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Building Capacity in Perinatal Psychiatry Project: Skills Development Training Programmes; Impact and Assessment Report

Provide commentary and supporting documentation on the impact of the 'Building Capacity' skills development training programmes, on building workforce expertise.

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Section Headings

Summary Conclusion

Recruiting and retaining workforce remains a significant issue: Not all expanding and new services have fully recruited, delaying complete service development and putting at risk strategies to ensure service sustainability, an ongoing commitment if Long Term Plan ambitions are to be met.

Post-crisis demands on mental health services have intensified[1], with an expected rise in mental disorders: Supporting the mental health workforce to prepare and deal with the new reality is essential and all efforts should be made to equip perinatal consultants with the knowledge and skills required to support specialist services.

The masterclass programme is that support mechanism: These sessions support and develop specialist knowledge and skills; for those in-post there was immediate benefit to the service and alongside developing those critical clinical skills, attendees reported increased levels of self-confidence that comes with expertise, enhanced leadership and communication skills**.**

Expand top-up sessions: They are a very effective way of remaining responsive to the changing service landscape and are a good mechanism for assessing unmet need and delivering the skills required to challenge that.

Devolved nations: Continue to include a cohort from the devolved nations and the Republic of Ireland, ensuring PMH services across all nations are supported and well-developed; there are obvious cross-border learning benefits to this, but it also adheres to the College's responsibility to support all members and constituencies.

[1] Maternal mental health during a pandemic: A rapid evidence review of Covid-19's impact | Maternal Mental Health Alliance

1. Project Expertise

The Building Capacity in Perinatal Psychiatry Project was commissioned by HEE to deliver a series of tailor-made training programmes to support the expanding perinatal psychiatry workforce:

- To ensure that psychiatrists across all grades and geographical regions develop the knowledge, leadership skills and expertise to develop and deliver excellent clinical services.
- To build awareness of the specialist knowledge, skills and behaviours essential for delivering perinatal mental health services.
- To support the sustainability of specialist skills and services.

'Building Capacity, Psychiatry Leadership in Perinatal Mental Health Services: Bursary Scheme', was a project hosted and delivered by RCPsych funded by and in collaboration with HEE (and NHSE). A key component of the scheme was an in-depth and extensive academic training programme for consultants and senior trainees engaged in developing and providing clinical leadership and training support to specialist perinatal mental health services.

Following the completion of the bursary programme, the Project delivered a pilot programme for a credential in perinatal psychiatry and a submitted a report[2] evidencing the mechanisms required to deliver a specialist training programme. One of key features was a (replicated) academic training component, known as the 'Masterclass Series': a ten-day seminar programme, engaging participants with case study analysis and reflections, to consider approaches to managing complex cases and formulating strategies; these sessions brought together clinical and academic leaders in their field alongside expert-users to lead, facilitate and share knowledge and experience.

Such was the success of the masterclass series, HEE supported a roll-out of these training programmes accommodating three main cohorts: a non-consecutive 10-day programme for new consultants, a non-consecutive 5-day top-up programme for previous attending consultants and a 5-day consecutive programme for senior trainees[3]. The Project is in mid-delivery of the 2021/22 series, with procurement sign-off for another series in 22/23 tentatively agreed.

In all iterations of the programme the participant feedback has been excellent and is indicative of the Project's commitment to delivering high quality programming, with expert facilitation and delivery across all sessions, in support of developing and sustaining specialist mental health services.

This report provides an opportunity for past attendees to reflect on their experience and the impact the programme has had on developing clinical skills, and more broadly how this support has impacted ability to communicate and advocate on behalf of the perinatal service. It includes commentary from lived experience representatives and service leaders, specifically those who supported consultants and senior trainees to partake in the programme, were asked to submit their views on how this model has delivered specialist skills and how that supports, in the long term, sustaining specialist perinatal services.

[2] 'Evidencing a Credential in Perinatal Psychiatry: Finding and Recommendations'; submitted to HEE, 2020.

[3] The 2020/21 programme additionally supported a cohort of SAS psychiatrists working in PMH teams and allied mental health services such as Liaison Psychiatry and Crisis/HTT teams.

2. Delivery Model

The programmes are tailored to support workforce development, specifically designed to accommodate new consultants to perinatal psychiatry, consultants who have previously attended the programme and require 'top-up' support and senior trainees aligned to perinatal services. It's formatted to encompass the perinatal pathway and additionally address upskilling required to support delivery commitments as detailed in the NHS Long Term Plan.

Reflecting the training and development needs of the constituent groups, the programme embodies and emphasises the required clinical expertise, knowledge of various treatment modalities, the importance of co-production with women and their partner with lived experience and other relevant agencies/disciplines.

Principally the programme addresses the critical skills required to deliver perinatal mental health services:

- Enable and support new consultants in perinatal psychiatry in their assessment, understanding and management of complex clinical work
- Encourage participants to integrate current evidence into clinical practice
- Develop self-reflection skills
- Support leadership development
- Emphasise the importance of the perspectives of women, infants, partners and families throughout the perinatal pathway
- Improve patient safety
- Improve the experience of women and families in perinatal mental health services.

All sessions are guided by considered and relevant Intended Learning Outcomes, with mandatory and supplementary reading material[4].

Capacity

The Project has designed and implemented a training programme to develop the clinical, leadership and teaching skills needed for consultant psychiatrists to establish, develop, maintain and lead specialist perinatal mental health services:

The Project accommodates psychiatrists at distinct stages of development and provides a suitable setting for each identified cohort[5], ensuring space for maximum learning opportunities via full-group didactic teaching and break-out discussions focused on relevant case studies. These sessions are facilitated by expert clinical, academic and lived experienced representatives[6]. The design of the programme allows for and encourages the development of peer networks.

The target groups consist of:

Newly appointed consultants	poised to take up substantive posts

[4] Appendix I: detailed programmes for each constituent group, including the SAS cohort, with the full ILOs, reading lists and session breakdown by day.

[5] Initially each cohort was maxed at 25 participants; this was expanded at a later stage to include additionally up to 10 participants from the devolved nations.

[6] Speaker biographies; Annex III

Senior trainees	aligned to perinatal services, so enabling and supporting the development of this group to ensure availability and sustainability within the medical workforce
In-post consultants	past participants of the *new consultant* programme requiring 'top-up' support to deliver the commitments of the NHS Long Term Plan
SAS cohort (2020/21 programme)	in support of SAS doctors in perinatal psychiatry and other services for women of child-bearing potential in their assessment, understanding and management of complex clinical work

Application Process

The Project maintained an open and transparent application process[7] with commitment to the target workforce (new and in-post perinatal consultants, trainees allied to a perinatal service, and past participants who require top-up support for delivering LTP commitments), ensuring an equitable geographical spread, in support of all perinatal services.

Supporting Devolved Nations

The needs of psychiatrists from the devolved nations and Ireland were always tangentially accommodated where space on the programmes allowed for it. These training programmes, the Project has conducted through the College, are financed by HEE for psychiatrists to support the developments in perinatal services in England; training and education is a major function of the College. However, awareness of the inequity of access to training, necessitated formal consideration of how to support the devolved nations and Ireland to participate in the programme, not least to ensure the Project reflect the College's commitment and responsibility to support all its members.

This provided the Project an opportunity to work collaboratively with senior psychiatrists and health bodies within these countries to support their perinatal services. Workforce need across the nations are similar and bringing together all nations within a safe space to discuss complex issues like how to support refugee women, a transborder issue, and universal themes such as safeguarding and learning from serious case reviews, with expert (all nations represented) input to guide colleagues in making their services fit for purpose. A joined-up programme provided a platform for devolved nation colleagues to explore/discuss their ways of working with English colleagues, of particular benefit for those working in rural areas.

Working in a creative manner with trainers and adapting aspects of how the Project delivers sessions, accommodated greater numbers in the cohort without affecting the quality of the programme. Didactic training continued to be of high quality and accessed equally by all participants, inter-mixed with smaller break-out groups (6 groups of 6 people) critically evaluating papers in a circular fashion, so all papers are reviewed by groups throughout and feedback.

Specialists from all UK Nations and The Republic of Ireland were formally invited to partake in delivering the 2021/22 sessions[8]; participants from the devolved nations were charged a reasonable fee which supplemented the overall programme funding pot, effectively paying for the additional speaker slots.

[7] Sample application process/conditions, Appendix II

[8] Dr Giles Berrisford (England), Dr Roch Cantwell (Scotland), Dr Margo Wrigley (Ireland), Dr Jo Noblett (Wales) and Dr Julie Anderson (Northern Ireland)

Delivered

'Specialist treatment for mental health problems in the perinatal period necessitates specialised skills and facilities to ensure high quality treatment and support is delivered, as evidenced in a range of publications'[9].

The Building Capacity in Perinatal Psychiatry Project has delivered training programmes reaching circa 500 participants. This report focuses on the 10-day masterclass series, currently in its third iteration.

The masterclass series is a specialist skills development programme, delivering the training and development needs of specialist perinatal psychiatrists leading perinatal mental healthcare teams. The programmes provide focused and intense training and are now considered essential in ensuring the sustainability and longevity of perinatal services (*Section 4, Evaluation*).

