusions** The characteristics of self-harm in pregnancy and the postnatal year are generally similar in women in the general population. However, in women with SMI, differences in characteristics between these two periods could represent different underlying issues, such as reactivation of previous miscarriage-related trauma antenatally; compared with mood regulation and younger age postnatally.
3.	**The diagnostic dynamic formulation: a plea to be taken forward- fast** Dr Ruth Brand Flu, MRCPsych. Dp MBA social services, Certificate Global Mental Health Leadership, Basic LD Learning Disability Family Therapy EMDR Therapist, Massage Therapist **Aims and hypothesis** A comprehensive formulation elucidates core problem in mental health, enhancing individualised treatment **Background** Current mental health policies with emphasis on diagnostic and management pathways has resulted in fragmentation of the complexity of mental and psychological health. Differential diagnosis have become the DD word, compromising wider observations, metacommunication and focussed treatment Training has improved the knowing' but not the 'know how'; How to recognise in the moment, psycho educate in lay terms or address. The push for medicalisation is very tricky. Adding on also the neurocognitive and cultural to the underused bio- psycho-social formulation can expand one's radar what is going on for the patient, reduces dichotomous views, which can be transformative. **Method** Written and unwritten reflections on the effect of colleagues' and mine experience on how the (re)formulation of stalemate cases tends to shift matters. **Results** i.e. 12' psychosis' cases, including children, learning disabilities and autism, one 'chronic schizophrenia' who made a full recovery through trauma work, or misinterpretations of a psychotic state due aberrant presentation of anxiety/social communication deficits and general unusual perception. The metacommunication and metaphysics of (Serial) complainants. Groups of developmental cases: DD with attachment, learning needs including learning disability, identified child (differential characteristics). In the moment reflections were required Idolisation and symbolisation of medication (effect). **Conclusion** Revisiting formulations in complex conundrums and stale mate cases is essential to promote mental health: education to teams and families is required to create such culture.
4.	**Audit to establish whether routine pregnancy testing is performed in women of childbearing age admitted to acute psychiatric female wards in Birmingham, UK**

	Miss Marianne Cobham, Medical Student, Warwick Medical School; Dr Jennifer Whitmore, Associate Specialist, Birmingham Perinatal Mental Health Service; Dr Giles Berrisford, Consultant Psychiatrist, Birmingham Perinatal Mental Health Service; Dr Paula Brownsett, Consultant Psychiatrist, Birmingham Perinatal Mental Health Service; Dr Anne-Marie Simons, Specialty Trainee, Birmingham Perinatal Mental Health Service; Ms Hayley Masterson, Perinatal Community Psychiatric Nurse, Birmingham Perinatal Mental Health Service; Ms Emma Gasson, Perinatal Community Psychiatric Nurse, Birmingham Perinatal Mental Health Service; Ms Catherine Kelly, Perinatal Community Psychiatric Nurse, Birmingham Perinatal Mental Health Service **Aims and Hypothesis** This audit aims to assess whether pregnancy tests are routinely performed on admission to acute psychiatric female wards across our Trust for women of childbearing age (15-45 years). **Background** It is standard medical practice that women of childbearing age are pregnant until proven otherwise. However, there is no mention of a pregnancy test being required on admission in our Trust policy. It is essential to identify pregnancy early, to facilitate access to maternity care, to optimise psychotropic medications and to commence folic acid. During the first trimester, the fetus is highly susceptible to damage from alcohol, drugs and medications as this is when the fetus' organs are developing **Methods** Electronic records for 56 inpatient admissions to female acute wards were reviewed for documentation of a pregnancy test and date of last menstrual period (LMP) for women of childbearing age. Admissions were from 1-31st January 2019, data from the PICU was from 1-28th February 2019 due to a lack of admissions in January 2019. **Results** On admission, only 25% of women underwent pregnancy testing **Conclusion** Pregnancy testing is not routinely completed on admission, representing a significant unmet need presenting risks to mother and fetus. Pregnancy testing is fast, simple and cost-effective and changes the way a woman is managed during admission. It is performed routinely on admission in medicine, and the same standard should be maintained in psychiatry. The Perinatal Service will seek amendment to the Trust Physical Health and Management Policy and mandatory Physical Health Questionnaire.
5.	**From ABC to DBT: A New Dialectical Behavioural Therapy Skills Group within a Perinatal Mental Health Community Team.** Dr Helen Hutchings, ST5, Sussex Partnership NHS Foundation Trust; Jayne Herriott, Perinatal Mental Health Nurse, Sussex Partnership NHS Foundation Trust; Dr Anna Roberts, Clinical Psychologist, Sussex Partnership NHS Foundation Trust **Aims and hypothesis** The aim was to offer an adapted dialectical behavioural therapy (DBT) skills group for use in the perinatal period. The predicted benefits included; improved overall well-being, increased understanding of mental health difficulties and improved interpersonal effectiveness. We also expected that the group would help participants develop skills in regulating emotions. **Background** DBT is designed to help people who experience strong and changeable emotions which affect their relationships and quality of life. The treatment involves developing; mindfulness, emotion regulation, interpersonal effectiveness and distress tolerance. **Methods** The 12 week skills group format was adapted from other DBT group models which were found in research and was adjusted bearing in mind the issues specific to the perinatal period. 10 clients were enrolled into the first group, which took place weekly for 2 hours at a non-NHS community facility.

