

NEWSLETTER



FACULTY OF
PERINATAL PSYCHIATRY
SPRING 2018



Newsletter Perinatal Psychiatry

Spring
2018

IN THIS ISSUE

- 2 | Editorial | Dr Aman Durrani**
- 3 | View from the Chair | Dr Trudi Seneviratne**
- 5 | New advice on avoiding fetal valproate | Dr Angelika Wieck**
- 6 | Lessons to change practice | Dr Roch Cantwell**
- 8 | A new perinatal service | Dr Maddalena Miele**
- 10 | CAMHS Corner | Prof David Foreman**
- 11 | CAMHS experience of a Perinatal clinic | Dr Chowdhury & Lo**
- 12 | It's time to Turn the Map Green | Dr Alain Gregoire**
- 13 | Workplace stress in Administrative staff | Dr Ahmed Yahya**
- 17 | Higher trainee experience | Dr Claudius-Adeniyi**
- 19 | Regional Update**
- 20 | Upcoming Events**
- 20 | The Library**

FEATURED

5 | Valproate prescribing

A practical guide for clinicians

8 | A new perinatal service in London

Dr Miele discusses the development of a new service

Editors: Dr Zeyn Green-Thompson and Dr Aman Durrani

Editorial

Village People

by Dr Aman Durrani

It takes a village to raise a child

African proverb

Many of you will be familiar with the above quote which emphasises that parenting is a shared responsibility, not just for the immediate or extended family but for every one of us in the community.

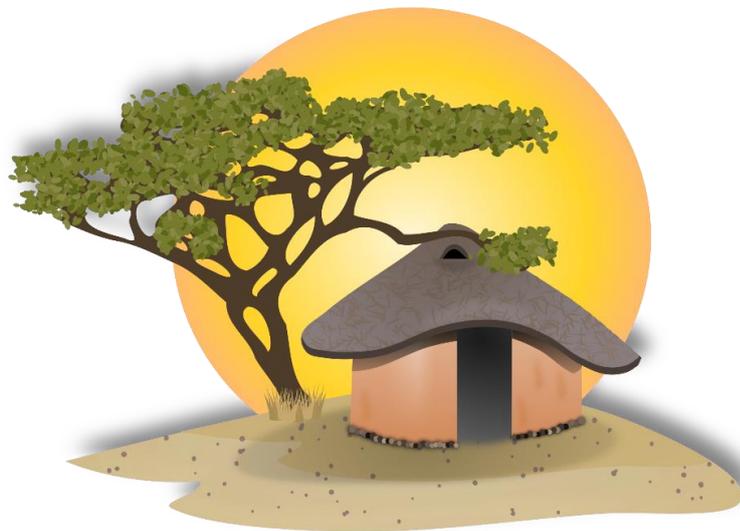
Every day we, meet mothers and families whose mental health difficulties are affected by social isolation, deprivation and inequality. Where is the 'village' ready to support them and their children? With the strain on public services, often it is our role as clinicians to help them through these difficult times and try and build a community around them. The voluntary sector plays such a crucial role in supporting our mothers and families and they must be supported to continue the amazing work that they do.

From an organisational perspective, it is heartening to see partnerships and collaborations across the country who are forming their own 'villages' to create a network and community of people with shared aims and goals. In Scotland we have a network of individuals and organisation as part of the **Maternal Mental Health Scotland** organisation with their amazing Change Agents who are women with a lived experience of maternal mental illness. Across

the UK the **Maternal Mental Health Alliance** has gone from success to success with its phenomenal campaigning and research highlighting gaps in service provision.

Of course there are many more examples of projects and organisations that are making real changes for women every day.

Perhaps perinatal mental health is reaching the 'tipping point' as mentioned by Malcolm Gladwell



when he promoted the idea of 'social epidemics'. This is when ideas, behaviours and messages spread rapidly throughout the population.

Could the recent conversations and messages of HRH The Duchess of Cambridge (more on these below from Trudi in her Chair's message); along with the investment in services in England as wave 2 funding closes; the development of a Perinatal Managed Clinical Network in Scotland; the promising developments in Northern Ireland (See Regional Updates); and positive discussions in Wales for more services, lead to better outcomes for mothers, children and their families?

For all of us passionate about perinatal mental health, this is really our window of opportunity to make real and lasting change for the future. It is up to us to build strong and vibrant 'villages' across the whole of the UK that are there for our future generations.

I leave you with this quote from anthropologist Margaret Mead and hope you enjoy this edition of the newsletter and are encouraged to submit articles for future editions.

Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it is the only thing that ever has.

Aman

View from the Chair

by Dr Trudi Seneviratne



The November Scientific Meeting seems like a long time ago now! ...but what a brilliant series of presentations.

Congratulations to Dean Connolly, winner of the Medical student essay prize for his essay on Sodium Valproate in pregnancy; Grace Crowley won the Medical student project prize for a data analysis of women with dysfunctional personality traits in early pregnancy and the Daksha Emson prize went to Dr Kike Olajide for an inspiring novel piece of research on the 'Development of a peer delivered psychosocial intervention to reduce the burden of perinatal depression in Nigerian mothers'. The standard overall in all our applicants was astounding! Well done to everyone who contributed.

This was preceded by an excellent Perinatal Mental Health Service Quality Network (PQN) day which celebrated its 10th birthday, celebrating a decade of peer review and accreditation supporting the improvement of perinatal services right across the UK year on year..... Thank you PQN team! We also had a wonderful evening experiencing dance and movement

psychotherapy. Many took to the floor in the College library with Gerry Harrison who demonstrated what she does with mothers & babies, when recovering on an MBU. Waka Hasegawa performed the most mesmerising pieces in her piano recital...as you know, some funds were donated to Action on Postpartum Psychosis (APP)...if you have any ideas about what you would like for November 2018, please let us know.

As part of the strategy, the Faculty commitments to the Maternal Mental Health Alliance's Everyone's Business Campaign include support for:

- Developing updated MMHA maps
- Developing an anti stigma/raising awareness campaign with MMHA, other Colleges, Service user, groups, others.
- New services (MBU's and specialist community teams) in evidencing outcome of effectiveness-RCPsych have developed an outcomes framework
- Education/training of psychiatrists and other multi/inter -disciplinary colleagues.

There continue to be perinatal service developments across the UK, and Wave 2 of the Community Services Development Fund, NHEngland has just closed. I'm greatly looking forward to the new and expanding teams who will be funded in this wave.

A Dragon's Den brought together the new bursary holders in Perinatal Psychiatry to present the interesting projects they are delivering to the unruly Perinatal Dragon's who included John Cox, Ian Jones and Margaret Oates. Well done to the bursary holders as they move into consultant posts, in the fullness of time...