The programme primarily engages new consultants in perinatal posts, senior trainees aligned to perinatal services and consultants who has previously attended the session and are invited to partake of the *top-up* offer:

- The current programme, 2021/22, commenced September 2021 with expected completion date October 2022; all sessions are being delivered virtually.
- The 2020/21 programme additionally accommodated two cohorts supporting Speciality Doctors; all session were delivered virtually.
- The 2018/19 cohort was part of the *evidencing a credential in perinatal psychiatry* workstream; all sessions were delivered face-to-face (Manchester and London).

Cumulatively these sessions have accommodated 308 participants.
Trusts that have engaged with the programme are listed and available; Annex II.
The range of material covered by session topic including mandatory and supplementary reading lists is listed and available for each programme (consultant, top-up, senior trainee); Appendix I

Target group breakdown

Snr trainee **- 96, plus 10 from devolved nations (expect 25 additional for October 2022 programme)**
Consultant **(new and top-up) – 141, plus 11 from the devolved nations**
Specialty doctors **- 50**

Value for money

It is beyond the scope of this report to confidently comment on the funding the Project has received per cohort and theorise and/or evidence the direct impact this has had on the numbers of women accessing specialist PMH services.

[9] NICE, Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance (2014) and Quality Standard (2016)

To determine actual live and non-live births (number of women accessing care within a discreet time frame) within a defined geographical range and correlate with a for-like range of participants from the programme, to extrapolate a meaningful figure of training cost per head against increased numbers of women accessing specialised care: This is a broader and separate research project.

The data the Project has collated and included in this report (community and specialist services participation, programme timeframe etc) could be used to inform a focused study on the impact of targeted workforce development supporting specialist services for the intended patient group.

3. Synopsis

This report provides a synopsis of session material developed and delivered to perinatal psychiatrists to develop their specialist skills in support of the perinatal pathway.

Annex 1: Senior trainee programme slide pack; example of material delivered
Appendix I: Complete programmes for each cohort; includes ILO's, mandatory and supplementary reading lists for each session

Perinatal Psychiatry Masterclass Programme: Aims

- Enable and support consultants in perinatal psychiatry in their assessment, understanding and management of complex clinical work
- Enable and support SAS doctors in perinatal psychiatry and other services for women of child-bearing potential in their assessment, understanding and management of complex clinical work (SAS cohort)
- Encourage participants to integrate current evidence into clinical practice
- Develop self-reflection skills
- Support leadership development *(Top-Up, New Consultant)*
- Emphasise the importance of the perspectives of women, infants, partners and families throughout the perinatal pathway
- Improve patient safety
- Improve the experience of women and families in perinatal mental health services
- Develop knowledge and understanding relevant to implementing the recommendations of the NHS Long Term Plan for perinatal mental health services *(Top-Up)*

The following key issues are fundamental to perinatal mental health care and were discussed and considered throughout the programme:

- Safeguarding children and adults
- Culture and difference
- Collaborative working with women, partners and families
- Women's own experience of perinatal mental disorders and care
- Legal issues

Top-Up Programme Themes:

These sessions focused on building and delivering on service expansion, as detailed in The Long-Term Plan:

ADHD - assessment and treatment in the perinatal context and implications for parenting
Autistic Spectrum Disorders in women
Eating disorders
Partners; assessment and signposting
Couple and family interventions
Compassionate Leadership
Infertility and fertility treatments
Premenstrual syndrome and menopause
The NHS Long Term Plan implementation; expanding service delivery

New Consultant Programme Themes:

PMH service development across the UK and Ireland; Assessment and communication
Lived experience, co-production, partners
The infant
Risk and Safeguarding: adults and children
Prescribing in the perinatal period
Personality Disorder
Legal and Forensic
Pre-pregnancy Counselling, pre-birth planning; addictions
Eating Disorders; pregnancy loss, infertility and complex pregnancy related issues
Leadership and service development

Senior Trainee Programme Themes:

The National Picture, Assessment and communication, the lived experience of women and their partners,
Mental disorders in the perinatal period, Pre-birth planning
Safeguarding, Prescribing in the perinatal period
Personality Disorder in the perinatal period, Psychological treatments, Interpreting the evidence in relation to prescribing in pregnancy
Risk, Evaluating the infant, Substance dependency and misuse, Leadership

SAS Programme Themes:

The National Picture: Assessment and communication
Lived experience, co-production, partners
Mental disorders in the perinatal period
The infant
Risk and Safeguarding adults and children
Prescribing in the perinatal period
Personality Disorder
Pre-pregnancy Counselling, pre-birth planning. Addictions
Eating Disorders. Pregnancy loss, infertility and complex pregnancy related issues
Mental Health law, Mental Capacity, Court of Protection. Advance Directives.

A specialist training programme for perinatal psychiatrists, encompassing the perinatal frame of mind – thinking about all women of childbearing potential and ensuring perinatal consultants are equipped to diagnosis not just onset symptoms but recognise recurrence, understand and deliver a biopsychosocial model of delivery in support of women and their families in the perinatal period: clinical presentation, family history prognosis and long-term follow-up.

4. Evaluation

Two surveys were formally sent: to consultants and trainees who have participated directly in these programmes; and to those who have supported participants to attend. The first survey was sent to over 200 past participants of the masterclass programme, with circa 60 completed surveys returned. The second to service leaders, circa 50, with over 20 responses returned (*section 3*).

4.1 Participant evaluation

They were asked a series of questions requiring commentary and thoughtful analysis, not just regarding the session topics and their increased clinical knowledge and ability, but also on any self-directed behavioural change following participation on the programme, such as improved leadership and negotiation skills. They were also asked to reflect upon changes to the service, how they support the PMH team and communicate the work of the team to the wider network of aligned services. Throughout the survey, and explicitly in answering question 3, they were asked to comment and evidence (where possible) the experiences of women who had/are receiving support within the perinatal service.

To ensure a rounded approach to the survey, the Clinical Leads/Facilitators were asked for their comments on the experience of delivering these programmes. Including the benefits of formally expanding the programme to support the needs of psychiatrists from the devolved nations and Republic of Ireland; to first and foremost ensure equity of access and improve learning across borders and for participants to benefit from sharing experiences and discussing different models of service development.

How did your participation on the programme change or improve your clinical practice?
How did your participation on the programme contribute to the service experience by women, infants, and their families?
If possible, can you obtain and include a recent lived experience comment on service provision and personal experience
How did the programme impact your supervision and management of the perinatal team and the development of other psychiatrists?
Did you share this learning in a formal or informal setting?
How did the PMH team and the service benefit from your participation?

Do you consider the masterclass programme essential to sustaining and supporting specialist services; can you provide commentary in support of your view?
Have your leadership skills been enhanced by the programme; if so, how?
Has the programme equipped you with the skills to demonstrate to your senior leadership, Trust, commissioners - the progress, unmet need and need for further investment (to perinatal services locally)?
If there are other subjects you think should be included as part of a future programme, please comment
Please comment on the applicability of this model, for other sub-specialities, as a means of building capacity and capability. **(Section 5)**

How did your participation on the programme change or improve your clinical practice?

The responses were very clear on three critical points: the masterclasses were enormously successful in building a specialist knowledge base; building confidence in clinical and decision-making skills; and providing space to establish a network of peers. Those who attended one of first masterclass series, commented their network is still functioning and vital for discussing service support and evidence-based practices, which was invaluable during the lockdown periods for peer support and exchanging ideas to practical delivery issues that the pandemic had thrown into disarray.

As one commentator succinctly put it *"It gave me a secure base of knowledge and understanding from which to work and continue to build my skills, competence and confidence".*

The sessions provided a safe space to conduct complex clinical discussions. Focused sessions on eating disorder and ADHD in the perinatal period, prescribing and discussion of risks and benefits of medication in pregnancy and breastfeeding, were all consistently and repeatedly reported as invaluable sessions - with the time and expertise allocated considered apt in terms of the intricacy and sensitivity around these subjects.

Around the broader issues of supporting services, family interventions and sessions on safeguarding, these were considered extremely beneficial, notably as participants saw their ability and sense of responsibility as leaders in these forums/discussions improve greatly, due to their participation.

The overarching sense from responders was the discrete sessions of the programme delivered as whole have been essential in developing them individually as specialist clinicians and leaders who can better challenge and advocate at critical points in the system, such as negotiating and communicating with senior trust management and commissioners, on behalf on their team and in support of specialist services.

"The masterclass sessions (and bursary programme) allowed me to become a perinatal psychiatrist. The masterclasses expanded my horizons, enriching my clinical skill by learning from perinatal experts. The masterclasses boosted the core clinical elements of perinatal mental health, for assessing, formulating and managing perinatal mental health problems from preconception onward but went beyond that, thinking about the whole context of the woman and her infant, their

relationship with each other, their family and their social circumstances. They improved my knowledge of what is known, but also of what is unknown."

How did your participation on the programme contribute to the service experience by women, infants, and their families?

General agreement from all responders that the intended patient population benefited in an immediate sense from the overall higher level of expertise derived from participation on the programme.

