



FACULTY OF PERINATAL PSYCHIATRY



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Mother and child - home and away

by Dr Zeyn W Green-Thompson
(Consultant Perinatal Psychiatrist)



Mother and Child - Home and Away

The pendulum of fashion and funding in the NHS swings from famine to feast and back again all too oft.

We have seen this as a College over the past year as the rise to prominence of Faculties enjoying fat years and, currently, our own Perinatal Faculty.

One needs not, to this audience, reiterate why the resources allocated to Perinatal Mental Health are much needed in the quest to provide excellent care to mothers and children (and fathers too...) and that they are also able to demonstrate a significant return on investment.

One might however be reminded that other integral and innovative services (whither

high quality, decently sized, fairly resourced, consultant led Community Mental Health Teams let alone Assertive Outreach Teams and others) have met a fate whose toll continues to be felt.

If, once the glow of the present Five Year Forward View dims after 2021, we are to continue to be regarded as an invaluable service by patients and government mandarins alike, we must build services that prove their worth.

One area that dovetails neatly with the much trailed emphasis on the mental health of school age children in the next FYFV is the early years work oft neglected by CAMHS services due to competing priorities. One mooted social media hashtag for Perinatal Mental Health has been "where it all begins" precisely because we know that this is a watershed moment in our human lifecycle. The opportunity to aid people to change long held maladaptive coping mechanisms and resolve impaired inter-personal behaviour for the sake of their own selves as well as their children is a window through which we are hopefully all to leap.

We may work primarily with the adult parents but we aid both in ensuring that we hold infant mental health dear.

This issue hopes to serve not only as a reminder but a call to arms with the wave upon wave of new services opening across the nation.

Pivoting from the home front for a moment, and recognising the UK amongst those nations leading the push for Perinatal

Mental Health, we also look abroad in this issue. Our Chair led a delegation to the recent Marce Conference in India and reports back. We also hear about efforts on the Infant Mental Health front in sub-Saharan Africa and a new Day Hospital in Spain.

Finally, on the subject of learning and sharing that on our doorstep and further afield, the Perinatal Faculty has spread its wings online into the land of Twitter (@RCPsychPeri for anyone who isn't a follower yet!)

Update from the chair

by Dr G Seneviratne



So much has been happening!

We saw the publication of the NNCMH suite of [perinatal pathways documents](#). There has been a change in the licence for Valproate, used to treat bipolar disorder, so that it can no longer be prescribed to women of child-bearing potential unless she is on a pregnancy prevention programme. As we have known for some time now, this is due to significant risk of birth defects and persistent developmental disorders in children. Angelika Weick and David Baldwin have been leading work with other Royal Colleges and government bodies to make sure changes are implemented and affected women are supported. The College has recently published a [position statement on withdrawal of and alternatives to Valproate](#). Please do share this widely.

We have also published the [framework for routine outcomes measurements for Perinatal Psychiatry](#)- designed for inpatient and community perinatal mental health services,

which we hope services will start implementing.

There has been expanded perinatal service activity across the UK. The Scottish Government announced funding for perinatal mental health services in September...and in Wales, there are now specialist community perinatal mental health services in six out of the seven health boards, and women experiencing perinatal mental health problems are already benefitting from these new specialist services.

In England, there has been a tremendous expansion of services following Wave 2 NHSE perinatal community services development fund (CSDF) every CCG in England will be developing a specialist community perinatal team by next year. Additionally, the new MBUs are being opened and it's thrilling to see the initial Exeter, Chorley, Dartford and Norwich MBU' being opened .



The Rosewood, Dartford MBU



Wonford House MBU, Devon Partnership...some of the team



Ribblesmere (Chorley) MBU team



Kingfisher Norwich MBU

I was lucky enough to visit the first Mother and Baby Day Hospital in Barcelona, steered by Dr Llouisa Garcia. Roch Cantwell and I were invited by Dr Ethel Felice to support perinatal services and learning in Malta and were honoured to stay at the residency of Her Excellency President Preca, keen to take the perinatal mental health agenda forwards.



We eagerly await the outcome of the Perinatal and early years steering group set up by the Royal Foundation earlier this yearand also of the Early Years ministerial group headed by Andrea Leadsom last autumn. The Exec has continued to work incredibly hard submitting papers to government, feeding into College papers and reports...thank you.

We are grateful to Liz McDonald and Dee Noonan who have continued to support the bursary holders and train more psychiatrist with specialist perinatal skills as part of the 'Building Capacity, Psychiatry Leadership in Perinatal Mental Health Services' ...with the initial bursary holders and a further 350 consultants and senior trainees receiving training through the various streams.... a fantastic achievement.... There is more to come!

Also published were a fantastic 'chocolate box' of new perinatal mental health leaflets (as described on Twitter!) Huge thanks again to Liz McDonald, Dee Noonan, Lucinda Green, the bursary holders and the College team who delivered these.

A fantastic achievement also to Eleanor Romaine, Sarah Ashurst Williams & Catherine Wilson who brought together an excellent trainees conference #mindbodybaby in October.

It was a delight to attend the first International Marce Meeting in a low and middle resource country –in Bangalore, India. Hosted by Professors Jane Fisher, current Marce president and Prabha Chandra who runs the Mother and Baby Unit there. It was a terrific melting pot of clinical academic research, and wonderful that there were so

many perinatal clinical academics from the UK there. It was a great opportunity to share the expansion of services in the UK and especially England in a symposium involving work of NHSE, with our Associate Clinical Directors, Giles Berrisford and Jo Black, as well as Perinatal Quality Network CCQI at the College. The importance of co-collaboration was highlighted by Naomi Gilbert, and we heard about the New Zealand services from Tanya Wright..... and many other global collaborations A highlight was one of our trainees on our Perinatal Faculty taking her work on Perinatal simulation training to a global platform..... well done Catherine Wilson! We have certainly come back to the UK with a few global projects with the Faculty being hatched.