We are delighted and honoured that The Royal Foundation and HRH The Duchess of Cambridge hosted a roundtable on maternal mental health in November.

In January, the Duchess met with Perinatal academic colleagues at Maurice Wohl Clinical Neuroscience Institute at the Institute of Psychiatry, Psychology & Neuroscience (IoPPN) at King's College London.



This was followed by a visit to the Bethlem Mother and Baby Unit, a roundtable of professions from universal through to specialist services, and an opportunity for the Duchess to meet with some services users and their families, as well as experience how a

Mother and Baby Unit offers a programme of coordinated care to support recovery.

HRH The Duchess really took her time speaking to many of the mothers, listening to their stories and sat in the sensory room with Ester and baby Nehemiah.

Professor Jane Fisher, the current president and Professor Prabha Chandra.

Look out for our Perinatal Trainees conference, organised by the trainees for 5th October, and of course the Perinatal Quality Network (12th Nov) followed by the Perinatal Faculty

to meet the needs of women and their families.

We have developed a comms sub-committee who are rather busy supporting dissemination of our activities. I hope to see more of you using social media to share our work. If there is anything you would like as part of the wider strategy for the forthcoming few years or additions to the website, which is about to be revamped, please let us know.

Warmest wishes



Trudi
Chair of the Perinatal Faculty



We look forward to the next steps working with the Royal Foundation and HRH, The Duchess given her strong interest in the mental health of parents and children.

The perinatal clinical outcomes framework that the Faculty have been working on is on the brink of being delivered and we are embarking on a collaboration with Child and Adolescent Psychiatry Surveillance System (CAPSS) to develop a Perinatal Surveillance System....more in due course on this.

I hope many of you will be able to go to the College International meeting in Birmingham this year, as well as the Marcé Society International meeting in Bangalore, 26-28th Sep, hosted for the first time in a low and middle income country, jointly by

Scientific Meeting (13th Nov), which will take on a slightly more global theme this year.

There is much to celebrate in the field of Perinatal Psychiatry, the work of the Faculty, Perinatal Quality Network, the Bursary scheme and all our partner agencies. The elections are underway for 7 new members of the Faculty Exec. Enormous thanks to the Exec members who will be ending their term of office this year, including the wonderful Andrew Cairns who has been our Finance Officer.

It certainly requires all our hands and minds, working together, in collaboration, to mould and sustain the perinatal future...so enjoy riding this unprecedented and incredible wave as both perinatal services and perinatal psychiatrists increase in number

New restrictions and measures to avoid fetal valproate exposure in pregnancy are imminent

by **Dr Angelika Wieck**

Honorary Consultant in Perinatal Psychiatry

Dr Sarah Jones

Consultant in Perinatal Psychiatry

Dr Ipshita Mukherjee

Specialist Registrar in General Adult Psychiatry

Greater Manchester Mental Health NHS Foundation Trust

After steadily increasing concerns over harm to the fetus, the introduction of new and far-reaching measures to restrict the use of valproate in women who are pregnant or of childbearing potential, is imminent.

Having a particular interest in this issue and having been involved with public hearings and expert advisory groups, we would like to highlight to the readership the scale of the problem and why new measures have become necessary.

What has the evidence shown?

The scientific evidence has shown that valproate is a major risk to the development of offspring when they are exposed to this

agent in utero is now overwhelming. We now know that, compared to control groups, exposed children are:

- 3.5 x more likely to be born with major congenital anomalies (11 % vs a general population rate of 3 %). Anomalies tend to be severe and can involve several organ systems.
- 3 x more likely to be on the autism spectrum and 5 times more likely to have autism.
- Less intellectually able (on average 8-9 points on different measures) and 7 x more likely to have developmental delay. About 30 - 40 % of children are thought to be affected in their cognitive development.

Although teratogenic effects were first reported soon after valproate's introduction for the treatment of epilepsy several decades ago, neurodevelopmental effects have only been systematically researched in the last 15 years. Evidence on the reproductive safety of valproate is almost exclusively based on research of children born to mothers with epilepsy, probably because valproate has only been used in the treatment of affective disorders since the 1990's. However, there is no known reason why the reproductive risks should be different if the indication is a mental disorder.

Can any measures be taken to avoid the risks when prescribing valproate?

Whereas malformations are caused during exposure in early pregnancy, it is very likely that the neurodevelopmental effects are linked with later stages of

pregnancy. It seems therefore that there is no safe time for pregnant women to take valproate. A dose that is safe for fetal development has also not been established and co-prescribing folic acid cannot, or at best only partially, prevent adverse effects.

What have clinicians been advised?

The Antenatal and Postnatal Mental Health NICE guidelines (2014) and NICE standards (2016) state that valproate should not be offered for treatment of a mental health problem to women who are pregnant or of childbearing potential. After warnings were strengthened at the European level, the UK Medicines and Health Care Products Regulatory Authority (MHRA) took several measures to increase awareness of the risks and limit harm. Like NICE, the MHRA advised clinicians in 2015 against prescribing valproate in girls and women of childbearing potential but they added that it could be prescribed if other treatments are ineffective or not tolerated. In 2016 it released a tool kit which included information for health professionals and patients to support clinicians talking about valproate with women and girls of childbearing potential.

What has recent prescribing practice been in Mental Health in the UK?

Recent local audits from Mental Health Trusts around the UK have shown that clinicians prescribing valproate to women who have childbearing potential do not document discussing the

reproductive risks or the need for contraception in significant proportions of cases. In the report of the Prescribing Observatory for Mental Health (POMH-UK) from 2015, this was the case in nearly half of new valproate prescriptions for bipolar disorder.

Are patients aware of the risks?

Although surveys of mental health patients do not exist, the results of these audits suggest that patients with mental disorders often do not know about the risks. This applies also to patients with epilepsy. A survey of over 2,000 women treated with valproate for epilepsy highlighted that almost 1 in 5 participants did not know that the drug can potentially harm the development and physical health of their unborn child should they become pregnant and that over a quarter were not given information about it by a health professional (Epilepsy Society, 2017).

How have the Regulatory Authorities responded?

Last year, the French equivalent of the MHRA announced that Depakote should not be used in women with bipolar disorder who are pregnant or of childbearing potential (Casassus, 2017). It also requested the European Medicines Agency (EMA) to review the effectiveness of its earlier measures.

The EMA has now published its review (9/2/2018) which also suggests that valproate should not be used in women with bipolar disorder who are pregnant or of childbearing potential unless they use effective contraception. **The**

option of using it if there is no alternative has been removed.

A package of other measures has also been advised, including a pregnancy prevention programme, and pregnancy tests before and during treatment. The guidance will now be considered by the European States in the next few weeks. The MHRA is currently considering actions for this country and are expected to announce them imminently on the 23rd of March.