Improving services for women and their families by considering how to ensure services are more integrated with clear pathways to aligned services, required additional thinking about the partner and family network at this critical time. The benefit of attending the masterclasses was most clearly exemplified within new and expanded teams: the increased level of awareness of common issues in the perinatal period and sharing that knowledge with the wider team, had a noticeable impact on improving initial assessment.

A common thread throughout the survey and most frequently commented on in this section; participants having a better understanding and ability to recognise specific perinatal issues within a broader clinical setting - the ability to better diagnose in the perinatal period.

Many commented that the masterclasses helped them to recognise the importance of a more compassionate approach to women and their families and have since adapted their own behaviour accordingly when assessing, planning and delivering care and support. These sessions have also led participants to think more meaningfully about external influences and personal circumstances that can affect health outcomes and be mindful not to perpetuate ethnic health inequalities by recognising and respecting culture and difference in planning care and supporting families.

An improved ability to better assess the parent-infant relationship following sessions on mother-infant interaction, infant psychology and understanding the importance of engaging and supporting the wider parent/partner/family network to achieve better outcomes for women and their babies.

Prescribing in the perinatal period, a complex subject, with responders clear they felt more confident in discussing the 'details around medication management with women than before'; the ability to discuss pregnancy and psychotherapeutic medication was much improved, with increased knowledge and awareness of the evidence base and latest research for prescribing during the perinatal period.

The top-up sessions focus on IVF, ADHD, psychological interventions and fertility were extremely well received in support of practice development and increasing confidence in building relationship with patients. These additional sessions also informed team development and responders commented on disseminating this knowledge with colleagues and across relevant teams.

Most all responders agreed these sessions helped them to develop their service to become more fully integrated, person and family-centred: the use of more inclusive language when referring to partners; an new/renewed emphasis on building relationships; a better understanding of and desire to provide holistic care and planning for women and their infants; fundamentally, a better understanding of the experience of the perinatal service user, that being the direct experience of the mother and the wider impact on the partner/family network.

"I and the senior leadership team have been much more mindful of the partner and curious of their experience. There has been a feeling this past year that we are slowly steering a course of raising the expectation of the PMH team and shifting the parameters – from mother and infant to "mother, infant, partner and families". That our routine processes can enable and establish a space for the voice of the partner - CPA and supervision sessions. This is not an "add on" – a tick box of numbers seen - but a mental shift, a dropping of a boundary and an opening to different creative series of conversations. Valuing the partner and what they bring. Allowing families to think together, identify strengths and difficulties, to support each other and respect that we are entering into their system (not them into ours). The couples and family interventions framework session has I think helped broaden my vision and articulate something that feels so intuitively right and important."

If possible, can you obtain and include a recent lived experience comment on service provision and personal experience.

Direct quotes obtained from mothers who are/have received care from a perinatal service, for the purposes of this report.

"I am so grateful and thankful that this service exists. The support I received was amazing, in a time of feeling overwhelmed and scared. I was surprised to learn that it had only been running around one year when I was referred, as the team were well-organised, there were systems/plans in place, it was all very professional (but also appropriately friendly) and seemed to be a "well-oiled machine". I cannot praise the Perinatal Mental Health team enough."

A comment from a service user who was under the team for 2 years during a previous pregnancy and attended for pre-conception counselling. She referred to the team "*getting me through*" the difficult period and giving her hope that she may survive a future pregnancy despite severe OCD and dreadful intrusive thoughts.

A young woman with severe postnatal anxiety and obsessional thoughts who was struggling to bond with and feed her baby because *"I was so scared, and I thought you would all think I was a bad mother and take my baby away, I wasn't sure I even wanted the baby, but everyone has been so kind and supportive and now I know I'm going home with the extra help I need".*

''Thank you for all you have done for me. The support, the time, the help. I feel I've come on a long way since the beginning. Thank you for believing in me.''

"I owe my life to this amazing service, I didn't realise how hard life had gotten until now. I'm still not 100% but I'm 90% of the way. [The staff] were very caring and helped me realise things weren't as bad as I thought in my head. Really not sure where I'd be if I didn't have this help."

"Hi Dr X. Really hope you are well, just wanted to send a little message to say Happy New Year. I've been thinking about you and just wanted to let you know that my baby and I are doing great. He's turned into such a little character and is really thriving. I'm definitely loving this stage. He turned one last month (can't believe it!) and it's just crazy to think how far I've come from the place I was in during pregnancy so just wanted to say thank you again as that's mainly down to you and your team and the support you gave me. It's so appreciated every bit of support you provided especially given the pressure on the NHS during this time and I will never be able to truly express the difference you made. Hope you had a lovely Christmas, enjoy some pics of (baby) so you can put a face to a name!"

Additional secondary sources reflect upon cases of women who are pregnant with high levels if anxiety (in some cases following an initial incorrect diagnosis) for both the woman and partner. Referral to the PMH team leading to an assessment, care plan, medication management (if required) and peer support activated, resulted in reduced anxiety, a calmer pregnancy and confidence that if she does become unwell the care she will receive will be prompt and reflect her pre-birth decisions. A patient with postnatal depression on several (GP prescribed) antidepressants was then referred to the PMH service, the assessment resulted in an alternative medication plan which saw quick improvement; '*the patient expressed gratitude for the input of the service, she felt she had been listened to and understood'.*

Both primary and secondary examples of patient experience testify to the value and regard the users have of the perinatal service and team they've interacted with, providing positive feedback.

How did the programme impact your supervision and management of the perinatal team and the development of other psychiatrists?

The overwhelming consensus from responders is the masterclasses have provided the expert knowledge, competence and confidence to share learning in informal settings and partake/lead formal training sessions (within their respective and across teams) and provide supervision.

"*It has been integral to my ability to provide good supervision as it has given me a knowledge framework that I can use to help to develop my trainees objectives and competencies. It also gives me credibility as a trainer*."

Participants have commented on sharing up-to-date knowledge with colleagues, GPs and other medics. Delivering bespoke training to allied professionals, such as training sessions for early intervention for psychosis, to home treatment and liaison teams, and receiving excellent feedback.

Many have commented on directing MDT and case-based discussions to ensure the team is informed and taking note of infant health, family environment and the wider network, to better understand the broader dynamics at play, to support and deliver better care planning.

The greater impact of specialised training from supporting speciality and associate specialist doctors and senior trainees, are the principles of perinatal psychiatry not only relevant for work in a perinatal mental health team but benefits the wider health system. Supporting CMHTs or Liaison Teams though formal and informal teaching sessions and/or being able to advise the team of, for example, "*odds of recurrence of major affective disorder episodes during and postnatally in women with bipolar affective disorder if left untreated, in the initial first assessment before referral occurs, is critical."*

In summary, responders where very clear and unanimous that the programme has helped them to understand much better the role of the other members of the team which has improved their ability to teach, support and supervise. They are more confident in their ability and skills as a perinatal psychiatrist and are willing and actively demonstrating their support in developing other psychiatrists, the team and aligned teams in recognising cases that require support and referral to the PMH team.

"I think the whole format of the first Masterclass and these follow-on Masterclasses have given me the confidence to offer supervision and manage the complexities of working in a perinatal mental health service. I am now doing individual case management/supervision sessions with all care coordinators in the team, I think this too offers something of compassionate leadership, holding a

reflective space and opportunity to think, have support holding risks and the emotional burden, discuss clinical judgements and plans, as well as development and learning. It has had a positive impact on clinicians feeling they are able to manage their caseloads, discharge when appropriate and clinicians make the time to do so every 8-12 weeks. The need to grow with others, alongside others, to share this learning, and then learn some more is infectious. I will have in April a perinatal ST trainee. I have developed a locum staff grade doctor working with the team now for 9 months. I have had SPRs do Special Interest days. Consultant colleagues in both EIP and CAMHS have requested expertise in perinatal as one of their learning goals and we are working together to set about achieving this."

Did you share this learning in a formal or informal setting?

Most all commented they are regularly engaged in sharing their perinatal knowledge in informal sessions through training on specific topics with aligned services, examples provided include –

- A talk on 'Prescribing in the perinatal period' for a local group of GPs
- A perinatal training package delivered to GPs, obstetricians, maternity services, health visitors, IAPT staff, crisis & liaison teams, adult CMHTs, CAMHS staff & AMHPs
- One participant recorded short introductory modules with the ICS available to staff online and aimed at new starters in acute teams
- A lecture on perinatal mental disorders to a GP teaching forum

While there was less reported opportunity for formal sharing, many did comment that they are undertaking both: sharing formally at medical CPD sessions; informally on a regular basis with teams during MDT discussions; and generally, through the established avenues of education, supervision and clinical discussions.

There were many who felt it incumbent (having experienced this comprehensive training programme), to improve the understanding of teams/services who come into contact with women of childbearing potential of the effect that their mental health may have on pregnancy and parenting, and vice versa, and important overall for ensuring women's access to health services and specialist support. Sharing knowledge and expertise on the seriousness of perinatal mental health and providing extensive signposting of indicators through training sessions with the full spectrum of health care professionals (medical, physician associate and midwifery students, AMHP's, junior doctors, GPs, Obstetrics, Speciality and associate doctors, pharmacists, CMHTs) as well as within their own teams and supporting and advising consultant colleagues, was a commitment nearly all responders were enthusiastic about.