The November Faculty Scientific Meeting was brilliant, and I am running out of space to talk about the wonderful speakers, so thank you to everyone and the trainees presentations and winnersI think a particular favourite for me was the work of Samantha Meltzer Brody and hormonal treatment for postpartum depression with Allopregnanolone a positive allosteric modulator of γ -aminobutyric acid (GABA A) receptors. The 2019 Scientific meeting will have more of a global theme.....! There is also a joint Faculties meeting with Medical Psychotherapy and Forensic faculties pencilled in.

On to 2019 and what a fantastic start with the publication of the NHS England 10 year long term plan including a large Perinatal mental health offer which all of you contributed to, so thank you again. These include:

1. **Increasing access to evidence-based care for women with moderate to severe perinatal mental health difficulties** and a personality disorder diagnosis;
2. **Extending services to preconception to 24 months after birth**, in line with the cross-government ambition for women and children focusing on the first 1,001 critical days of child's life;
3. **Expanding access to evidence-based psychological therapies** within specialist perinatal mental health services so that they also include parent-infant, couple, co-parenting and family interventions
4. Increasing access to evidence-based psychological support and therapy in a maternity setting by **implementing maternity outreach clinics**, that will integrate maternity, reproductive health and psychological therapy for women experiencing mental health difficulties directly arising from, or related to, the maternity experience
5. Ensuring **partners of women accessing specialist perinatal mental health services and maternity outreach clinics receive evidence-based assessment of their mental health and are signposted to support** as required.

This means that 24,000 additional women and their families will be able to access

specialist perinatal mental health services by 2023/24 (in addition to the 30,000 more families that will be seen within the Five Year Forward View for Mental Health).

We look forward to the innovative service developments across the UK in 2019...and reaching out to do more global work.

I'm delighted that we are strengthening the service users and carers arm of the Executive this year and grateful to so many who have offered to be part of faculty business.

We are looking to develop some international training packages.....which is at embryonic stages at the moment.... please offer if you are interested

Please start tweeting as Zeyn has said.... The information flow is very rapid these days to stay on the pulse of perinatal progress! We need a Perinatal Faculty Twiterrati! I expect ALL members to be tweeting by Christmas 2019 [@RCPsychPeri](#)

I will have to stop for now.

My warmest wishes for a wonderful 2019 as the year progresses.

Trudi

Chair of the Perinatal Faculty

The Case for Infant Psychiatry

by Prof David Foreman

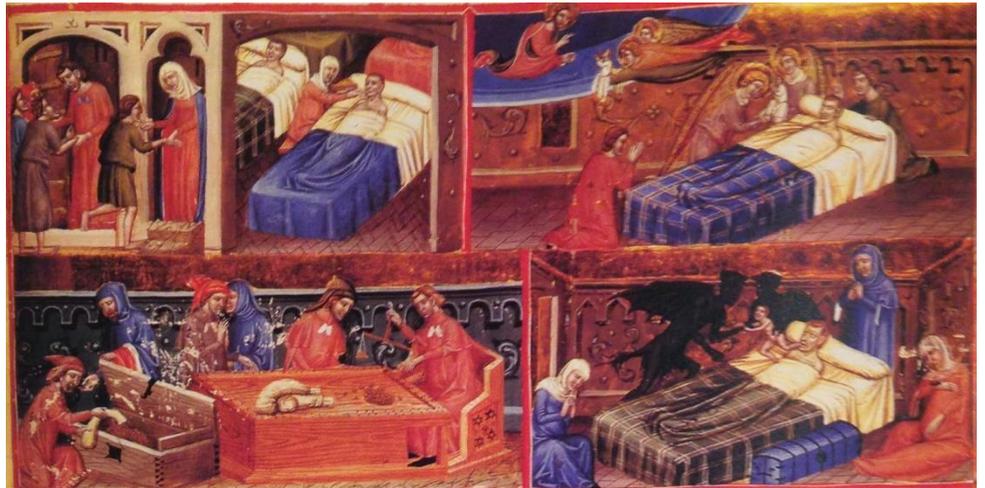


While public engagement with mental health has been gathering pace, one area, infant mental health, is in decline. In primary care, the Sure Start programme, which delivered 3,500 centres on time in 2010 [1] and demonstrated detectable changes up to age 7 [2] has lost 1,000 centres since then [3].

Secondary care for our youngest children has also suffered, with a decline in preschool child psychiatry services detectable since 2006 [4]. Ironically, this decline occurred despite evidence that our youngest children suffer mental health problems at a similar rate to older ones and as young as we can measure, of similar types [5].

Intervention in this period is also the most cost-effective time to intervene for mental health problems [6].

Additionally, there is an influential view that the problems of very young children and babies should not be managed by psychiatrists, but by psychologists or other professionals allied to medicine. So, this newsletter looks at what



doctors generally, and psychiatrists in particular, can do for infants' mental health.

Think about what an infant can do and compare it to an adult: the infant does a lot less. This means that distinguishing between normal and abnormal behaviour in an infant is harder, as the available range is smaller. Despite this, more than one third of infants referred to a preschool mental health clinic attracted a diagnosis, the proportion increasing with age [7].

Combining observation and screening instruments detects them in primary care [8] so the GP surgery, which all young children inevitably attend, could be valuable in picking up problems early. Diagnosis is fundamentally about the discerning the way in which a patient is different from ordinary peers. Doctors were trained to be good at this thousands of years before operationalised criteria were even thought of. No other profession has this investigatory tradition, and the relatively narrow behaviour range of infancy is a worthy challenge for doctors' powers of observation and examination.

The 13th Century illustration, above, of the reception and

treatment of the impoverished sick in a monastery infirmary from the Bibliotheque Nationale, Paris, reminds us that the broader practice of medicine has always combined non-physical with physical treatments. Indeed, the modern trend to role fragmentation in a multi-disciplinary team may lead to less effective care, if it undermines care continuity [9]. As Jolley commented in relation to the elderly (another group often unable to communicate their needs) "Every device is deployed to separate patients and families from consultants: to fragment patterns of care and to divert ('signpost') expectations and responsibilities elsewhere" [10]. We have never before needed physical treatments as a gateway to our patients, and we should not need it now. In fact, the range of interventions needed to support optimal early child development are classically medical, encompassing the physical, psychological and social domains of the infant and family [11]. Perinatal and child psychiatrists can contribute hugely to infant mental health, and it will benefit people throughout their lifespans if they do.