What are the implications for prescribers?

There will be a significant impact on the management of pregnant women and women with childbearing potential. It is likely that psychiatrists and GPs are required to review all their female patients with a mental disorder and childbearing potential who are taking valproate **within a short time scale** and to stop the drug or replace it with an alternative agent. Clinicians occasionally have patients, particularly in the community, who may not tolerate or do not want to take alternatives. These are difficult clinical issues but it is important in those patients, according to MHRA, to follow a pregnancy prevention programme if the patient continues to take valproate.

Lessons to change practice

MBRRACE-UK REPORT 2017

by Dr Roch Cantwell



Although reports on deaths from psychiatric causes have been reported in the UK since the 1980s, and have led real improvements in services, the 2017 report from MBRRACE-UK (the group which reports on all maternal deaths for the UK Confidential Enquiries into Maternal Deaths) marked a step change. For the first time, the Enquiries also examined the care of women who survived their illness.

We know that women who have a previous history of bipolar affective disorder or postpartum psychosis are at very high risk of becoming unwell in the early time after delivery. Recommendations are clear – any woman with this history should have a mental health assessment in pregnancy to evaluate their risk, and interventions put in place to reduce that risk. It was the care of these women that the Enquiries examined. Some of the new lessons learned, with examples from the Enquiries and recommendations for improvements in practice, are listed below.



Timeliness of mental health responses

Mental health liaison services did not always react in a timely way that took into account the needs of maternity inpatient services.

A woman became unwell during her maternity admission while in labour. The on call mental health team was contacted on the evening of admission. Despite becoming increasingly psychotic with distressing delusional beliefs that her baby was dead, she was not reviewed by a mental health nurse for over 16 hours. She then waited in labour suite for a further 8 hours before being seen by a psychiatrist, who initially suggested she remain there until the following day. By the early hours of the subsequent morning she had become so disturbed that she required urgent admission, at which point she was judged "too unwell" to go to a mother and baby unit.

RECOMMENDATION

- **Managers and senior healthcare professionals responsible for perinatal mental health services (including those working in maternity and primary care services) should ensure that:**
- (i) there are clearly specified care pathways so that all primary and secondary healthcare professionals involved in the care of women during pregnancy and the postnatal period know how to access assessment and treatment**

(ii) staff have supervision and training, covering mental health problems, assessment methods and referral routes, to allow them to follow the care pathways

- **If a woman has sudden onset of symptoms suggesting postpartum psychosis, refer her to a secondary mental health service (preferably a specialist perinatal mental health service) for immediate assessment (within 4 hours of referral).**

Narrow interpretation of risk

Mental health services don't always recognise that women with previous psychotic depression, and those who have had previous mental illness and a family history of postpartum severe mental illness, may also be at high risk of postpartum severe illness themselves.

A woman, who was pregnant with her second child, had a history of postnatal depression, requiring six months of antidepressant treatment in primary care. Her own mother had a history of postnatal depression after her first pregnancy, and postpartum psychosis after her second. The woman developed significant depressive symptoms within weeks of giving birth, with accompanying suicidal ideation. She was only referred to mental health services some months later, after a significant overdose. She had overvalued (probably delusional) beliefs of incompetence as a mother, distressing imagery of harm to her children, and strong suicidal ideation and planning. She was eventually admitted to inpatient care.

Recommendation

- **If there is a family history of postpartum psychosis or bipolar disorder, maternity and primary care services should be alert for change in mental state in late pregnancy and the early postpartum and, if present, should refer for urgent psychiatric assessment.**
- **Referral for specialist psychiatric assessment in pregnancy should be considered for women with current mood disorder of mild or moderate severity who have a first-degree relative with a history of bipolar disorder or postpartum psychosis.**
- **Any past history of psychosis should prompt psychiatric referral and assessment in pregnancy.**

Forward planning for future risk

If a woman experiences a severe postpartum mental illness, there is a responsibility on services caring for her to inform her of risk in future postpartum periods and the availability of interventions to reduce risk.

A young woman developed postpartum psychosis after the birth of her first child, requiring admission within three weeks of childbirth. She had had a traumatic delivery with significant blood loss. The perinatal mental health team assessed her and she was admitted to a mother and baby unit. She received good inpatient care and was appropriately followed up by

specialist services. At the point of discharge from care, her illness was explained to her as being due to her traumatic delivery, and her risk therefore less marked. It was suggested that she could be seen in future pregnancies at her request or “should further problems arise”. There was no recorded discussion of risk minimisation strategies.

Recommendation

Following recovery, it is the responsibility of the treating mental health team to ensure that all women experiencing postpartum psychosis receive a clear explanation of future risk, including the availability of risk minimisation strategies, and the need for re-referral during subsequent pregnancies and that this is shared with other relevant health professionals.

This is only a small sample of the findings. More recommendations were made on completing the late pregnancy mental health plan, ensuring continuity of care, joint mental health and maternity management when there is diagnostic uncertainty, prescribing issues and long-term management, among others.

The full report can be accessed here (paged 37-49).

On a positive note, there were also examples of good care.

A young woman with a history of depression became acutely unwell 5 days after delivery. Her community midwife, noticing her disturbed mental state at a routine visit, arranged an urgent psychiatric assessment and remained with her for several hours until she was admitted to hospital. She made a full recovery.

A woman developed a postpartum depressive psychosis requiring MBU admission approximately six months after the birth of her first child. Her developing depressive and psychotic symptoms were under-recognised and she had strong ideas of suicide and infanticide by the time of her referral to mental health services. Her inpatient care was good and, on discharge, a well-recorded discussion took place about risk in future pregnancies and the need to seek psychiatric referral. In a subsequent pregnancy two years later she was appropriately referred to specialist services. A plan was put in place for her late pregnancy and early postpartum management, and she did not relapse acutely.

A new perinatal mental health service Central & North West London FT

by Dr Maddalena Miele

CNWL Perinatal Mental Health
Clinical Lead



The new Central North West London FT perinatal mental health service (PMHS) went live in May and was officially launched in June last year, only 6 months after the trust was successful in winning the bid for the first wave of NHSE community perinatal fund.



The three new multidisciplinary teams serve the London boroughs of Brent & Harrow, Westminster, Kensington & Chelsea and

Hillingdon. The teams work in partnership with four large maternity units and five local authorities, providing a comprehensive, evidence-based package of care. January was a very productive month for the CNWL Perinatal Mental Health Service.



On the 17th January the first CNWL perinatal mental health network was held at Trust HQ; and included the Milton Keynes PMHS. The CNWL PMH network will meet quarterly to look at quality improvement, professional development with the formation of discipline sub-networks, training, research and innovation. The long-term goal is to develop and improve the service and meet the CCQI standards.