How did the PMH team and the service benefit from your participation?

The immediate and often repeated comments reflect on enhanced skills through improved knowledge and competence, supporting the team with clinical and non-clinical updates on recent advances, normalising safeguarding discussions, structured pre-birth planning meetings and so on - all of which support the service and improves outcomes for women. This was commented on in various ways by nearly all the responders. However, the additional personalised accounts of the change to services and teams, in different settings and scenarios, provide an interesting range of examples testifying to the change in mindset and behaviour of those participants, benefitting the development of the service.

- One commented that their participation led to them actively step-up. With the temporary absence of a consultant which would have normally resulted in a locum contract, bringing with it perhaps a sense of uncertainty and variability, the service and team benefitted from the stability, sense of continuity and expert knowledge that their newfound confidence and ability brought.

- Another reported arguing strongly and successfully for a perinatal service, when there was no appetite to start one locally. They felt more knowledgeable (specifically on the risks of not having one) and confident to argue strongly on why one was necessary. The sessions on leadership and navigating the political sphere, gave them the language and ability to influence commissioners. The programme was instrumental in developing their skills to negotiate with decision makers on how to address unmet need, through specialised service provision.

- A participant commented that staff at the trust are more aware of the PMH team and what the service does and how it supports women. This general awareness is becoming embedded in the wider delivery setting; the knowledge that a team with specialist advice and support is available and can be consulted when pregnant and women of childbearing age are admitted.

- Another described embedding the ethos of the perinatal frame of mind, keeping the mother infant dyad at the heart of the service and embracing compassionate leadership, after finishing the masterclass programme. Purposefully raising awareness and educating teams that they joint work with about perinatal risk, preconception health and counselling. The community team is working towards the long-term plan ambitions by changing the focus of service delivery through training, development and recruitment to deliver more evidence based psychological interventions, embedding systems to support working with women up to 24 months and screening partners. The peer network and experts they met through the programme continue to be a source of peer supervision, help and support when challenged with clinical work. Without the masterclasses they would have been poorly equipped to meet the complexity of supporting women in the perinatal period.

Do you consider the masterclass programme essential to sustaining and supporting specialist services; can you provide commentary in support of your view?

From the 58 responses received, an unequivocal 'Yes': the responses all considered this programme vital to developing and maintaining clinic competence and sustaining specialist services.

Perinatal psychiatry is a specialised area of psychiatry with little formal education available other than this programme: 'general' psychiatry does not equip clinicians with the specific knowledge to advise or deal with women in the perinatal period for multiple reasons, most notably medicolegal, prescribing (in the perinatal period) and safeguarding. It is a crucial stage in both the mother and baby's life; the skills and ability required to 'intervene' in a positive way during this time can produce long-reaching effects.

New psychiatrists to perinatal can be daunted entering a highly specialised field such as this. The masterclasses have really helped to build confidence, ensure consultants are learning and applying evidence-based practice and are kept abreast of new developments. With the added benefit of long-lasting peer support from the cohort network, made possible through attending the programme.

As a specialist area, training requires a high level of engagement and expertise to ensure a valuable experience. The "genuine enthusiasm" of the programme leaders was "infectious" and the expectation of active engagement by participants rather than passive attendance was considered a

positive, “an incentive to engage and work harder”. It was also very useful to have protected time from work to focus on developing clinical and leadership skills.

“This was an innovative programme to provide an additional opportunity for updating knowledge. However, having attended two sets of masterclasses over the last 4 years, I believe they are essential for providing a high standard of care and should be replicated in other sub-specialities as well.”

“*I absolutely and strongly recommend masterclass programme to continue for years to come as it has tremendous value for every professional related to perinatal services. Considering many perinatal services across the country is relatively new, as a service there is so much to learn, adapt, adopt and mould the service along the way, it becomes very important to keep up to date with the progress happening in every aspect of perinatal services and the masterclass programme is a "One Stop" solution, where most of the aspects are covered and discussed in both qualitative and quantitative way, by some of the esteemed and knowledgeable professionals involved in perinatal or related services. Having worked in perinatal services for about three years now and prior to that not having much exposure to managing women during perinatal period, looking back, I can say that attending Masterclass at the beginning of my job as a consultant psychiatrist in a perinatal team in 2018 helped me immensely not only to be more confident in my work but also to allay some of my anxieties, related to prescriptions and a few other aspects of perinatal services. The top-up sessions in 2020 only consolidated my learning and made me a better perinatal psychiatrist. I have derived so much benefit from the programme that I would like it to be continued every year as an update for us Psychiatrists working in perinatal services as things keep evolving and at times changing in perinatal services*.”

By all accounts the masterclasses have been a very powerful tool for enhancing knowledge and learning and as a model has the potential to be as valuable for other sub-specialities, especially in a period of service expansion. Suitable and accessible training in specialist services is not always available and that a series such as this was able to cover such a breadth of topics was vital for new consultants in the field.

Have your leadership skills been enhanced by the programme; if so, how?

A majority ‘yes’ to this survey question: participants over and over comment on increased confidence in their knowledge and skill and ability as a leader; helping them to be more engaged with key stakeholders, trust management and commissioners in advocating for specialised care and on behalf of perinatal services.

- Chairing MDTs, contributing to management decisions, supervising junior members of the team and ensuring ‘baby in mind’ ethos at team meetings and with other colleagues.
- More confident about medication management and more competent in liaising with other teams/professionals within/external to the trust.
- Developing clinical leadership skills and a better understanding of the importance of clinical leadership in strategic planning and service delivery.
- Insights into the benefits of inclusive leadership and increased ability to liaise with other colleagues across boundaries.
- Developing as a leader has meant using formal supervision and team spaces to acknowledge the emotional landscape is exhausting – COVID, suicide, remote working, personal circumstances – and being able to recognise and celebrate the work we do together and value each other.
- The masterclasses have significantly improved knowledge of perinatal mental health clinically and at service level. Increased confidence as service leaders which supports and maintains clear,

robust pathways and cohesive working relationships with partners in maternity, health visiting, social care, primary care, IAPT and across mental health services.
- Better understanding of how important senior engagement is for the sustainability of the perinatal service in funding discussions.

A comment summarised in one scenario the justification for skills-based development programmes that in addition to developing specialist knowledge and behaviours, seek to build confidence for those difficult clinical-led decisions on safeguarding and prescribing.

"My increased knowledge has enabled me to show leadership in patient scenarios with perinatal focus and to encourage all adult psychiatry colleagues to be aware of child-safeguarding needs. For example, I am currently in rotation on an acute general adult inpatient ward. A patient was admitted who was in the final weeks of pregnancy, had a diagnosis of emotionally unstable personality disorder and was dysregulated, requiring seclusion. There was a lot of anxiety about how to manage the situation. I was able to be confident in prescribing rapid tranquilisation (whilst my consultant colleague felt less confident) and subsequently took a lead in making a plan ahead of the birth."

Has the programme equipped you with the skills to demonstrate to your senior leadership, Trust, commissioners - the progress, unmet need and need for further investment (to perinatal services locally)?

Its equipped participants to better communicate and navigate the administrative systems governing mental health services: the skills to negotiate on behalf of their service with an array of senior figures; the ability to express the commitment required and the serious challenges of delivering a specialist service and the impact when those services are not present or functioning, the high risk and unmet need of mothers, infants, families; and the ability to confidently demonstrate progress, to maintain pressure for supporting/expanding (when required) the service to continue to meet need and develop further to address unmet need.

"*The masterclasses have given me the knowledge and confidence to speak directly with our trust senior leadership team. I have ensured that MBU accreditation was celebrated, and patient feedback has been shared with the trust board. I have been able to engage to the extent that perinatal now has an Associate Medical Director (me) and I am an integral part of our SLT, meeting with trust SLT and commissioners, with a clinical voice showcasing the progress of the service, and successfully advocating for funding to meet the perinatal long-term ambitions and sharing our good practice*."

"I am looked upon with high regard within my trust and commissioners and they always seek my advice and guidance with regards to the service development as they visualise the positive of our service on patients. My commissioner said in the last contact meeting "Everything about our perinatal service has always been positive."

Most responders concluded they feel improved personal ability and increased confidence in advocating at all levels (including with senior leadership and trust management) on behalf of their service, with some explicitly undertaking wider strategic roles in order to influence service development. A minority remain cautious on maintaining secure funding but feel more aware of these issues and the commissioning/service development internal decision-making pathway and are more capable of negotiating and partaking in those discussions.

If there are other subjects you think should be included as part of a future programme, please comment.

- On expanding services and developing teams: further guidance on the commissioning process and methods for securing investment in perinatal services; supporting the development of new aligned roles for expanding services with relevant job descriptions
- Support with reaching and providing help to women (in the perinatal period) who are victims of domestic violence
- More targeted sessions and guidance on reaching and supporting minority groups and the LGBTQ+ community
- More support on infant mental health
- Further support with substance misuse and rehabilitation psychiatry in the perinatal period
- Expanding the programme to accommodate the autistic spectrum disorder and young people; recognise this is considered a less severe mental illness and beyond the current diagnostic parameters, but incorporated into a session with a case vignette and space to discuss types of interventions, could be considered part of a broader preventative measure/initiative
- Focused session on the intersection point of perinatal and aligned services with further exploration/explanation of roles and responsibilities and clear support pathways
- Implementing a research strategy as part of service development

4.2 Programme Development & Delivery: Clinical Lead/Facilitator Comments

The Clinical Leads/Facilitators were asked to comment on delivering these programmes, including discussing the benefits of formally expanding the programme to support the needs of psychiatrists from the devolved nations and Republic of Ireland.