	Results The clients gave positive qualitative feedback about their experience and the treatment. The skills group effectiveness and acceptability was assessed using outcome measures: Core 34, Mental Health Confidence Scale and the Difficulties in Emotion Regulation Scale (DERS) and these overall results were also positive. **Conclusions** The first DBT skills group was well-received by the clients involved. Clinicians were motivated to sign up for the opportunity to develop a new therapeutic skill set and to help increase the therapy provision to the patient group. Overall, the initial pilot showed promising results and DBT groups are currently being offered across the whole of the Sussex and East Surrey Specialist Perinatal Mental Health Service.
6.	**Review of the Evidence Base for the CBT in Health Anxiety** Dr Patrick McLaughlin, ST6, SLaM NHS Trust **Objectives** Individuals with health anxiety disorder are burdened with the preoccupation of suffering from a serious physical or mental illness resulting in a range of safety seeking behaviours, high healthcare utilisation and significant social and occupational impairment. This study examines the treatment rationale, and evidence base, for CBT in health anxiety disorder. **Methods** Studies were identified though a search of PubMed and PsychINFO. A systematic search was conducted which identified 16 RCTs meeting eligibility criteria comparing CBT treatment with a condition group. Condition groups included treatment as usual, wait-list controls, alternative forms of psychotherapy, pharmacotherapy, and other active non-pharmacological interventions. One further non-RCT involving pharmacotherapy is also included below to provide a comprehensive overview of the existing evidence base for treatment of health anxiety disorder. **Results** CBT has demonstrated consistent efficacy in the treatment of health anxiety disorder although fewer trials have been published compared to other anxiety disorders. It remains unclear which areas of particular aspects of CBT are most effective in the treatment of health anxiety disorder. Pharmacotherapy remains an efficacious treatment alternative to CBT in health anxiety disorder. **Conclusions** There is amassing evidence that cognitive behavioural therapy is effective in the treatment of health anxiety disorder. Whilst promising results for CBT in replicated RCTs should be acknowledged, further investigation into which elements of therapy are effective are required. Additionally, further well-designed trials with large participant numbers, prolonged follow-up times and credible control groups are also needed.
7.	**Sodium Valproate - Risk minimization audit in women of child bearing age** Dr Ashma Mohamed, Specialty Doctor in Perinatal Psychiatry, Surrey and Borders Partnership Foundation NHS Trust; Dr Azhar Aswad, Specialty Doctor in Perinatal Psychiatry, Surrey and Borders Partnership Foundation NHS Trust; Dr Abigail Crutchlow, Perinatal Clinical Lead, Surrey and Borders Partnership Foundation NHS Trust; Alison Marshall, Lead Pharmacist, Surrey and Borders Partnership Foundation NHS Trust **Aims** To identify all women of child bearing age on Sodium Valproate within SABP To audit if the identified women fulfilled the Valproate Pregnancy Prevention programme **Background** Valproate is an effective treatment for epilepsy and bipolar disorder It is highly teratogenic, and evidence supports that use in pregnancy leads to neurodevelopmental disorders (30–40% risk) and congenital malformations (10% risk)