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Video Interaction Guidance (VIG) in the Perinatal Period

by Dr Fionnuala Stuart (Consultant Child and Adolescent Psychiatrist)



"Watching the footage back: that was just, I mean, that was huge for me (...) actually being able to see myself, like, almost step out of myself and see myself, and see my interaction – it really helps me understand and digest what was happening."

"It helped me to be more calm with my baby when I am mentally not well. It helped me to be calm with her."

Quotes from parents who took part in a one year pilot program where Video Interaction Guidance (VIG) was provided by health visitors and family support workers to parents and infants under one where there were concerns around

bonding(1). For those who have not come across it yet, VIG is an evidence-based intervention which seeks to support participants to develop more meaningful and rewarding connections with important others in their lives, through the shared detailed analysis of video clips of 'better than usual' real life interactions.

It has been around since the early 90s and has been used with families with a wide range of difficulties and from across the life span (2). It is recommended in two NICE Guidelines (3,4), and also listed as a recommended intervention in the First 1001 Days All Parliamentary Party Group report: Building Great Britons, February 2015 (5). VIG has an established UK training and accreditation programme through AVIGuk (www.videointeractionguidance.net) which includes ongoing video-reflective supervision and rigorous accreditation criteria.

At this point I should declare an interest as I approach the end of my VIG practitioner training, I will be joining a small but growing group of psychiatrists (perinatal and child and adolescent), and a much wider group of professionals from other disciplines, who are using VIG in a wide variety of settings in the perinatal and infant mental health arena. These include: mother and baby units, community perinatal mental health teams, joint local authority and NHS teams working with parents whose babies are in care proceedings including parents with substance misuse/dual diagnoses, parents with premature babies, NHS and third sector infant mental health

teams, third sector projects working with parents where there is domestic violence and post adoption support teams.

There are many other effective video feedback interventions based on the same aims of enhancing parental sensitivity while helping parents guide their children's development and behaviour (6,7). However, in this article, I will focus on VIG, as the technique I am most familiar with, and because I think the collaborative, flexible and self-reflective nature of the technique and training provide a good 'fit' with the complex and emotionally charged reality of perinatal mental illness, from the 'mild' to the 'severe' ends of the spectrum.

Begin at the beginning

The growing interest and expansion of VIG in the perinatal and infant mental health field is fitting given that VIG has its origins in the work of Professor Colwyn Trevarthen, a psychologist and psychobiologist (8). His observations of how parents and babies follow each other, the rhythm, the tone and the 'pauses' that help communication work, inspired Harry Biemans, a Dutch Child Psychologist, to develop the 'Principles for Attuned Interactions and Guidance' (see Fig. 1). From these, VIG as we know it today was further developed by Hilary Kennedy and others in Dundee (2).

These principles are not only the 'building blocks' of the emerging relationship between the parent and the baby, but also underpin the growing relationship between the VIG practitioner and the parent, and the

relationship between the VIG trainee and supervisor, something I will return to later.

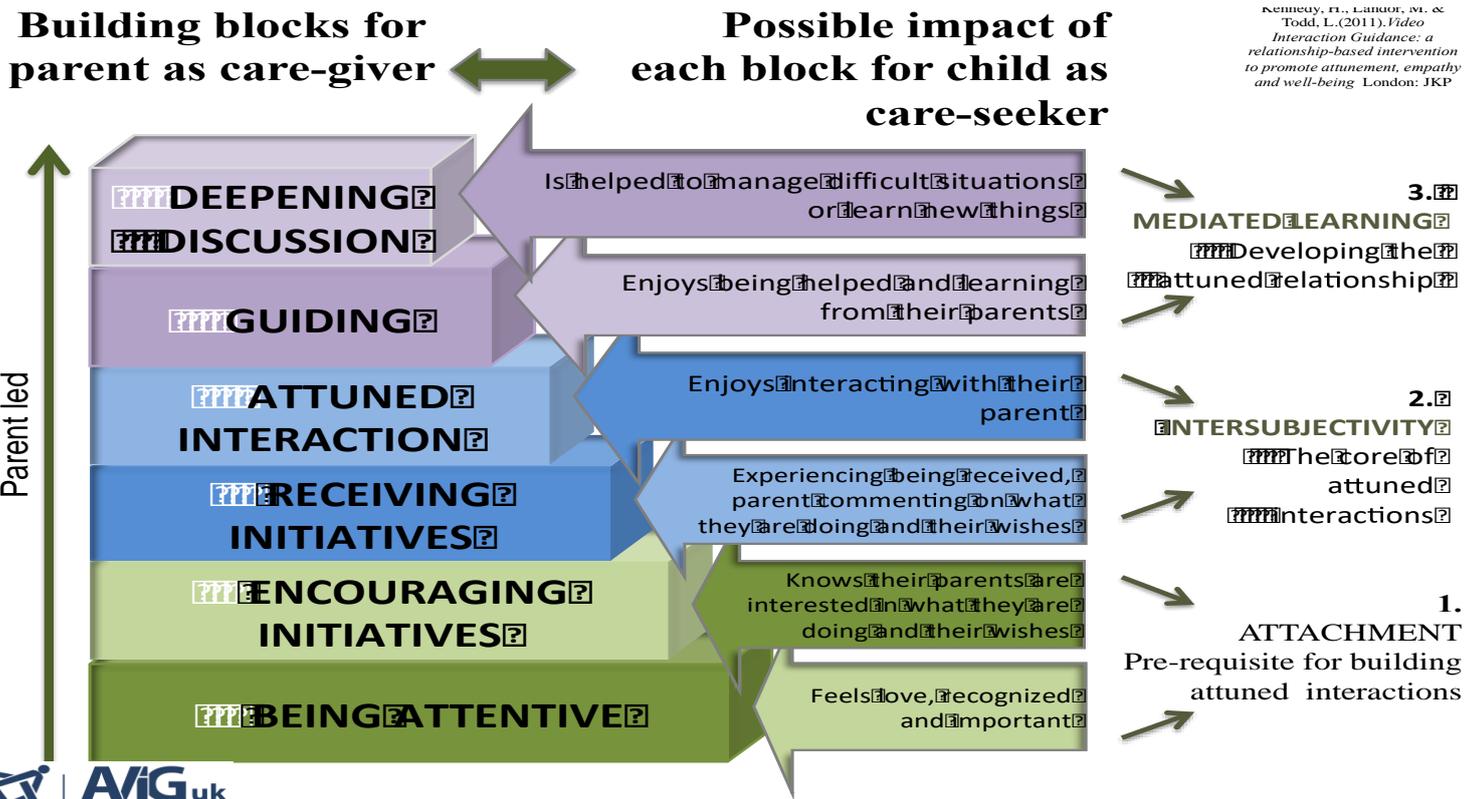
In addition to promoting parental sensitivity, which has been shown to be an important mediator between parental mental illness and adverse outcomes for the child (9,10),