Dr Liz McDonald, Consultant Perinatal Psychiatrist, Visiting Lecturer Tavistock and Portman NHS Foundation Trust
Clinical Lead and Facilitator 'Building Capacity in Perinatal Psychiatry' Project, Masterclass Programme
Lead Developer 'Consultant and Senior Trainee Masterclass Programmes'

The **senior trainee** week-long programme was developed to ensure the core knowledge required to work in this role within a PMH team was met. Therefore, many of the common disorders were explored as well as assessment, pre-birth planning, psychological therapies and prescribing. The needs of the infant were addressed through sessions devoted to assessing the infant, attachment and safeguarding. The care of and voice of the woman and her partner was addressed in explicit sessions as well as being embedded in the other topics. The programme is designed to include didactic teaching, critical appraisal, self-reflection and group work. The trainees are always very engaged and lively, enjoying the immersive setting, and the mix of teaching styles and breath of experts who contribute to the programme delivery. They develop lasting relationships with each other, keep reflective journals and commit to the training of others within their teams, and other agencies. This week-long model of delivering the training appears to work well for this group as it is relatively easy for them to get study leave and be absent from clinical work. It also means that they are equipped early in their placements with the tools to do the job. We accept trainees who are in full placements in PMH teams as well as those doing one or two 'special interest' sessions. This latter group bring extra clinical support to the PMH teams and in many cases leads to the trainees seeking longer placements within the teams.

The **new consultant** programme is designed to meet some of the myriad needs of consultant psychiatrists working within the PMH setting. The participants include those who are new and younger consultants for whom perinatal psychiatry is their first post to more experienced psychiatrists who have switched to perinatal from another sub-speciality or CMHT post. We have also had several child and adolescent psychiatrists who have taken up perinatal posts attend the

programmes, and this training is invaluable to them. The course is run over several months. This allows the participants to develop their thinking in a meaningful way as they acquire new knowledge and skills. The course is designed to deliver new information but much of the programme is designed to ensure that they develop their critical appraisal, self-reflective, communication and listening skills. They are asked to look at their practice from the point of view of the woman, the partner, the infant and family as well as that of their teams and other agencies. Compassionate leadership and self-compassion are models that are encouraged and discussed. They form lasting relationships with each other due to the considerable amount of group work and their own desire and motivation to keep learning and to have peer support. They are usually very engaged and grateful for the programme which is an unusual opportunity for learning at this stage in their careers.

Devolved nations and Ireland: Over the years we have tried to support the learning of trainees and consultants in the devolved nations and Ireland. If there has been spare capacity, we have offered these places to the other nations. However, as the popularity of the masterclasses has grown, we are usually over-subscribed. With two trainee sessions a year we do manage to offer all appropriate applicants a place.

This year following demand from the other nations we decided to increase the group size by 10 and to support this we took on another facilitator, Dr Roch Cantwell. These participants are funded by their own nations. We have made changes to the way the programmes are delivered to ensure that the participants continue to have sufficient and high-quality group work which is an essential and popular part of the programme. The senior trainee programme worked very well in this regard and the first two days of the consultant training have gone smoothly. It is more demanding for the facilitators as we try to get to know the individual participants and what their needs are. I think we will refine what we are doing as we go along to improve the experience for the attendees.

Dr Lucinda Green, Consultant Perinatal Psychiatrist
Clinical Lead and Facilitator 'Building Capacity in Perinatal Psychiatry' Project, Masterclass Programme
Lead Developer 'Top-Up Masterclass Programme in Perinatal Psychiatry'

The Top Up programme was developed for consultant psychiatrists who had already completed the 10-day New Consultant Perinatal Mental Health Masterclass Programme.

This 5-day programme focused on subjects relevant to implementing the NHS Long Term Plan within perinatal mental health services. There were also some sessions covering subjects not previously covered in other perinatal mental health training courses. These included ADHD and Autistic Spectrum Disorders in women, and psychological and psychiatric care for women and partners having fertility treatment. There was also a focus on compassionate leadership and service development. Participants were very engaged and valued the opportunity to have small group discussions with psychiatrists from across England to share good practice. They commented on how relevant and helpful the learning was for the development of their services and how much it would potentially improve the care of women and families in the perinatal period.

Dr Roch Cantwell, Consultant Perinatal Psychiatrist. Lead Clinician, Perinatal Mental Health Network Scotland. Vice-Chair, Perinatal and Infant Mental Health Programme Board
Clinical Lead and Facilitator 'Building Capacity in Perinatal Psychiatry' Project, Masterclass Programme
Lead Developer for devolved nations 'Consultant and Senior Trainee Masterclass Programmes'

The inclusion of clinicians and materials from all 4 UK nations and Ireland has enriched the programme. It has exposed participants to a wider understanding of service models and design and broadened the small group discussions, which are an essential component of the learning. It challenges participants to think in a more sophisticated way about how to meet patient need, which I consider the purpose of a course designed to foster leadership skills.

4.3 Devolved Nations; Ensuring equity of training opportunities

Scottish Perspective

The Project has been able to accommodate requests for Scottish trainees to attend the masterclass series and has been funded and supported by NES and SG. Scottish trainees who attended the training have had nothing but praise for the quality of the organisation, teaching and content. While development on a separate programme in Scotland continues, it is unlikely to recreate the extensive psychiatrist-specific suite of learning that the Project has developed. For that reason, it is hoped that a Scottish contingent may continue to benefit from involvement in this programme.

Northern Ireland Perspective

This programme has been very accommodating in facilitating training for NI consultants and trainees. Funding from the PHA to enable access for consultant and senior training has additionally enabled a close working relationship with senior clinical leaders from across the 4 nations and Ireland. Our joined-up support for the programme and invitation to partake in 'service development' discussions is very welcome and further supports the development of specialist services and aligning good practice and sharing of (intellectual) resources.

Welsh Perspective

The massive expansion in the perinatal workforce in recent years across the UK has resulted in huge problems with a lack of a trained workforce. The Building Capacity programme is a fantastic response to this challenge and has provided vitally needed training to the new workforce. These programmes are now seen as a model for what is needed across other professions which have also seen an expansion in their workforce. With limited funding available, it is difficult to conceive of Wales developing and delivering as complete and strong a training program, and so the invitation to participate in this one has been extremely beneficial to the trainees and consultants new to perinatal. As a model, this is the optimal way forward to ensure all women can expect to receive the same level of skill and expertise from every PMH service. In summary, Wales has benefited enormously from the work of the Project team who have directly sought to include all nations of the UK given the limitations of funding.

5. Building capacity and capability

Please comment on the applicability of this model, for other sub-specialities, as a means of building capacity and capability

Any area of medicine that requires specialist skills and knowledge, this is a very efficient and effective way of communicating with and teaching a group of clinicians. All received comments reported in various ways how indispensable a training programme this has been and were united in considering it an excellent model for developing skills and building interest in other sub-specialities. Replicating this platform by providing a comprehensive programme with expert knowledge delivered through didactic teaching sessions mixed with facilitated break-out discussion forums - is a winning formula.

Disparately located specialist clinicians can learn so much from each other and from leaders/innovators in the field with this type of model; programmes of this nature help to ensure good practice, capable practitioners and supported teams, resulting in well-resourced and skilled specialist services.

Responders considered specialist services including forensic, neurodevelopmental, eating disorders, substance misuse, liaison and addiction psychiatry, and IPTS/ psychological services would specifically benefit from this model of skills development

"*The master classes changed my career, my practice and my joie de vivre. They allowed me to become skilled in a way that I could not have done without them and were a springboard into developing expertise. I believe that similar programmes for other specialities would be equally as valuable. They allow a greater immersion in the subject, and a relationship with other learners and experts that is extremely fruitful. The masterclasses should be lauded as an exemplar of what can be achieved. What a gift and opportunity they were. I feel so lucky to have been able to attend them, and proud of what they have allowed me to achieve personally, and for our service."*

6. Recommendations

Is there evidence to support a recommendation for embedding skills development programmes as a key component of sustaining specialist services?

A second survey was sent to service leaders (circa 50) who have been involved in the Building Capacity in Perinatal Psychiatry project over the years. The project was keen to reflect their views as: many of the consultants and trainees that have participated in the multiple iterations of the programme have come from their services; they've participated directly in the programme by providing expert facilitation of many sessions; and have a first-hand account of the impact this type of skills development model has on service delivery.

The survey comprised of five statements/questions; the responses are anonymised and interwoven to reflect a short statement indicative of the answers received.