A delegation of NHSE led by Dr Giles Berrisford, Associate National Clinical Director for Perinatal Mental Health, Jo Luckie, coordinator of the London Perinatal Mental Health Networks and Tracey Robinson Perinatal Mental Health Programme Project Manager visited the service on the 24th January. The delegation was received at the South Kensington Mental Health Unit where the model of care and achievements of the service were formally presented. Two experts by lived experience provided a very moving account of their experience of accessing the services. The feedback from NHSE was very positive with praise for CNWL PMHS integrated, patient centred, evidence based and holistic model of care.



On the 31st of January the 4th London Perinatal Mental Health Networks Conference - "Achieving equal access across London" - was held at the Royal College of Psychiatrists. The three Mental Health Trusts that were successful in securing the first wave of community perinatal funds, CNWL FT, SLAM and North Central London Partnership, were invited to present their progress in implementing and delivering the PMH services. Dr Chryssi Jayarajah, Consultant Perinatal Psychiatrist in Hillingdon and Dr Maddalena Miele, CNWL PMH clinical lead, presented the innovative perinatal mental health model of care delivered by CNWL. It was a

wonderful opportunity to share our achievements and our vision as well as to be honest about the current and future challenges



CAMHS Corner

by Professor David Foreman



The Pregnant Brain and its Disorders

Child and Perinatal Psychiatry share a common interest; the mother-child dyad. Given what we know about their interaction, we can imagine ourselves as members of a relay team, with child mental health practitioners picking up the dyadic baton once it passes beyond those working

with new mothers and their infants.

Crucially, perinatal psychiatrists can intervene earlier, and new research has offered tantalising glimpses of the importance of the antenatal period in ensuring mother and child health. We now have evidence from two recent neuroimaging studies that, like the rest of the mother's body, the brain prepares itself for the arrival of the new infant, and one of the areas that are maximally affected by these preparatory changes may also correlate with risk for postpartum psychosis.

In normal women, the right middle temporal gyrus, right inferior frontal gyrus, and right posterior cingulate cortex thins dramatically during pregnancy, and remains thinner for at least 2 years postpartum [1]. Remember that thinning is one way the brain improves functional efficiency; and thinning in these areas have also been implicated in better maternal attachment, while the areas themselves are associated with effective performance of Theory of Mind tasks.

Let's now turn to the other imaging study [2]. It's not directly comparable, as the mothers included weren't all primiparous. However, women at risk of postpartum psychosis showed larger frontal cortices than healthy controls. It is tempting to speculate that the brains of women at risk of postpartum psychosis are not responding to hormonal signalling safely.

So, we now know, for the first time, that there are very significant structural changes the normal maternal brain undergoes to prepare for childbirth, and these changes may be different

for those at risk. This suggests a closer clinical focus on the antenatal period, possibly focussing on subsyndromal presentations, or paying closer attention to everyday phenomena such as "baby brain". It was not so long ago that baby blues were seen as something harmless and transient, rather than a significant risk factor for subsequent postnatal depression.

Meanwhile, for the children, there is now evidence that ensuring a downward trajectory in depressive symptoms (not just diagnosis) from mid-trimester onwards, can continue to bring them benefits as late as six [3] while early childhood maltreatment in mothers may affect the brain sizes of their own babies [4].

Clearly, as clinicians, we are not yet in a position to routinely measure brains. However, we are trained in observing much more deeply than is necessary to tick the boxes of ICD or DSM, and to monitor how our observations change with our interventions. The antenatal period, when even the hardest to reach mothers are accessible, seems a good place to use these skills.

1 Hoekzema E, Barba-Müller E, Pozzobon C, *et al.* Pregnancy leads to long-lasting changes in human brain structure. *Nat Neurosci* 2017;**20**:287–96. doi:10.1038/nn.4458

2 Fusté M, Pauls A, Worker A, *et al.* Brain structure in women at risk of postpartum psychosis: an MRI study. *Transl Psychiatry* 2017;**7**:1286. doi:10.1038/s41398-017-0003-8

3 Park M, Brain U, Grunau RE, *et al.* Maternal depression trajectories from pregnancy to 3 years postpartum are associated with children's behavior and executive functions at 3 and 6 years. *Arch Womens Ment Health* 2018;**1**:1–11. doi:10.1007/s00737-017-0803-0

4 Moog NK, Entringer S, Rasmussen JM, *et al.* Intergenerational Effect of Maternal Exposure to Childhood Maltreatment on Newborn Brain Anatomy. *Biol Psychiatry* 2018;**83**:120–7. doi:10.1016/j.biopsych.2017.07.009

Perinatal Psychiatry Clinic: A CAMHs Experience

by Dr Arabinda N Chowdhury and
Ezra Loh

Consultant Psychiatrists, CAMHs
Forward Thinking Birmingham.



The negative impacts of perinatal mental health difficulties or disorders are huge and influence the mother, baby, father/partner and the family members (Humphreys et al, 2016). Research has shown that the prevalence of mental disorder is increased in women after childbirth and that untreated perinatal psychiatric disorders can prolong maternal morbidity and interfere with maternal bonding. Therefore the early recognition and treatment of any perinatal mental disorders is every clinician and health professional's duty (Kannabiran et al, 2007).

Perinatal Psychiatry poses a unique type of clinical challenge when managing the teenage population. In recent moves of increasing the inclusion age under CAMHs up to 25 years, the issue of Perinatal mental health service

becomes more pertinent. In CAMHs it operates with two objectives: firstly as a duty of care the teenage population is advised to avoid pregnancy because of its several negative impacts (FPA, 2010)) and secondly the young mothers should get appropriate mental health and social support during the antenatal and postnatal periods.

To address the first issue poses a problem. The young girls are very commonly accompanied by their parents, usually their mother. It is felt that in clinical consultation open questions about sexual practice, pregnancy and contraception is difficult and may cause embarrassment to the client or their parents. But as a duty of care it is obvious that they should be aware of the importance of avoiding teen-age pregnancy besides avoiding alcohol and substance abuse. So it is decided that we shall offer a pamphlet with two simple messages on it at the end of the consultation. The messages will be (i) to avoid teen-age pregnancy and (ii) to avoid alcohol and substance abuse. If they are interested to discuss any of these issues they are welcomed to discuss separately, keeping their confidentiality intact.

For the second issue we designated a day slot per month as Perinatal Clinic to deal with the mental health issues of the young person more intensively. This clinic is assisted by two medical consultants- a General Adult Psychiatrist and a Child & Adolescent Psychiatrist, one Clinical Psychologist and one Infant Mental Health Practitioner. Clinical template and follow up procedures are designed to focus their need along with different info sheets like psychotropic

medications used in pregnancy, harmful perinatal effects of alcohol and substance abuse.