Tronick (13); 'mid-range contingency' referring to parent-baby interactions that are neither too withdrawn (parent preoccupied with their own thoughts and feelings) nor too vigilant and intrusive (parent overly preoccupied with the baby)(14); and 'mind-mindedness', the capacity of

concerns into 'helping questions' or goals, e.g. ("To have a better bond with my baby").

A brief (10-15 mins) filming session of the parent-baby dyad is then set up in such a way as to capture the best possible interactions available at that

Figure 1. Principles of Attuned Interactions and Guidance - The building blocks of VIG



perinatal VIG seeks to support and enhance other related concepts which have been shown to be important to the healthy emotional and cognitive development of the baby (10,11). These include: parental 'reflective function', that is a curiosity about the meaning and intention of their baby's signals and a capacity to view their baby as separate from themselves (12); a parent's ability to recognize their baby's need for a break ('rupture') and then gently re-attune to their new emotional state (repair) as described by

parents to accurately read their children's cues and put them into words related to thoughts and feelings (15).

Outline of the VIG method

VIG begins by exploring with parents what it is *they* are concerned about in their relationship with their baby. This may differ from what professionals are concerned about and these concerns will be borne in mind, but what is important to the parents is an important starting point and support them to form these

time, e.g. gently encouraging a parent to hold their baby at the optimum distance for interaction. From this film, 3-4 short clips and/or stills will be edited of successful interactions linked with the parent's helping question, and particularly looking for moments or short sequences where the parent has left space for and then received an 'initiative' from their baby (a look, gesture or vocalization) in a sensitive, attuned way. These clips and stills are then 'microanalysed' together with the parent in a 'shared review', watching and re-watching them,



sometimes with the sound off and in slow motion, to enhance the joint discovery of what it was that the parent was doing that lead to the successful interaction. If the baby is on the parent's lap during the shared review, often watching themselves in a loving moment with their baby can naturally prompt a further attuned moment between parent and baby which the VIG practitioner can notice and gently reinforce.

The VIG practitioner follows the parent's pace, allowing space for them to voice thoughts and ideas triggered by the clips, receiving these ideas and building upon them, while keeping the focus of the conversation in the 'here and now' and on the helping questions by a careful return to the video. From moment to moment they will judge when to bring in information, e.g. prompting parents to identify which of the principles of attuned interaction (Fig. 1) they were demonstrating in the clip. The aim is for parents to be 'in the driving seat' in shared reviews and to become active agents in their own change. At the end of each shared review, the practitioner will 'check in' to see if the helping questions are being adequately addressed and whether they need to be modified.

A VIG 'cycle' comprises a filming and a shared review and the average length of a VIG intervention is 3-4 cycles, though there is a recognition that with parents with a history of childhood trauma and abuse who are dealing with other complex problems (e.g. substance misuse, domestic violence) more cycles may be

required. Throughout the intervention but particularly towards the end, the focus of the shared review will include reflecting upon how positive changes in their interactions with their baby might lead on to changes in other areas of their parent's life e.g. their relationship with their other children, their partner, their community. We know that parental mental health problems do not exist in a vacuum, with socioeconomic status and inter-parental conflict being important mediating factors on parenting and parent-child relationships (9,16,17). Therefore this inclusion of 'context' in the VIG intervention is important and an integral part of the ending is the VIG practitioner supporting the parent to plan 'next steps' in achieving positive change in other areas of their life.

There is a growing recognition of the existence and impact of prenatal and postnatal mental depression in fathers and interest in the relationship between maternal and paternal perinatal depression (18,19,20,21). Research into other paternal mental health disorders and their impact in the perinatal period has been largely lacking, though the available literature suggests that different disorders have a unique effect on the father's parenting, relationship with their child and the emotional outcomes for children (22). VIG has been used with fathers in a wide range of settings including the perinatal period. Indeed an RCT assessing the VIG as an intervention for parents of premature babies suggested that it might be particularly beneficial for fathers

in terms of parental bonding (23).

An additional possibility is offering VIG to both parents as part of the same intervention, with separate cycles initially, starting with the parent who is struggling most in their interactions with the baby, then progressing to a shared review with both parents, where each parent can appreciate the strengths of the other in the shared clips. This approach could also work well for single parent families where another adult such as a grandparent provides significant support in caring for the baby.