- The masterclass sessions: A meaningful tool to improve clinical practice; and positively impact supervision/management of the perinatal team and development of other psychiatrists?
- How has the service benefited from consultant(s) attending these sessions?
- Do you consider these programmes an effective way of developing specialist skills, and therefore critical to maintaining and sustaining specialist perinatal mental health services?
- Has the programme equipped past participants with the skills to negotiate and advocate on behalf of the service when communicating with senior leadership/Trust mgm/commissioners, on the progress, unmet need and need for further investment?
- How should future programmes be developed to continue to meet need and be capable of delivery in the face of chaotic circumstances (considering the two years we've spent in pandemic mode)

Responses:

The masterclass sessions: A meaningful tool to improve clinical practice; and positively impact supervision/management of the perinatal team and development of other psychiatrists?

The perinatal masterclass series has been an enormous success and invaluable in supporting consultants and new trainees in developing their knowledge and skills, and their confidence in caring for and managing patients during the perinatal period. The most obvious difference is a greater understanding of the perinatal frame in mind, parent-infant interactions, specific medication and safeguarding aspects of perinatal.

It has equipped participants with the necessary knowledge, via reflections and clinical support and advice from senior clinicians, service leaders and academics, to the extent that it would be surprising if a routine or rare clinical situation has not been discussed throughout the course of the programme. The sessions while intense present a mix of methods (presentation, discussion, reflection and group work) to allow for variety and supports sustained attention.

Testimonials from senior clinicians who supervise colleagues who have attended the programme, comment on their ability as being "better able to formulate their cases with enhanced biological, psychological, social and cultural aspects, aetiology, holistic treatment and care, within the formulation".

It's been of enormous value in creating specialists and clinical leaders who are well prepared to provide a better service than previous generations of patients were offered, and it is hard to see how a programme of this nature with the "enormous experience and knowledge of the trainers leading this course could be bettered".

How has the service benefited from consultant(s) attending these sessions?

The programme has been enormously valuable in supporting clinicians with managerial and team leadership skills during a time of significant expansion of perinatal services. Their enhanced skills have supported the expansion of the specialist workforce, the multidisciplinary team, especially colleagues who are new to perinatal mental health.

The sessions have been critical in developing the medical workforce and enabling sharing of learning with the wider MDT. Perinatal mental health is a fast-changing field and it's essential that perinatal consultants keep up to speed with the latest research and service developments.

For new consultants and consultants new to perinatal psychiatry it has provided an excellent overview of the specialty and addressed key aspects of clinical practice that are not accessible elsewhere. It has supported them with understanding the wider commissioning landscape and enabled them to contribute more effectively to service development.

Do you consider these programmes an effective way of developing specialist skills, and therefore critical to maintaining and sustaining specialist perinatal mental health services?

An unequivocal yes: They are an excellent way of drawing people towards the specialty and improving retention. The programme is extremely well conceived and structured, in its breadth and depth, and it should serve as an excellent model of specialist training for other subspecialities.

The mode of delivery through numerous masterclasses, supervisions, opportunity for group work and presentations have been valued greatly by those who attended. They provide a real breadth of knowledge from essential updates on the optimum use of medication to what women and their

families are asking for in terms of services and ongoing care. The course leaders are very careful to always consider the needs and views of the women in their care as well as their partners and include those voices in the development of the programme, which is both appropriate and necessary.

It is important and essential to continue this programme as perinatal services continue to expand.

Has the programme equipped past participants with the skills to negotiate and advocate on behalf of the service when communicating with senior leadership/Trust management/commissioners, on the progress, unmet need and need for further investment?

Psychiatrists who have attended the masterclasses have played active roles in advocating for investment and contributed to service expansion in line with the FYFV and LTP, "I can attest to the fact that many psychiatrists have become more vocal and more active locally after attending the programme".

How should future programmes be developed to continue to meet need and be capable of delivery in the face of chaotic circumstances (considering the two years we've spent in pandemic mode).

A hybrid of face to face and online learning should be (re) considered going forward; these programmes are instrumental in building networks and allowing participants to form peer-groups of support, which can be more difficult when sessions are delivered wholly online.

Continue and expand the top-up sessions: They are a very effective way of remaining responsive to the changing service landscape and are a good mechanism for assessing unmet need and delivering the skills required to challenge that.

Pandemic and post-pandemic practice: Develop and deliver a separate one-day event to analysis and discuss what has worked and what hasn't, via patient feedback, clinician reflections and input for the multi-disciplinary team; ensuring services are prepared in the event of a similar level of disruption to services in the future.

Devolved nations: Continue to include a cohort from the devolved nations and the Republic of Ireland, ensuring PMH services across all nations are supported and well-developed; there are obvious cross-border learning benefits to this, but it also adheres to the College's responsibility to support all members and constituencies.

Conclusion

Recruiting and retaining workforce remains a significant issue. Comments from participants reflect the enormous challenges services are facing: the existing issues with recruitment in rapidly expanded services compounded by the stresses and strains placed upon providers throughout the pandemic. Services have struggled to recruit staff, delaying the development of a complete service and putting at risk strategies to ensure service sustainability, an ongoing commitment if Long Term Plan ambitions are to be met[10].

Post-crisis the demands on mental health services have intensified, with an expected rise in mental disorders, underpinned by fear, anxiety, despair and confusion owing to the dramatic changes in societal norms, precipitated by this current crisis. Supporting the mental health workforce to

[10] 170820-UK-specialist-PMH-map.pdf (maternalmentalhealthalliance.org)

prepare and deal with the new reality is essential. All efforts should be made to equip perinatal consultants with the knowledge and skills required to support specialist services.

The masterclass programme is that support mechanism. At multiple points in the survey, the attendees reflected upon the excellent support they received throughout the programme most manifestly the clinical expertise made available to them: In their own words, the development of their specialist knowledge and skills was an immediate outcome and of benefit to the service. Almost all reported an increased level of self-confidence that comes with expertise, not only in making those perinatal specific clinical-led decisions, on safeguarding and prescribing for example, but also in leadership, in communication (with senior management) and in advocating for service support and funding. The enthusiasm and commitment with which all facilitators and guest speakers engaged them, a common thread echoed throughout the report, reinvigorating in-place consultants and motivating new consultants to be ambitious in leading their services, and for senior trainees a vision of a fulfilling career pathway.

Appendix I

Perinatal Psychiatry Masterclass for Senior Trainees
17th-21st January 2022

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

Dear Participants,

We want to give you a very warm welcome and say how delighted we are that you are able to participate in the 2022 series of Perinatal Psychiatry Masterclasses, funded by HEE and hosted by the Royal College of Psychiatrists. Drs Lucinda Green, Roch Cantwell and Liz McDonald have developed this current programme and we will be present each day of the course to facilitate and contribute to the training.

There will be 26 participants from England, one from Scotland, three from Wales, two from Northern Ireland and four from the Republic of Ireland.

You will receive a link to your masterclass programme where you can view the programme and read about the requirements for using ZOOM. Below you will find the full programme and recommended reading lists, as well as biographies of the expert trainers and teachers you will meet during your week.

We would like you to encourage you to get yourself a journal to support your reflections on the course. This will be for your own learning and will not be submitted to the College.

Feedback is extremely important to us:

- to ensure that we provide and maintain a high and consistent standard of training
- to provide feedback to HEE that the funding of this programme has been worthwhile in developing the psychiatric workforce
- to provide a basis for future provision of masterclasses in perinatal psychiatry

We would like you to complete this form after each day. Once your feedback is received you will be issued with a CPD certificate for the day. Each day will contribute to 6 CPD points.

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

On the first day we would like everyone to introduce themselves to the group saying something about where you work, why you have wanted to join this course, what your future career plans are and what you hope to achieve by attending the course.

There are some rules we would like you to abide by during your participation in the programme:

- we very much hope that you will attend all the sessions
- we will ensure you get handouts if you miss a session but there will not be recordings of the sessions available
- please do not record the sessions
- please do not share the materials
- please attend each day promptly
- please have your name displayed on your ZOOM profile
- please keep your video on
- please keep mute on when not speaking
- please read the papers on the mandatory reading list prior to the session on interpreting the evidence in prescribing
- please maintain confidentiality in relation to case discussion and clinicians' own personal experiences

We look forward to seeing you all in January 2022
Best wishes
Liz, Lucinda and Roch

The aims of this masterclass programme are to:

- enable and support senior trainees develop skills and knowledge in their assessment, understanding and management of the complex clinical work involved in working with women of childbearing potential and in the perinatal period
- encourage participants to integrate current evidence into clinical practice
- develop self-reflection skills
- emphasise the importance of the perspectives of women, infants, partners and families throughout the perinatal pathway
- improve patient safety
- improve the experience of women and families during the perinatal period and within perinatal mental health services.

The following key issues are fundamental aspects of perinatal mental health care and will be discussed and considered throughout the programme:

- safeguarding children and adults
- culture and difference
- collaborative working with women, partners and families
- women's own experience of perinatal mental disorders and care
- legal issues

Themes

Day 1	Introductions Overview of where the UK and Ireland are in relation to service development; assessment and communication; the lived experience of women and their partners
Day 2	Mental disorders in the perinatal period; pre-birth planning
Day 3	Safeguarding; prescribing in the perinatal period
Day 4	Evaluating the infant; substance dependency and misuse; interpreting the evidence in relation to prescribing in pregnancy
Day 5	Personality Disorder in the perinatal period; psychological treatments; risk, leadership

Programme:

The facilitators for the week will be Dr Liz McDonald, Dr Lucinda Green and Dr Roch Cantwell
Each session within the day will have a didactic component and small group work/discussion.