Findings of CAMHs Perinatal Clinic (Jan- Sept 2017):

During the last 9 months we have 23 Perinatal cases (one is not pregnant but trying to be pregnant after a miscarriage). Following table shows the salient findings which supports a more intensive antenatal and postnatal service provision.

Clinical Issues	N (22)	%
Unplanned Pregnancy	18	81.8
Partner Present and Supportive	4 (23)	17.4
Partner Absent	19 (23)	82.6
Violent Partner	5	22.7
First Pregnancy	18	81.8
Own family aggressive/ negative judgment	5	22.7
Antenatal Depression	6	31.8
Postnatal Depression	9	40.9
Antenatal Anxiety	2	9.1
Postnatal Anxiety	3	13.6
Postnatal OCD	2	9.1

Perinatal Fathers: 4 seen

- 2 are happy and supportive and adjusted with pregnancy/postnatal period
- 1 upset and increased anxiety- recourse to excessive alcohol drinking (this is third baby)
- 1 increased anxiety but learning the skill of baby handling

Special areas needed attention for a comprehensive perinatal service care plan:

- A. Detailed history and subsequent clinical intervention for issues like-
- Planned or unplanned pregnancy?
 - Mutually consented?
 - Pregnancy by force (any violence or sexual abuse involved - ?safeguarding issue/ trauma focus psychological therapy)
 - Fatherhood accepted? (If present- discussion regarding support and bonding issues)
- B. Family reaction and support? The need for a Family Meeting (if agreed- to mitigate conflicts)
- C. Referral and liaison with the postnatal obstetric unit to follow up any postnatal eventuality/social services.
- D. Research Opportunity for service development: Health professionals of this CMHT hub may academically utilize these clinical materials to study further and may focus on important clinical issues of perinatal mental health management of young person's for further service development.

References:

FPA (2010). Teenage Pregnancy Factsheet. Family Planning Association. Available at: <http://www.fpa.org.uk/factsheets/teenage-pregnancy> Accessed on 27.9.17

Humphreys J, Obeney-Williams J, Cheung RW, Shah N (2016). Perinatal psychiatry: a new speciality or everyone's business? *BJPsych Advances*, 22(6): 363-372.

Kannabiran M, Pearson R, Narayan G (2007). Perinatal psychiatry. *BMJ Careers*. Available at: <http://careers.bmj.com/careers/advice/view-article.html?id=2222>. Accessed on 27.9.17



It's time to Turn the Map Green

by Dr Alain Gregoire, Chair of the Maternal Mental Health Alliance

It's been a busy year for the Maternal Mental Health Alliance (MMHA). We are now a coalition of over 85 national organisations, working together with a vision to see all women across the UK get consistent, accessible and quality care and support for their mental health during pregnancy and in the year after giving birth.

We are moving towards charitable status as a CIO (Charitable Incorporated Organisation) which means we will soon be recruiting for trustees so keep an eye out on our website for information on how to apply.

Excitingly, the MMHA's **Everyone's Business Campaign** has expanded to include Coordinators in Scotland, Northern Ireland and Wales who are working to turn our campaign map green. In January, an MMHA workshop on perinatal mental health in Northern Ireland brought key stakeholders together to take forward plans to improve services. Small steps are being taken but there is much more that needs to be done.

With the help of the Royal College of Psychiatrists, we are producing an updated RAG-rated map

showing where in the UK women and families can access specialist services which meet national guidelines. Green shows specialist services which meet national standards. The current map has proved an extremely useful tool in highlighting the gaps that still exist. We will be launching the updated map in a few months which will show how the map is gradually changing colour as new teams in England and Wales have received additional dedicated funding.

But we cannot be complacent. The map shows that perinatal mental health services are not fixed in the UK. Women still face an unacceptable postcode lottery when it comes to accessing specialist perinatal mental health services. Many lives are needlessly being put at risk.

New funds announced for specialist community multi-disciplinary perinatal mental health services must not be wasted, absorbed elsewhere or misspent - they should deliver well-planned and coordinated services in England and Wales. We also want to see outstanding areas of need funded in Scotland, Northern Ireland and Wales. It is unacceptable that there is still no MBU in Northern Ireland or Wales.

As well as our campaigning, we are also working on the ground with four local areas as part of the MMHA's **Mums and Babies in Mind project**. The project has produced a tool to enable decision-makers to assess their perinatal mental health services against national standards. We have had positive feedback on this tool and hope that many other decision-makers will use it to identify the strengths and weaknesses of their services. You can find the tool on our website alongside a host of useful resources and blogs created by

the Mums and Babies in Mind project.

As 2018 gets underway we are in full planning mode for our second [MMHA Conference](#) which takes place on 6th September 2018 on the theme of 'Diversity: understanding and reaching the missing families.' There are already some great speakers booked so please let your networks know and encourage them to attend.

Finally, but most importantly, a big thank you to everyone who has done so much over the past year: the MMHA is nothing and achieves nothing without the active, energetic and collaborative activities of its member organisations and of individuals everywhere. Don't wait for the MMHA to 'do' things: continued progress depends on YOU!

Find out more about the MMHA and its work and resources here: www.maternalmentalhealthalliance.org and follow us on Twitter @MMHAlliance

Investigating Workplace stress and Time management in Administrative staff who work in Psychiatric Specialist Services

by Dr Ahmed Saeed Yahya, ST4
Speciality Trainee Psychiatry

Dr Nisha Shah, Consultant Perinatal Psychiatrist

Dr Jude Chukwuma, Consultant
General Adult Inpatient Psychiatrist

Introduction

Medical secretaries and team administrators have vital roles in holding together specialist psychiatric services. However, their huge workload demands are often underestimated particularly in the current financial climate. A good secretary is the 'pillar' of most psychiatric specialist services which would likely collapse without this support. The current Consultant contract highlights the importance of 'proper secretarial support' within a specialist service (Waltham Forest Consultant response 2014).

We investigated the current workload demand on the

administrative staff in our local specialist perinatal mental health service. The demands and expectations of the service were increasing with greater workload for the administrative staff over the last two years. The staff reported emotional strain from dealing with the nature of the referrals to the service. Previously there had been attempts to reorganise their workload with a set timetable. There was also the introduction of a monthly staff support psychotherapy group led by a senior psychotherapist within the service.