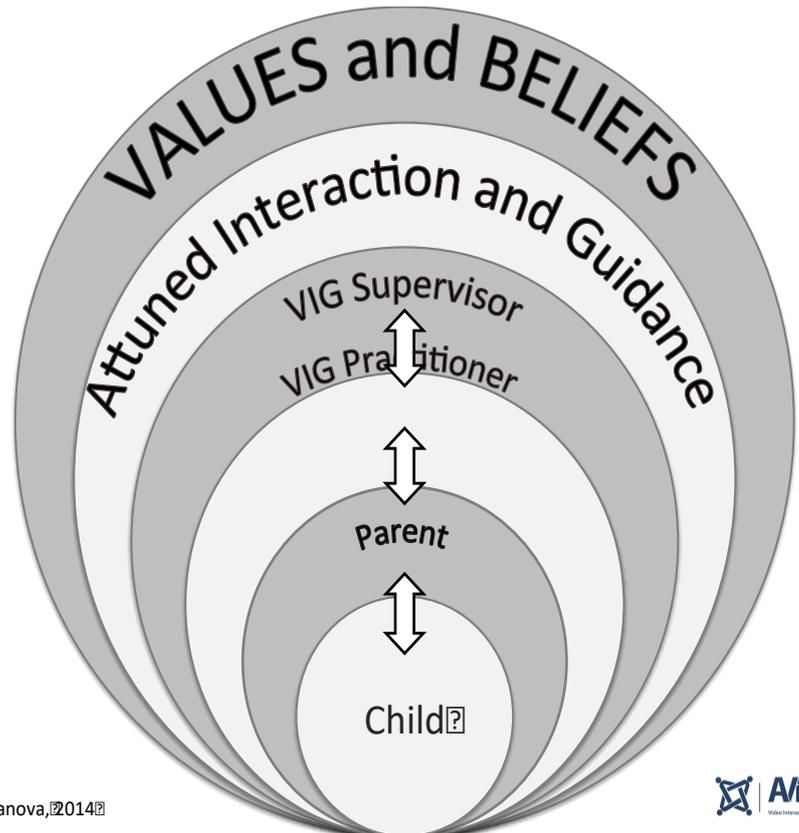
VIG Training, Supervision and Continuing Professional Development

The VIG training process is essentially learning VIG with real families under close supervision, with the trainee 'in the driving seat' and an active participant in their own learning. The trainee films their shared reviews and brings this film, along with their proposed edited clips from the parent-baby filming to supervision. The VIG supervisor, drawing on the principles from Fig. 1, scaffolds each trainee's learning, building on their unique strengths as they microanalyse together clips of successful moments of attunement between the trainee and the parent. Thus, the VIG practitioner through experiencing attuned interaction with their supervisor is better able to attune sensitively to the parent, which, in turn, supports the parent's capacity to attune to their baby (Fig. 2). In cases where the severity and risk associated with perinatal mental illness is high, VIG supervision can play an important role in

supporting the clinician as outlined in a case study where VIG was used alongside other treatments for a mother with a history of childhood abuse and attempted suicide and self harm in the early post natal period (10).

The VIG training process has recently been streamlined so that accredited practitioner level could be completed in a year, with a mid point review and final accreditation day where trainees present edited clips of their work and a structured self assessment of their skills to an external supervisor. Those who wish can then apply to more advanced level training and then accredited supervisor training. The latter involves taking on supervisory cases with support from experienced VIG supervisors and so teams embarking on VIG training can eventually become self-sustaining.

VIG practitioners at any stage in training are encouraged and supported to participate in regular multidisciplinary 'intervision' events where VIG work is presented and reflected upon in a supportive group setting. 'Building Babies' Minds' is one such regular event in London for those working in perinatal and infant mental health settings. Recent presentations have included antenatal VIG (24), VIG in groups (25), and VIG using an interpreter. There is also an online forum available through the VIG website allowing sharing of ideas and resources. The intensity of the supervision and ongoing CPD has facilitated



Kennedy & Silhanova, 2014



Figure 2 Embedded Attunement in the VIG process

those without a formal clinical training to take up VIG training, as a voluntary parent mentor organization in Essex have done recently (<https://www.parents1st.org.uk/once-in-a-lifetime-videos-vig>).

Conclusion

VIG is an effective, flexible, strengths based intervention which can be used across the spectrum of perinatal mental disorder with both mothers and fathers to support their growing relationship with their baby. Building a strong, empowering therapeutic alliance with parents is a key component of VIG and this task is supported by the reflective supervision integral to the training and practice of VIG.

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Hidden Half - Bringing postnatal mental illness out of hiding (National Childbirth Trust)

by Dr Fionnuala Stuart (Consultant
Child and Adolescent Psychiatrist)

The NCT's new campaign - ['Hidden Half - Bringing postnatal mental illness out of hiding'](#) came out of an online survey commissioned by the NCT in March 2017 which asked about women's experience of the 6 week GP postnatal check. Over 1,000 women with children aged 2 yrs or younger from across the UK responded:

-50% of the women surveyed reported that they experienced mental health or emotional difficulties at some time during pregnancy or in the year after birth and, of those, 42% said that their difficulties were not identified by a doctor or other health professional - the 'hidden half' of the campaign title.

- a fifth of women questioned said they were not asked about their emotional or mental wellbeing at their 6 week postnatal check

- for two thirds of new mothers, the postnatal check up was squeezed in with checks on the baby, leaving little time to focus on the mother

- half of the women who had emotional or mental health

problems that they wanted to discuss at the 6 week check didn't feel able to: 60% citing that they felt embarrassed, ashamed or worried that the health professional would think they were not capable of looking after their baby; 25% said that this was because there wasn't enough time; 28% thought the health professional wouldn't be interested and 15% thought that they wouldn't be sympathetic

- 82% of the women surveyed who received treatment for mental health problems said that it helped, emphasising the value of early intervention.

The three proposed recommendations from the campaign are:

1. Fund the six week maternal postnatal check so that GPs have the time to give every new mother a full ten minute appointment for the maternal check.

2. Improve guidance to GPs on best practice around maternal mental health, specifying a) a separate appointment for the maternal six week check and b) specifying best methods of encouraging disclosure of maternal mental health problems.

3. NHS bodies should support and invest in initiatives to facilitate and further develop GP education in the area of maternal mental health through a range of media.

[The Centre for Mental Health](#) have reviewed the Hidden Half report including an estimation that it would cost in the region of £27.4 million per annum to ensure all new mothers in England received a 10 minute

check-up in addition to a similar appointment for their baby.