Day 1 Monday 17th January 2022		
Facilitators: Dr Lucinda Green, Dr Roch Cantwell and Dr Liz McDonald		
09:00-09:15	Registration	
09.15–10.15	Welcome and introductions Participants and facilitators introduce themselves	Drs Lucinda Green, Liz McDonald, Roch Cantwell
10.15 – 10.45	Perinatal Mental Health Services – what's happening across the nations?	Dr Lucinda Green Dr Roch Cantwell
10.45 – 11.00	BREAK	
11.00 - 12.00	How does the Perinatal Frame of Mind inform our assessments?	Dr Liz McDonald
12.00 – 13.15	Formulating and communicating assessments	Dr Lucinda Green
13.15–13.45	Lunch	
13.45–15.00	What does the literature tell us about women's experience of care and treatment in the perinatal period?	Dr Clare Dolman
15.00-15.15	BREAK	
15.15–16.00	Partners and Fathers in the perinatal period	Dr Lucinda Green
16.00-16.45	Small group discussions: How do we ensure that the woman and her family have a good experience of care in the perinatal period? What have I learnt today, how will it influence my practice, how will I share what I have learned?	Dr Clare Dolman Dr Lucinda Green Dr Liz McDonald Dr Roch Cantwell
ILOs	1. Understand the different approaches to development and delivery of PMH services within the different nations. 2. Describe the range of factors that can affect a woman's mental health in the perinatal period and her experience of pregnancy and parenting. 3. Summarise, formulate and communicate assessments to enable women, families and professionals to understand the factors which have contributed to her mental health problems, associated risks and/or her risk of developing a perinatal mental illness. 4. Demonstrate an awareness of the barriers to care for women in the perinatal period 5. Understand the factors influencing women's decision-making around pregnancy and childbirth 6. Recognise how healthcare professionals can improve the experience of women and families receiving perinatal mental healthcare 7. Recognise the effect of a woman's perinatal mental illness on her partner.	
Recommended reading:	1. Perinatal Mental Health Services - CR232 (rcpsych.ac.uk)	

	2. Scotland: Perinatal and Infant Mental Health Programme Board: delivery plan - September 2021 to September 2022 - gov.scot (www.gov.scot) 3. https://www.pmhn.scot.nhs.uk/delivering-effective-services/delivering-effective-services-report/ 4. Scottish care pathways 5. England care pathways 6. Wales: together-for-mental-health-delivery-plan-2019-to-2022.pdf (gov.wales) 7. Ireland:https://www.hse.ie/eng/services/list/4/mental-health-services/specialist-perinatal-mental-health/specialist-perinatal-mental-health-services-model-of-care-2017.pdf 8. PMH Partners Ambition FAQs. PMH Partners Ambition FAQ - National Perinatal Mental Health Workspace - FutureNHS Collaboration Platform 9. NHS England (2016) The Five Year Forward View for Mental Health 10. NHS England (2019) The NHS Long Term Plan 11. Lever Taylor, B., Billings, J., Morant, N., Bick, D., & Johnson, S. (2019). Experiences of how services supporting women with perinatal mental health difficulties work with their families: a qualitative study in England. BMJ Open, 9(7):e030208. 12. Dolman, C., Jones, I., & Howard, L. M. (2013). Pre-conception to parenting: a systematic review and meta-synthesis of the qualitative literature on motherhood for women with severe mental illness. Archives of women's mental health, 16(3), 173–196 13. Ruffell, B., Smith, D.M. & Wittkowski, A J. (2019) The Experiences of Male Partners of Women with Postnatal Mental Health Problems: A Systematic Review and Thematic Synthesis. Child Fam Stud.;28: 2772–2790.	

Day 2 Tuesday 22nd January 2022		
Facilitators: Drs Lucinda Green, Roch Cantwell and Liz McDonald		
09.15–09.45	OCD and anxiety disorders in pregnancy and postnatally	Dr Lucinda Green
09.45-10.30	Small group discussion: Case examples of anxiety in the perinatal period	Drs Lucinda Green, Roch Cantwell and Liz McDonald
10.30–11.00	Depression in the Perinatal period	Lucinda Green
11.00-11.15	Break	
11.00–12.00	Small group discussion: Case examples of depression in the perinatal period	Drs Lucinda Green, Roch Cantwell and Liz McDonald
12.00-13.00	Schizophrenia – what does this diagnosis mean for women in the perinatal period?	Dr Liz McDonald
13.00–13.45	Lunch	
13.45 – 14.45	Post-partum psychosis and BPAD	Dr Liz McDonald
14.45–15.15	Pre-birth planning	Dr Lucinda Green
15.15-15.30	Break	

15.30–16.30	Small group discussion Writing a pre-birth plan.	Drs Lucinda Green and Liz McDonald
ILOs	1. Understand the course of depression, OCD, schizophrenia, BPAD and Post-partum psychosis within the perinatal context 2. Understand how to organise and chair a perinatal mental health pre-birth planning meeting to ensure that the woman, her partner and other family members and the relevant professionals have a shared understanding of any concerns, needs and risks as well as the woman and family's strengths. 3. Develop effective perinatal mental health care plans collaboratively with women, partners, other carers and professionals.	
Recommended reading:	1. Di Florio A &Jones IR. (2019) Postpartum Depression. BMJ Best Practice. 4. 2. Bergink, V., Rasgon, N., & Wisner, K. L. (2016). Postpartum Psychosis: Madness, Mania, and Melancholia in Motherhood. The American journal of psychiatry, 173(12), 1179–1188. 3. Challacombe, F. L., Bavetta, M., & De Giorgio, S. (2019). Intrusive thoughts in perinatal obsessive-compulsive disorder. BMJ (Clinical research ed.), 367, l6574. 4. Forde R, Peters S, Wittkowski A. Recovery from postpartum psychosis: a systematic review and metasynthesis of women's and families' experiences [published online ahead of print, 2020 Feb 4]. Arch Womens Ment Health. 2020;10.1007/s00737-020-01025-z 5. Pre-Birth Planning: Best Practice Toolkit for Perinatal Mental Health Services (2019) Pan-London Perinatal Mental Health Networks. https://www.healthylondon.org/wp-content/uploads/2019/01/Pre-birth-planning-guidance-for-Perinatal-Mental-Health-Networks.pdf 6. AriannaDi Florio, et al Post-partum psychosis and its association with bipolar disorder in the UK: a case-control study using polygenic risk scores Lancet Psychiatry 2021; 8: 1045–52	
Day 3 Wednesday 19th January 2022		
	Facilitators: Drs Lucinda Green and Liz McDonald	
09.15-11.00	Safeguarding in the perinatal period	Dr Lucinda Green
11.00–11.15	Break	
11.15-12.45	Continued: Safeguarding in the perinatal period Small group work exploring cases.	Dr Lucinda Green
12.45–13.30	Lunch	
13.30–14.00	General principles when prescribing for women of childbearing potential.	Dr Liz McDonald
14.00-15.00	Prescribing anti-psychotic medication and mood stabilisers in pregnancy and breastfeeding	Dr Angelika Wieck
15.00-15.15	Break	
15.15-15.50	Prescribing anti-depressant medication in the perinatal period: how do we translate evidence into practice?	Prof Ian Jones
15.50–16.30	Question and Answer session	Dr Angelika Wieck

		Prof Ian Jones Dr Lucinda Green Dr Liz McDonald
ILOs	1. Describe the factors highlighted in child serious case reviews which can affect children's safety and wellbeing and increase the risk of abuse and neglect. 2. Recognise how perinatal mental health services, working effectively in partnership with a range of professionals, can ensure child safeguarding concerns are identified early and that effective care, treatment and support for women and families can reduce the risk of harm to infants and children. 3. Be familiar with currently available evidence on the reproductive safety of the main psychotropic drugs, resources that provide high quality evidence updates and current influential prescribing guidance	
Recommended reading:	1. Department for Education (2018). Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children. London: HM Government 2. Howard, L. M., Oram, S., Galley, H., Trevillion, K., & Feder, G. (2013). Domestic violence and perinatal mental disorders: a systematic review and meta- analysis. PLoS medicine, 10(5), e1001452 3. Hahn, C. K., Gilmore, A. K., Aguayo, R. O., & Rheingold, A. A. (2018). Perinatal Intimate Partner Violence. Obstetrics and gynecology clinics of North America, 45(3), 535–547 4. McAllister-Williams, R. H., Baldwin, D. S., Cantwell, R. et al (2017). British Association for Psychopharmacology consensus guidance on the use of psychotropic medication preconception, in pregnancy and postpartum. Journal of psychopharmacology (Oxford, England), 31(5), 519–552. 5. National Institute for Health and Care Excellence (2014). Antenatal and Postnatal Mental Health - Clinical Management and Service Guidance. Clinical Guideline 192. 6. MHRA: Valproate use by women and girls (2018). www.gov.uk/guidance/valproate-use-by-women-and-girls 7. Pre-conception advice: Best Practice Toolkit for Perinatal Mental Health Service (2019) Pan-London Perinatal Mental Health Networks. www.healthylondon.org/wp-content/uploads/2019/05/Pre-conception-advice-Best-Practice-Toolkit-for-Perinatal-Mental-Health-Services.pdf	
Day 4 Thursday 20th January 2022		
	Facilitators: Dr Liz McDonald and Dr Roch Cantwell	
	Mandatory reading: These papers are available on the webpage. They must be read with the letter from Dr Wieck and Prof Jones before the session. 1. Continuation of Atypical Antipsychotic Medication during Early Pregnancy and the Risk of Gestational Diabetes Yoonyoung Park, Sonia Hernandez-Diaz et al Am J Psychiatry. 2018 June 01; 175(6): 564–574. doi:10.1176/appi.ajp.2018.17040393. 2. Maternal Use of Specific Antidepressant Medications During Early Pregnancy and the Risk of Selected Birth Defects. Anderson et al. JAMA Psychiatry. doi:10.1001/jamapsychiatry.2020.2453	
09.15-11.00	How do we interpret the evidence in relation to prescribing in pregnancy?	Prof Ian Jones and