However, despite these changes there was still a lot of pressure. Managing the work load has been an on-going difficulty. The clinicians in the service have expressed concern and have looked into ways this can be remedied to some extent. Prolonged periods of stress can lead to health consequences such as burnout. Burnout can be defined as "an affective reaction to on-going stress whose core content is the gradual depletion over time of individual's intrinsic energetic resources (Demerouti et al 2002). This psychological condition develops gradually but can remain unnoticed by the individual concerned for a long period of time.

Ruotsalainen et al 2015 note that the United Kingdom Health Care sector has the highest estimated prevalence of work related stress. Stress can be defined as a relationship between a person and his/her environment that is perceived by the person as taxing, exceeding his/her resources, or endangering his/her wellbeing (Ruotsalainen et al 2015). Increased stress can be related to symptoms of depression and anxiety,

decreased job satisfaction, psychosomatic health complaints and difficulties with interpersonal relationships. An area that we wished to look into was time management. Time management is an area of great interest within the Royal College of Psychiatrists. It is frequently claimed that successful time management strategies can reduce stress and improve personal efficiency. Kuster et al 2017 have stated that workplace stress management programmes can reduce stress in employees.

Time management describes techniques and habits that enable one to make the best use of their time. It is how one spends their time on the right things at the right time (Hobkirk 2015). It is defined by Hellsten 2012 as time analysis, planning, goal setting, and prioritising, scheduling, organising and establishing new, improved time habits. Hellsten and Rogers 2009 have written in their paper that individuals who receive time management training engage more frequently in time management behaviours

In this report we summarise the findings from the dual administration of a workplace stress and time management questionnaire to the four secretaries in our London based specialist service.

Methods

We conducted a literature search to identify relevant publications over the last five to ten years. Keywords included stress in NHS administrative/ clerical staff. Our search yielded two systematic reviews, one institutional publication and sixteen original research articles. Further searches were conducted using the Google scholar search engine

and reading the bibliographies of relevant journal articles. We surveyed the Royal College of Psychiatrists' members' site to look into the latest literature published by the College. Dr Yahya (Specialist Registrar within the service) committed two of his afternoon sessions to assist the secretaries with their tasks. This would permit us to get a better understanding of the roles and responsibilities of the secretaries within the service. It allowed him on an informal basis to ask the staff about the pressures and their levels of satisfaction with their job roles/responsibilities.

We researched the current service needs in terms of administrative support and obtained a document listing the current secretarial duties. This list was already extensive with twenty nine listed tasks that they held accountability for. We were informed that this list had extended over the preceding months causing greater pressures. Attempts had been previously made to reorganise their work into a set timetable and allocating tasks equally between the four secretaries. However, we discovered from conversing with the staff that this was not working well as they would work different days and travel across the various sites in the borough. One of the secretaries within the service did not have a permanent contract and was employed via the trust staff bank. She was looking for a permanent job role elsewhere and it was likely that there would be no funding to replace her position. The secretaries reported constant disruption throughout the day with frequent emails and answering telephone calls. New tasks would arise throughout the day which required their immediate attention interrupting their current tasks.

The opportunity to observe and take up the responsibilities of the secretarial role was helpful for us to discuss and identify ways in which the job could be more manageable. Finding out that a large part of the working day was spent answering telephone calls, responding to emails, chasing up incomplete referrals, cancelling and rescheduling meetings made us think about the drive from the Royal College about good time management. In particular value adding activities, non-value adding activities and activities which are necessary but non value adding. It would be helpful to eliminate 'waste' which is defined as any activity or use of resource that is non-value adding and therefore a poor use of time.

We would use a quantitative survey to measure both work place based stress and then use a similar type survey to measure time management. We obtained informed consent from our four administrative colleagues to each complete two questionnaires for us. These were left on the desk of each individual staff member to complete. We asked that no identifiable information was provided to ensure that the responses were anonymous. Questionnaires were numbered one to four so we could identify which two of the questionnaires were completed by the same person.

The first questionnaire was the workplace stress scale. This was a quick test created by the American Institute of stress and the Marlin Company for employees to measure their job stress levels. There were eight statements labelled A to H and participants were asked how each of the individual statements described how they felt about

their current job role. Responses were scored using a five point scale ranging from zero (never) to five (very often). Total scores were interpreted as follows: If an individual scored fifteen or lower on the questionnaire then this suggested that they were relatively calm and stress was not much of an issue. If the total score ranged between sixteen to twenty then the levels of stress were fairly low. If the total score ranged between twenty one to twenty five then they had moderate stress levels. A score of twenty six to thirty suggested severe levels of stress and finally scores of between thirty one to forty highlighted 'potentially dangerous' stress levels.

The second questionnaire was a quick self-measurement questionnaire produced by the advanced corporate service to look into time management. Similarly it was a Likert scale listing twenty five statements with each addressing how the respondent managed their time. Responses were scored using a three point scale ranging from zero (never) to two (always). Total scores of forty five to fifty suggested outstanding time management skills. Scores ranging from thirty eight to forty four highlighted strong time management skills. Scores ranging from thirty to thirty seven meant that the individual was managing their time fairly well but sometimes feel overwhelmed. Scores ranging from twenty five to thirty six implied that one's work career was likely to be stressful and less than satisfying unless steps were taken to manage their time more effectively. Finally scores of less than twenty five implied that work needed to be done on their time management skills.

Interpreting Workplace Stress Scale scores

Total score of 15 or lower	Relatively calm. Stress isn't much of an issue.
Total score of 16-20	Fairly low stress levels. Tough day now and then.
Total score 21-25	Moderate stress. Some aspects of job are likely to be pretty stressful.
Total score 26-30	Severe stress levels. Life at work can sometimes be miserable.
Total score 31-40	Stress levels are potentially dangerous.

Interpreting Time Management Questionnaire scores

Total score of less than 25	Work needs to be done on time management skills.
Total score 25-36	Work career is likely to be stressful and less satisfying unless steps are taken to manage time more effectively.
Total score of 30-37	Managing time fairly well but sometimes feel overwhelmed.
Total score of 38-44	Strong time management skills.
Total score 45-50	Outstanding time management skills.

Results

We had a complete response rate for this study with each of the four secretaries completing both questionnaires. Both

questionnaires took only a few minutes complete.

Participant 4 scored a total of fifteen on the workplace stress questionnaire and thirty five on the time management questionnaire. This demonstrated that stress wasn't much of a factor and they were managing their time fairly well but sometimes felt overwhelmed.

Participant 3 scored a total of twenty seven on the workplace stress questionnaire and twenty four on the time management questionnaire. This highlighted that stress levels at work were 'severe' with work life sometimes being miserable. A score of twenty four on the time management survey suggested that the individual's work life was likely to be stressful and less than satisfying unless steps were taken to manage their time more effectively.