	It should not be used in girls and women of childbearing potential unless other treatments are ineffective or not tolerated It may be initiated in girls and women of childbearing potential only if the conditions of Valproate Pregnancy Prevention Programme are fulfilled. **Methods** Retrospective list of women between 18 to 55 on sodium valproate in the last 3 years An audit tool was created using the guidance taken from the MHRA / NICE advice on Sodium Valproate Prevent Programme Request was sent to all mental health teams within SABP trust to provide a list of all women on Sodium Valproate for the last 3 years. We received a list of 28 patients from the CMHRS's who have been or on Sodium Valproate across the trust 2 were over the age of 55 so they were excluded, so the final number of identified cases was 26 Each identified patient's case note on SystmOne was searched for evidence of compliance with MHRA / NICE prevent programme All of the data from SystmOne were methodically tabulated on an excel sheet The results were analysed using excel pivot table and graphs **Results** 22 of the 26 are on Sodium Valproate currently 4 of the 26 were on Sodium Valproate previously but not taking now Out of the 26 identified women, the evidence that the risk has been discussed is only available in 50% of the cases In 17 out of 26 cases, there was no evidence to suggest that there has been an arrangement for a highly effective contraception 12 out 26 cases, there was no evidence of Contraception in place, (1 is NA as the patient is currently pregnant). In 12 out of 26 cases, the annual risk acknowledgement form was completed, and all the 12 patients were provided with a copy of the risk acknowledgement form 2 out of 26 patients were referred due to unplanned pregnancy but only graded as a routine referral **How do Specialist services implement the prevent programme?** Discuss the risks with the patient Exclude pregnancy before the first prescription is issued Arrange for highly effective contraception before the first prescription is issued Complete the Annual Risk Acknowledgment Form with patient See the patient urgently (within days) if referred back in case of unplanned pregnancy or if she wants to plan a pregnancy Provide a copy of the Patient Guide to the patient **Conclusions** Ensure the women understands the risks to the unborn child of using Valproate during pregnancy and provide (The Patient Guide: What women and girls need to know about Valproate) Ensure women understands the need to comply with contraception throughout treatment and undergo pregnancy testing when required – e.g. if there is any reason to suggest lack of compliance or effectiveness of contraception. Complete and sign the Annual Risk Acknowledgment Form (at initiation and every annual visit); give a copy to her and send one to her GP. Mental health professionals and GPs should have proactive discussions with women regarding effective contraception and support women in accessing this. Ensure all women prescribed Sodium Valproate are managed in line with the guidance outlined in Prevent, including an annual medication and health review. SystmOne has the ability to incorporate prescribing software exclusively for medications in the clinical tree – utilisation of this may help with identification and audit of women taking Valproate. Consider building a risk acknowledgement form into Systm1 when Valproate is prescribed. Regular re-audit inviting all mental health teams within SABP to participate on annual bases.

Ensure inclusion of leaflets on Sodium Valproate as part of the patient information packs.
To include education on Sodium Valproate Prevent Programme in the doctors' induction programme/ eLearning module.

References

Agency, M. &. (May 2018). Information on the risks of Valproate (Valproate Pregnancy Prevention Programme).

Medicine complete, B. (2019, February 12). BNF. Retrieved March 1, 2019, from Medicine complete.

Sano Drug Safety, D. (2016, January). Important information for Healthcare Professionals on the Risks of Valproate in Female Patients. UK: www.mhra.gov.uk/yellowcard.

8.

Using Non-Violent Resistance (NVR) psychological approach in family therapy

Dr Haroon Yaqub, CT2 Birmingham Childrens and Womens NHS Foundation Trust, Forward Thinking Birmingham

Aims and Objectives

To effectively educate and support parents in successfully using Non-Violent Resistance strategies through family therapy.

Background

Whilst working in the child and Adolescent mental health services (CAMHS), I came across families struggling to cope with their child's destructive and aggressive behaviour. Parents were left helpless and no longer able to cope. Patients displaying these difficult behaviours often were diagnosed with Autistic Spectrum Disorder (ASD), Attention Deficit Hyperactivity Disorder (ADHD), Conduct Disorders and Emerging Emotionally Unstable Personality Disorder (EUPD). NVR Is a psychological approach developed by Haim Omar and colleagues at the University of Tel Aviv, Israel. It is based on a number of principles to help parents and families to cope with their child's difficult behaviour. Key principles in NVR are raising parental presence, de-escalation, overcoming parental disobedience, taking non-violent action and reconciliation gestures.

Methods

I worked with two families at the Blakesley Centre, Forward Thinking Birmingham, CAMHS. Both families had a child with ASD who was exhibiting aggressive and disobedient behaviour. I worked with a family therapist over 16 sessions, (8 sessions with each family) to help educate and introduce key concepts of NVR which were subsequently practiced by parents.

Results

Both families reported a significant improvement in behaviour and their relationship with their child.

Conclusion

NVR therapy was successful with the two families I worked with. This is a relatively new area within systemic family therapy, further research is required to establish this approach.

Notes

Dates for your diary

Psychodynamic Psychiatry:

A psychoanalytic approach to understanding mental disturbance and its impact on staff

1 November 2019

RCPsych, London

Faculty of Perinatal Psychiatry Annual Conference

12 November 2019

RCPsych, London

A film evening will be hosted on 11 November, with a screening of Irene's Ghost

Sexual violence and mental health

6 December 2019

RCPsych, London

As mental health professionals our patient population are disproportionately affected by sexual violence. Hughes et al, in their recent editorial in Epidemiology and Psychiatric Services: 'Sexual violence and mental health services: a call to action' recommend a wider focus on sexual violence as part of routine care.

Join our annual Women's Mental Health conference to consider how our mental health services can better support this call to action.

More details at:

www.rcpsych.ac.uk/events

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