Infant Mental Health in South Africa – towards the development of Afrocentric training

by Dr Anusha Lachman

Department of Psychiatry

Stellenbosch University, South Africa

An estimated 250 million children younger than 5 years old in Lower and Middle Income Countries (LMIC) are at risk of falling short of their potential because of adversities they face in their early, formative years. In settings marked by environmental fragility, poor quality care that is often too late, results in negative maternal and neonatal outcomes. Infants living in disadvantaged homes in Higher Income Countries (HIC) are also at risk, making the agenda of early childhood truly global.

Maternal mental disorders are approximately three times more prevalent in LMIC. A developing brain is patterned by the nurturing care of trusted adults, and poor mental health in mothers might be expected to have adverse consequences on the infants' development. Nurturing interactions are crucial to mitigating early risks and prenatal stress becomes one of the most powerful

influences on mental health later in life.

Infant Mental Health (IMH) is a rapidly expanding field internationally and it is widely accepted that early intervention during the first 1000 days of life could potentially alter their developmental trajectories. IMH involves understanding that a child's overall behaviour and functioning occur within specific cultural and environmental contexts, and that individual family experiences, beliefs, and perspectives may influence child-rearing practices.

Despite the far-reaching political changes that South Africa has undergone in recent years, children continue to be plagued by enormous psychosocial problems, which affect and impede their development. Over the past 18 years, early intervention and, in particular, parent-infant psychotherapy (PIP) has been recognized as a relevant and valuable intervention (Dugmore 2011). PIP in a local community was shown to be effective and acceptable because reflective practice and supervision formed the basis of the intervention (Berg 2012), whereby the cultural context in which parents and infants were embedded needed to be understood and appreciated before an intervention could be meaningful (Berg 2016).

The reality however remains that access to PIP is often limited to a select few, usually in urban settings. The allocation of scarce resources in LMIC is often prioritized according to disease burden and more immediate health outcomes such as neonatal survival, rather than being focused on infant services where the greatest impact is likely to only be seen decades in future. Linda Richter

in the Lancet Series (2017) highlighted that starting at conception, interventions to promote nurturing care, and providing resources to support children and their families can feasibly build on existing health and nutrition services at limited additional cost.

Mental health challenges in the perinatal period continues to be overshadowed by complex systemic issues in the health system – ranging from lack of collaborative care between obstetric antenatal and psychiatric services, stigma, cultural misconceptions and lack of sustainable service delivery models.

The shortage of clinicians (both in private and public sectors) with specialized training in assessing infants and their caregivers is a major barrier to providing adequate services in South Africa. Resolving the gaps in human resources entails the use of "non-specialists" to deliver mental health and other interventions. This model of "task shifting" in the delivery of health care (e.g. using nurses, community health workers, allied professionals) has been successful in LMIC.

While training approaches in the arena of IMH are evolving, the demand for training experiences that accommodate diversity and cultural sensitivity is a recognized challenge. Until 2016, no formal academic qualification in IMH existed on the African continent, where opportunities to train in the field were limited to those who could access training in Europe, and at a significant cost. A platform for scientific sharing and a local evidence based research agenda is urgently required on the African continent, to bring in learning material and experiences from local settings

to supplement knowledge, perspectives and research from the Western world.

To meet the increasing need for local, culturally-sensitive IMH services, a formal Masters Degree (MPhil) in Infant Mental Health was created and convened by two local clinicians (Prof Astrid Berg & Dr A Lachman) in 2017 at Stellenbosch University. The part time degree is offered over two years to medical and allied health professionals. The course includes an adapted model of Infant Observation, exposure to community and hospital based infant clinics, theory modules on the science of early development and a research assignment.

Succeeding in making the field more ethnically diverse eventually leads to educators experiencing the challenges of teaching in a multicultural classroom – and as we enter the second year of the first intake of students many questions arise. What defines and who is best qualified to provide the teaching of infant specialists? The child psychiatrist? The psychotherapist? The paediatrician? Despite their different backgrounds – all remain linked by a common thread – the pursuit of infant wellbeing and the promotion of dyadic success. How then do we fairly test the core competencies of IMH while being sensitive to the diverse educational backgrounds and multicultural experience?

The discipline of infant mental health is gaining ascendancy internationally with the advances in neuroscience research as well as with a shifting focus in public mental health on upstream factors that affect mental health throughout

the life span. The South African MPhil in Infant Mental Health is pioneering in the initiative to upskill local expertise in a culturally sensitive and Afrocentric direction.

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A generational change or quantum leap?

by Dr Michael Lumb (Cons Obstetrician)

I greatly enjoyed obstetrics & gynaecology as a medical student with its unique blend of medicine, surgery and psychology, with obstetric intervention being challenged by proponents of natural childbirth.

What puzzled and intrigued me was why a few women appeared to reject medical advice, to embark on a course of action that seemed risky or dangerous. Psychiatry, which I did next, seemed to be regarded as totally distinct from other branches of medicine. I was struck by the thought that anyone could develop mental health problems if enough bad things happened to them. It seemed clear that peoples' behaviour and their physical health were closely related.

When I began my specialist training in obstetrics & gynaecology, an unwelcome surprise on my first day was meeting a patient with puerperal psychosis who had gone on maternity leave when I was working with her in my previous job. She didn't stay on the maternity ward long and I hope she was transferred to a mother and baby unit. Apart from that case, however, I don't remember any mention of mental health problems when doing antenatal clinics or working on delivery suite or the wards.

I discovered that female staff are not always more sympathetic towards patients in this specialty, and recall being dressed down by a consultant for trying to comfort a patient that she had upset on a ward round, and being told by a midwifery ward sister that "We don't have time to be nice!"

In my last year before becoming a consultant, I looked after patients who are now termed vulnerable women or women with complex needs, principally pregnant drug users, many of whom were HIV positive. My consultant's approach to the patients was to treat them with kindness and understanding, and to encourage them to talk about how they were feeling. I noted how appearing unhurried and calm really encouraged patients to speak up and ask questions, as well as giving more detailed answers.