Participant 2 scored twenty six and twenty four respectively. The interpretation of this were similar to that of participant 3 in that stress levels at work were severe and that the individual's work life was likely to be stressful until steps were taken in regards to time management. Finally participant 1 scored 22 and 35 in the two questionnaires. The levels of stress were severe but they were essentially managing their time 'fairly' well. However, they sometimes felt 'overwhelmed' in regards to managing their time effectively.

The mean total score for the workplace stress questionnaire was 22.5 with the range from 15 to twenty seven respectively. The mean total score for the time management questionnaire was 29.5 with the range from twenty four to thirty five.

Discussion

In this study we aimed to quantify the current levels of stress with the administrative staff who are the linchpin of our service. Three out of four secretaries had work stress levels that were concerning with two participants scoring 'severe' stress levels whilst the other disclosed 'moderate' stress levels. Both secretaries who reported 'severe' stress levels also stated difficulties with time management. The scores from our other two secretaries on the time management questionnaire suggested some work around this area would be beneficial.

The high stress levels demonstrated in this study are worrying. Karasek's job-demands control model is one of the mostly widely studies of models of occupational stress. It reports that a high strain job forms a negative feedback loop that can cause feelings of lack of control which in turn inhibits learning and affects the employee's confidence. (Karasek 1979)

It was suggested that introducing voice recognition software or an admin pool would be beneficial in reducing service expenditure. This would mean that the secretary would no longer be required to do the typing. However, when we reviewed the specific duties of the medical secretary it was apparent that their role is much more than this. They were very much the interface in the communication between the Consultant and their patient. A quote from the BMJ states that 'most secretaries are strongly associated with a superior service, good team morale and higher staff retention (Spence 2013).'

Some of the secretarial duties within the service included; sending out appointment letters to patients and professionals; taking minutes of professional meetings; updating the database and process/chasing up referrals. They were responsible for scanning all documentation, accepting deliveries, handling professional/client telephone queries, meeting clients/professionals, training new members of the team, ordering stationary and managing the service email inbox (Perinatal secretarial duties 2016).

Looking into time management and delivering some training around this to our administrative staff may well be a helpful strategy in reducing their work stress levels. Dr Michael Hobkirk from the Royal College of Psychiatrists speaks about the importance of prioritisation. Psychiatrists have been the target audience with this drive but work around good time management can also be applied to clerical staff. Dr Hobkirk makes reference to the time management matrix whereby outstanding tasks can be placed into one of four quadrants within the matrix. These are urgent important tasks; non-urgent, important; urgent not important and finally not urgent, not important tasks. Other good time management techniques include undertaking the most difficult, important tasks during one's energy peaks. Other beneficial strategies include; avoiding procrastination and spreading tasks over the course of the week to avoid feeling 'overwhelmed' (Hobkirk 2015).

The NHS institute for innovation and improvement have been supporting NHS teams to redesign and streamline their management

and operative function. A particular focus has been on the concept of 'Lean thinking.' This principle concentrates on the elimination of waste and focuses on whole systems and processes (Hobkirk 2015). Good time management factors into this process.

We conclude from our study that a course in good time management may well help to counter the current stress levels in our specialist service. Any loss of secretarial support would lead to a decrease in the productivity of a service. Medical secretaries are part of a specialised profession and it is clearly apparent that when a secretary goes on leave the service is visibly challenged. It is important to do what we can as clinicians to preserve what appears to be a diminishing resource within our speciality.

Limitations

There may have been some form of response bias in this study. Staff may have provided some responses which they felt were more appropriate. We minimised this by asking that staff details were anonymised. Our study sample was also small but this was a small local study to improve the working demands of our specialist service.

Acknowledgement(s)

We thank the administrative staff working in the Perinatal Service at North East London Foundation trust for taking part in this study. We also thank the Homerton University Hospital Library for assisting us with our literature search.

Financial Support Statement

There has been no financial support for this work.

References

Demerouti E, Bakker A, Nachreiner F, Ebbinghaus M (2002). From mental strain to burnout. *European Journal of Work and Organizational Psychology* 11, 423-441.

Hellsten L (2012). What do we know about time Management? A Review of the Literature and a Psychometric Critique of Instruments Assessing Time Management. InTech.

Hellsten L, Rogers T (2009) Development and Preliminary Validation of the Time Management for Exercise Scale. *Measurement in Physical Education and Exercise Science*. 13, 13-33.

Hobkirk M (2015) Leadership and Management series: Part 2- Time management for Psychiatrists.

Kuster A, Dalsbo T, Thanh B, Agarwal A, Durand-Moreau Q, Kirkehei I (2017). Computer-based versus in-person interventions for preventing and reducing stress in workers. *Cochrane Database of Systematic Reviews*.

Karasek R (1979) Job demands, Job decision Latitude and Mental Strain: Implications for Job Redesign. *Administrative Science quarterly* 24, 285.

Li-Ping C (2014). Job stress and burnout in hospital employees: comparisons of different medical professions in a regional hospital in Taiwan. *BMJ Open* 4, 1-8.

Table of North East London Foundation Trust Perinatal Secretarial duties (2016).

Ruotsalainen J, Verbeek J, Marine A, Serra C (2015). Preventing occupational stress in healthcare workers. *The Cochrane Database of Systematic Reviews*.

Spence, D (2013) Doctors no longer need medical secretaries. *BMJ* 346, 226.

Waltham Forest Consultant response to consultation document on 'Modernising the medical administrative resource.....'(2014).

Experience of a Higher Trainee in perinatal psychiatry in London

by Dr Olusegun Claudius-Adeniyi

ST6 Perinatal Psychiatry
East London NHS Foundation Trust

Given the dearth of qualified medical practitioners in Nigeria and my decision to practise in rural and semi-urban areas with minimal infrastructural support, I made an effort to train in Obstetrics & Gynaecology as well as General Surgery in order to be of benefit to the population of these isolated areas.

My medical experience proved however to be replete with forays into mental health. I was faced with all manner of mental illness including perinatal mental disorders. An uncomfortable realisation was that faith healers and witch doctors were the preferred treatment of choice for perinatal mental illnesses. My not being a qualified psychiatrist did not help my cause in discouraging this practice. Thus, on relocating to the UK, my first choice of speciality was naturally psychiatry. And the choice of perinatal psychiatry is very personal - a subconscious atonement for my previous shortcomings and a form of cultural restitution.

I became fascinated by perinatal psychiatry from my core training years and so was grateful that my final posting in a higher training schedule has been to a Mother &

Baby Unit (MBU) in a cosmopolitan city like London.

The East London MBU is in Hackney which is a thriving part of London and a melting pot of different cultures [1]. This 12-bed MBU has played host to patients from different cultural backgrounds, with patients coming from as far as Afghanistan, Africa, Asia and closer home, Eastern Europe. They vary from the literate to the illiterate, from those who speak English fluently to the many that require interpreters. The striking realisation is the need for intense socio-economic support often required by many of these patients.

I have witnessed the deleterious effect of immigration related problems including the lack of access to public funds on mental ill health and the recovery process. I have also observed the severe impact of loneliness and social isolation in slowing down the process of recovery. I have seen the powerful role of family dynamics in the healing process. I have come to realise the very significant role of faith in the healing process for some [3]. To this end, the MBU provides an imam and chaplaincy services. Importantly, I have been able to put my personal cultural and national background to good use in aiding the establishment of a rapport and engagement with otherwise difficult patients who shared a sense of identity with my ethnicity.

What have I learnt from all these experiences as a trainee? The lessons learnt are immense and valuable. I have enhanced my knowledge, understanding and respect for other cultures. As culture often plays a significant role in illness presentation, it

equally plays a vital role in recovery [2]. I have learnt that good knowledge of pharmacotherapy will come to nought without awareness of psychosocial, economic and spiritual factors that makes for holistic wellbeing. I have also realised that good communication is a crucial factor in the recovery process.

This posting has enhanced my conviction about the importance of effective perinatal services, both as cost-saving measure for the government and a proactive way of improving maternal health.

References

1. Deen, S & Nye, C (2013). Hackney exhibition portrays 100 years of migration. BBC Asian Network, <http://www.bbc.co.uk/news/uk-england-london-23006717>. Accessed 19th February 2018.
2. Ayonrinde, O (2003). Importance of Cultural Sensitivity in Therapeutic Transactions - Considerations for Healthcare Providers. Disease Management & Health Outcomes, Volume 11, Issue 4, pp 233-248.
3. Verghese, A (2008). Spirituality and mental health. Indian J Psychiatry Oct-Dec; 50(4): 233-237.

Your College Needs You

SPECIALTY DOCTORS' COMMITTEE VACANCIES

"We are the Royal College of Psychiatrists and its functioning is dependent on us...the members. In order to make a difference to patients and raise the profile of SAS doctors across the nations, we all need to get involved. Joining the SAS Committee leads to new challenges and leadership opportunities. Your College needs you!"

Dr Monique Schelhase, Chair, Specialty Doctors' Committee

Are you keen to contribute to the psychiatric community, gain invaluable networking opportunities by working on behalf of the Royal College of Psychiatrists AND boost your CV? **Would you like to get involved?**

To work on the Specialty Doctors' Committee the following positions are currently open for SAS representatives:

- **Perinatal Faculty**
- Academic Faculty
- Addictions Faculty
- Eating Disorders Faculty
- Liaison Faculty
- Neuro-psychiatry Faculty
- Medical Psychotherapy Faculty

If you have any queries, please do not hesitate to **contact us:**

specialty.doctors@rcpsych.ac.uk

If you are interested in applying, please **read** the job descriptions and forward a copy of your CV to the Specialty Doctors' Committee Manager, Vivine Muckian.

vivine.muckian@rcpsych.ac.uk

We look forward to hearing from you.

Regional Update

Northern Ireland

by Dr Julie Anderson
Chair of the NI perinatal faculty

The new faculty is going well.

Our main priorities are increasing awareness of the issues relating to perinatal psychiatry, developing specialist community services in each of the five health trusts in NI and developing an education/training program for generic mental health services.

research and audit work and some case discussions.

Some specialist trainees are leading on a project relating to female patients on Valproate and ensuring the implementation of MRHA toolkit across NI.

The main challenges continue to relate to our lack of government, financial pressures and raising the awareness of the need for specialist perinatal services across mental health services in a context where other significant pressures remain prominent.

In addition to the work of the faculty, there are other areas of ongoing work relating to perinatal services.

In addition, the public health agency has a group meeting regularly at a higher level to identify how to move forward on the recommendations in the RQIA review of perinatal services in NI in 2016. Consultant psychiatrists from each of the trusts form part of this group.

Across NI there continues to be areas with some specialist services (Dr Janine Lynch in Belfast and Dr Jo Minay in Craigavon). Enthusiasm and commitment to this population of women remains high, but the speed of progress remains frustratingly slow (I'm not known for my patience!). We continue to appreciate the input and support of the College centrally.



We have a perinatal conference planned in Belfast for April. Roch and Ian have kindly agreed to speak at the morning of this and then the afternoon will take on a more NI prospective – plans for the future, hopefully with input from Department of Health and Public Health Agency, presentations of relevant local

Within each of the 5 trusts, there are individuals with an interest in this area. Most of the trusts have local groups meeting with clinicians and managers to look at how the trust will move things forward.

Upcoming events



Maternal Mental Health Scotland 5th Annual Conference

Monday 14 May 2018
Glasgow

*The Journey to Parenthood:
Getting there safe and sound*

Topics

- The Best Start: The Future of Maternity and Neonatal Services in Scotland
- The Scottish Perinatal Mental Health Network 2018 Update
- Why support is more helpful than advice
- Medication for Mummies.
- Virtual Therapeutic Relationships?
- Maternal Mental Health: It's everyone's business
- Preparing for a stay in a mother and baby unit: A couple's perspective
- A conversation with a Perinatal Mental Health Social Worker
- Dads and Mental Health
- What can make a difference when experiencing perinatal mental illness: Parents lived experience
- How to help mums really connect with themselves and their baby.

Cost: £95 individuals / £65 members
Limited free places for women, partners and family members affected by perinatal mental health issues

www.mmhs2018.eventbrite.co.uk
info@maternalmentalhealthscotland.org.uk



WORLD ASSOCIATION FOR
INFANT MENTAL HEALTH

World Association Infant Mental Health

May 26-30 2018, Rome



<https://www.waimh.org/i4a/pages/index.cfm?pageid=3279>



International Marcé Society

26-28th September 2018
Bangalore

<http://www.marce2018.com/index.php>



MATERNAL MENTAL
HEALTH ALLIANCE
Awareness Education Action
to improve the lives of mothers and their infants

Maternal Mental Health Alliance Conference 2018

6th September 2018, London

*Diversity – understanding and
reaching the missing families*

www.maternalmentalhealthalliance.org



Perinatal Trainees Conference

5th October 2018
London

Perinatal Quality Network

12th November 2018
London

Perinatal Faculty Scientific Meeting

13th November 2018
London

The Library



GLOBAL ALLIANCE FOR
MATERNAL MENTAL HEALTH

Recently launched!

<https://globalalliancematernalmentalhealth.org/>



British Association of Psychopharmacology

Guidelines for Psychotropics in
pregnancy and post partum

www.bap.org.uk/guidelines