The other really important lesson I learned as a senior registrar was that low risk patients in busy antenatal clinics could be cared for better by their community midwives. I have a clinic with 30 minute slots to see women with complex needs together with the relevant specialist midwife. We are extremely fortunate in that we have an excellent midwife who specialises in mental health and works very closely with a specialist perinatal mental health nurse. Not having a hierarchical approach and working with midwives, mental health nurses and psychiatrists as a team is vital.

I have observed a gradual change in attitudes towards mental health amongst obstetricians. Attitudes have shifted from seeing it as nothing to do with them and unrelated to mainstream medicine, to wanting to know more about the

subject and how it impacts on their pregnant patients, via knowing that they have colleagues who seem to be interested in seeing these patients. Some of my obstetric colleagues seem to lack the confidence to discuss mental health problems and one said that if a patient said that she was depressed he wouldn't know what to say! Whilst guidelines are available, 'breaking the ice' seems to be difficult and may feel awkward. The media have a more balanced approach to reporting mental health and the stigma is breaking down with more patients able to talk about their problems.

NHS England second wave funding for community PNMH will allow some gaps in services to be plugged, providing posts can be recruited into. Our CCG had not commissioned specialist Perinatal Mental Health services prior to this. This will allow training to address gaps in knowledge and more specialist perinatal mental health care provision. Some of the barriers to women getting good care from their GP centre on the individual doctor's knowledge, training and confidence as well as time pressures.

Recent work using GP champions to provide targeted training should help, as well as sharing information about medication risks and benefits in pregnancy which has been agreed with PNMH professionals, obstetricians and GPs. Increasing knowledge and confidence through midwifery training is being rolled out in out Trust and similar material used for trainee and Consultant Obstetricians. I feel optimistic that the next few years will see perinatal mental health in its rightful place in the care of pregnant women.

View from within and without

by Naomi Farrow



I come wearing many hats in the Perinatal world but am probably best known as the Founder and Chair of a maternal mental health charity based in Norfolk called "Get Me Out The Four Walls". I set the charity up after suffering from severe postnatal depression after the birth of my twin girls in 2014. Whilst suffering, I realised that there was very little support in Norfolk for mothers of postnatal depression. The simple idea of entering a Community Hall with a playgroup going on was something that filled me with dread, bearing in mind the anxiety and depression I was feeling at the time. However, living in a rural part of Norfolk meant that if I didn't get out of the house I was going to become incredibly lonely and isolated which I also acknowledged was a big contributor to my depression.

Not wanting to get out alone, and seeing an opportunity to help others, I decided to set up what was initially a Facebook group and organised my own social meets for all mums to attend, not just mums with depression. It was important to me that these were very informal and at varying different locations across the county. It was incredibly important when running these meets that everyone felt included and valued and this is the ethos that we still work to now. It started with just me organising three meets a week and now in 2018 we get on average 1800 attendees to our meets a year, have over 30 volunteers, 40 meets a month, 5 employed staff and 5000 mums in our group. We also offer a PND only group that consists of a forum for mothers to talk openly and organise meets just for mums that want to talk about their mental illness. We are now at a point where we are moving over to a website which has its own social media platform which will make it much easier to manage and coordinate and much more professional.

This brings me to my next hat, which was very much a campaigning hat. Whilst I had set up the charity, I was determined to make change in my home county of Norfolk. After seeing the publication of the "Five Year Forward View for Mental Health", I was chuffed to see that perinatal mental health had its own section. I was even more thrilled when the "Implementation Of The Five Year Forward View" was published outlining the investment that was to be made into perinatal mental health. I contacted my local MP (Norman

Lamb) to assist me in engaging mental health stakeholders and commissioners in Norfolk to bid for a specialist perinatal community mental health team. Norfolk were successful in bidding for this and received Wave One funding. Due to the involvement that I had in the bid process I was asked by the Norfolk and Suffolk Foundation Trust to remain on their implementation groups for the development of the community team assisting them with recruiting all of the staff for the roles and casting a service user opinion on any decisions being made.

Shortly after, I took up my current role working for NHS England as a Quality Improvement Officer for the East of England. This is an incredibly insightful job and it has been great to see the implementation and development of all of the wave one sites and most recently the planning and development of the Wave 2 sites.

Having been involved in the creation of Norfolk's specialist team as a service user, I really saw how important a service user voice is in developing services. This has been something that I have continued to champion whilst working for NHS England and is something that I would continue to advise other regions to invest time and dedication in setting up.

Like many things in healthcare, there will always be improvements that can be made but one thing that has become apparent to me is the huge array of dedication and commitment by the professionals that work within this field, not only offering a

great service to patients but also in pushing and driving forward change in their area of expertise.

Going forward, I think it's incredibly important for commissioners to continue to build on the investments that they have made in previous years to meet the planned trajectories as set out in the Five Year Forward View. From a personal point of view, I feel it would be beneficial for more research to be put into the link between Caesarean births and babies entering NICU shortly after delivery. Having been one of these mums I think it can be an incredibly traumatic and stressful time for a mother in what is meant to be one of the most amazing and memorable times of your life. I am also incredibly sceptical about the need for birthing plans. I often question whether these build mothers' expectations up to something that very rarely goes to plan. I personally believe this can leave mothers feeling very much as if they have lost control and failed from the offset. I'm not sure whether something as simple as changing the word "plan" to "options" would be better.

To finish, Perinatal Mental Health continues to be an area extremely close to my heart as it is to many others and I am very much excited about what the future of Perinatal Mental Health and what this looks like in all service areas.

For more information on "Get Me Out The Four Walls", visit www.getmeout.org.uk or feel free to contact Naomi on naomi@getmeout.org.uk

Devolved nations update

Wales

Dr Sue Smith

In Wales we continue to develop community services in all the Health Boards. Bids have gone in for another pot of money which is not specifically for Perinatal but Perinatal is one of the favoured options. The Welsh Government are also actively chasing what we have done with our money so far and to look at inequalities between health board areas – we live in hope that this means they may want to fill the gaps! An MBU in Wales is still on the table though a meeting that was meant to happen a couple of weeks ago was postponed – but we are assured the plan is still for there to be one.

Scotland

Dr Aman Durrani

[The Perinatal National Managed Clinical Network](#) continues to visit health boards to understand what services and facilities are available for women and their families across Scotland.

There is also work around implementation of recommendations from a Mental Welfare Commission Perinatal Themed report from 2016. These include the following which may have an impact on Scottish colleagues and teams over the coming year:

- o Health boards should ensure that clinical staff in their community mental health and crisis response/assertive outreach teams receive training in perinatal mental health which enables them to safely assess and, where appropriate, manage women during pregnancy and postnatally

- o Health boards should ensure that staff working with women during pregnancy and postnatally have completed the [NES online training module in Maternal Mental Health](#).

Day Hospital in Spain

Ground breaking Spanish Perinatal Mental Health Day Hospital opens in Barcelona

by Dr Lluïsa Garcia-Esteve (Perinatal Psychiatrist)

Perinatal Mental Health Unit
CLINIC-BCN

Hospital Clinic, Barcelona
(Spain)

We are pleased to announce that the very first Mother-Baby Day Hospital has opened in Catalonia, Spain. Located on the campus of the Maternitat-Hospital Clínic, in Barcelona, it is coordinated by Dr. Lluïsa Garcia-Esteve, perinatal psychiatrist and first President of the Marcé Society Spanish group.

The Perinatal Mental Health Unit CLINIC-BCN is composed of a community perinatal mental team, who serve half of the city of Barcelona, and the brand new mother-baby day hospital. The Mother-Baby Day Hospital CLINIC-BCN is a therapeutic and voluntary resource that offers intensive and specific therapies during the first year following birth ensuring the continuity of care for mother and baby. It has been inspired by two Baby Mothers Unit in England, the Channi Kumar Mother and Baby Unit in the Royal Bethlem Hospital of London and the Brockington Mother & Baby Unit of Stafford. I want to thank Dr

Gertrude Seneviratne and Professor Ian Brockington for their assessment and support in this Catalan project.

The objective of this Unit is to improve the prevention, detection and intervention of severe mental disorders during the first postpartum year through the use of specialized treatments.

These treatments are based on multidisciplinary interventions that favors maternal breastfeeding, the mother-baby relationship, as well as positive parenting. The Unit has 10 places for mothers and 10-12 for babies with an approximate stay of three months and as such will assist approximately 60 women and their babies every year. The centre offers diagnostic evaluation and psychotherapy, both individualized and group, and has specific programs for perinatal mental disorders such as postpartum depression, bipolarity and puerperal psychosis, as well as bonding disorders. Sensitive maternal behaviour is promoted and the mothers are offered assistance, attention, care and accompaniment in order to improve their mental health.

The risks and benefits decision making process is carried out together with the mother and different therapeutic options are evaluated, including psychopharmacology treatments that are compatible with breastfeeding. Likewise, evaluations of the newborns are carried out for early detection of neurodevelopment disorders.

Depression and other psychiatric disorders are common during pregnancy and the postpartum

period which is why developing programs that are focused to meet the needs of mothers with perinatal mental health disorders is crucial to improve the quality of care.

It is hoped that the pioneering CLINIC-BCN will lead the way for other similar centres to open in Spain to widen the Perinatal Mental Health services offered to new mothers.

Resources and Events

RCPsych Library

The goal of the College Library is to supply the resources members need to develop their practice. The collection is built completely on member recommendations, so if you cannot find something you need, just let us know.

We offer College OpenAthens accounts to members, which allow access to a wide range of databases and journals.

Databases – the College provides access for members to Medline, PsychINFO and Embase.

Journals - Lancet Psychiatry, the American Journal of Psychiatry and the BMJ.

Books - We have a physical library and members are welcome to borrow books, which we will send out in the post for free. We also provide access to online versions of the BNF and the Maudsley Prescribing Guidelines (new edition coming soon).

For any articles not available through our own subscriptions, we offer inter-library loans, finding what you need in another library and sending it out to you by email.

We also offer a free and unlimited literature searching service for those who do not

have the confidence or simply the time to search through the medical databases. This can also be combined with training for anyone who wants to refresh their skills.

You can find all these resources on the College website:

<https://www.rcpsych.ac.uk/usefulresources/library/archivesinfoservi.aspx>

Or get in touch with us directly:

infoservices@rcpsych.ac.uk

020 3701 2520

020 3701 2547

For parents and families...

8 new RCPsych Patient leaflets

A new set of perinatal mental health leaflets written jointly by perinatal psychiatrists, women with lived experience of perinatal mental illness, and their partners have been published by RCPsych.

These new titles are evidence-based and provide expert advice in simple, easy to read language.

They cover the following issues:

- [What are Perinatal Mental Health Services?](#)
- [Mother and Baby Units \(MBUs\)](#)
- [Postpartum Psychosis for Carers](#)
- [Perinatal OCD for carers](#)
- [Children's Social Services and Safeguarding](#)

- [Lithium in Pregnancy and Breastfeeding](#)
- [Valproate in women and girls who could get pregnant](#)
- [Antipsychotic Medication in Pregnancy & Breastfeeding](#)

For children...

1. [My Mummy & Me: All about Perinatal Mental Health Problems \(Royal College of Psychiatrists \(book\)\)](#)

by Narelle Mullins, Eleanor Ball, Paul Carter (ISBN: 9781911623007) from Amazon's Book Store.

2. [My mum's got a dodgy brain \(video\) \[https://www.youtube.com/watch?v=z_rHzI_IGBI\]\(https://www.youtube.com/watch?v=z_rHzI_IGBI\)](#)

Select upcoming events

8th World congress IAWMH (International Association Women's mental health Paris March 5- 8th)

<http://iawmh2019.org/>

AIMH (UK) 2019 Conference: Relational Trauma in Infancy

<https://aimh.org.uk/2019-conference-tickets/>