	Workshop: participants will have reviewed the papers above and will participate in small and large group work to consider the themes.	Dr Angelika Wieck
11.00-11.15	Break	
11.15- 12.30	Continued: How do we interpret the evidence in relation to prescribing in pregnancy?	Prof Ian Jones and Dr Angelika Wieck
12.30-13.15	Lunch	
13.15–15.00	Approaches to evaluating infant emotional development in perinatal clinical practice	Dr Maddalena Miele
15.00-15.15	Break	
15.15–16.45	Working with and understanding women with substance dependence and misuse in the perinatal period.	Dr Emily Finch
ILOs	1. Understand the kinds of methodological problems that hamper research into the reproductive safety of psychotropic drugs and be able to take these into account when interpreting peer-reviewed publications 2. Be able to apply current evidence and general principles for the pharmacological management of pregnant and breastfeeding women to clinical scenarios. 3. Understand the key ways in which perinatal mental health problems can affect the ability of women to interact with their infant 4. Demonstrate a basic knowledge of the current clinical approaches to assessing parent-infant relationships 5. Outline the determinants of a sensitive parent-infant interaction 6. Understand the issues encountered in measuring how common substance misuse in pregnancy is. 7. Explore ways to identify substance misuse in pregnancy 8. Understand what interventions are available to reduce the harm from substance misuse in pregnancy	
Recommended reading:	1. P.O. Svanberg , J. Barlow & W. Tigbe (2013) The Parent–Infant Interaction Observation Scale: reliability and validity of a screening tool, Journal of Reproductive and Infant Psychology, 31:1, 5-14. 2. Stein A, Pearson RM, Goodman SH, et al. Effects of perinatal mental disorders on the fetus and child. Lancet. 2014;384(9956):1800-1819. 3. Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health – page 220 pregnancy section – 4. Ibiza paper 5. Check chapter for more refs	
	Day 5 Friday 21st January 2022	
	Facilitators: Drs Lucinda Green, Roch Cantwell and Liz McDonald	
09.15–11.00	Personality Disorder in women: what do we need to consider in the perinatal period?	Dr Nic Horley
11.00-11.15	Break	
11.15–12.30	Psychological interventions for women in the perinatal period. Followed by Q&A.	Dr Nic Horley
12.30–13.15	Lunch	
13.15–14.45	Risk in the perinatal period: what lessons have we learned?	Dr Roch Cantwell

14.45–15.00	Break	
15.00-15.30	Compassion focused leadership and self-care- what does this mean for you?	Dr Lucinda Green
15.30–16.00	Small group discussions: Compassion focused leadership and self-care- what does this mean for me?	
16.00-16.15	Going forward: what else do you need to do to improve your skills and knowledge as a perinatal psychiatrist?	Large group to share ideas.
16.16-16.30	Final thoughts and close of course	Dr Lucinda Green Dr Liz McDonald Dr Roch Cantwell
ILOs	1. Understand how personality function may become disordered in pregnancy and postnatally 2. Appreciate the importance of assessment and treatment of personality disorder by perinatal mental health services 3. Understand the different psychological therapies for women with mental disorders and their use during the perinatal period 4. Describe the epidemiology of self-harm and suicide in the perinatal period. 5. Describe the distinctive clinical features of maternal suicide. 6. Recognise risk in relation to maternal suicide and apply this to clinical assessment. 7. Understand the advantages of compassionate leadership approaches for leaders and teams 8. Recognise the importance of self-compassion	
Recommended reading:	1. Steele KR, Townsend ML, Grenyer BFS (2019) Parenting and personality disorder: An overview and meta-synthesis of systematic reviews. PLoS ONE 14(10): e0223038. https://doi. org/10.1371/journal.pone.0223038 2. Parenting and Borderline Personality Disorder: Ghosts in the Nursery Louise Newman and Caroline Stevenson Clin Child Psychol Psychiatry 2005 10: 385 DOI: 10.1177/1359104505053756 3. Adshead, G. Parenting and personality disorder: Clinical and child protection implications Advances in Psychiatric Treatment · January 2015 4. Blankley et al. Borderline personality disorder in the perinatal period. Australas Psychiatry 2015; 23:688-92. 5. Petfield L et al. Parenting in mothers with borderline personality disorder and impact on child outcomes Evidence-Based Mental Health 2015;18:67-75 6. Risholm Mothander, P., C. Furmark, and K. Neander (2018), Adding "Circle of Security–Parenting" to treatment as usual in three Swedish infant mental health clinics. Effects on parents' internal representations and quality of parent-infant interaction. Scandinavian Journal of Psychology. 59: p. 262-272 7. Oates M & Cantwell R (2011) Deaths due to psychiatric causes. Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer 2006- 2008. British Journal of Obstetrics and Gynaecology, 118 (s1), 132-142. 8. Cantwell R, Knight M, Oates M, Shakespeare J on behalf of the MBRRACE-UK mental health chapter writing group (2015) Lessons on maternal mental health. In Knight M, Tuffnel D, Kenyon S, Shakespeare J, Gray R, Kyrinczuk JJ (Eds.) on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care – Surveillance of maternal deaths in the UK 2011-13 and lessons learned to inform maternity	

	care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2015: p22-41. 9. Cantwell R, Youd E and Knight M on behalf of the MBRRACE-UK mental health chapter-writing group (2018) Messages for mental health. In Knight M, Bunch K, Tuffnell D, Jayakody H, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014- 16. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2018: p42-60 10. West, M., Eckert, R., Collins, B., &Chowla, R. (2017) Caring to Change. How compassionate leadership can stimulate innovation in health care. The King's Fund	

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Royal College of Psychiatrists - Perinatal Psychiatry Masterclass Programme

Consultants Top-Up Course

The aims of this masterclass programme are to:

- enable and support consultants in perinatal psychiatry in their assessment, understanding and management of complex clinical work
- encourage participants to integrate current evidence into clinical practice
- develop self-reflection skills
- support leadership development
- emphasise the importance of the perspectives of women, infants, partners and families throughout the perinatal pathway
- improve patient safety
- improve the experience of women and families in perinatal mental health services
- develop knowledge and understanding relevant to implementing the recommendations of the NHS Long Term Plan for perinatal mental health services

Date	Themes
1. 7th September	ADHD - assessment and treatment in the perinatal context and implications for parenting
2. 20th September	Autistic Spectrum Disorders in women
3. 28th September	Partners
4. 15th October	Couple and family interventions
5. 5th November	Compassionate Leadership
6. 17th November	Infertility and fertility treatments
7. 3rd December	Premenstrual syndrome and menopause
8. 10th December	The NHS Long Term Plan implementation

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Programme

Learning objectives and reading lists are provided before each day.

Each session within the day will have a didactic component and small group work/discussion.

All 5 days are facilitated by Dr Liz McDonald and Dr Lucinda Green.

Day 1: Tuesday 7th September 2021

Day 1	Topic	Speakers
9.15-10.45	ADHD – assessment and treatment in the perinatal context and implications for parenting	Dr Sally Cubbin and Dr Amanda Elkin
10.45-11.00	BREAK	
11-12.30	ADHD – assessment and treatment in the perinatal context and implications for parenting	Dr Sally Cubbin and Dr Amanda Elkin

Intended learning objectives:

At the end of day 1 participants will be able to:

1. Recognise how ADHD presents in adults, with a particular focus on women.
2. Understand how untreated ADHD may affect women in the perinatal period.
3. Consider medication treatment options for ADHD in the perinatal period.
4. Feel confident in writing a CD prescription.

Reading

Essential reading

1. Cubbin, S., Leaver, L., & Parry, A. (2020). Attention deficit hyperactivity disorder in adults: common in primary care, misdiagnosed, and impairing, but highly responsive to treatment. The British journal of general practice: *The journal of the Royal College of General Practitioners*, 70(698), 465–466.
2. Choice and Medication leaflet: A guide to help you choose between the medications to help with symptoms of ADHD in pregnancy and breast-feeding

Recommended reading

1. Choice and Medication: medication-specific 'handy factsheets' on: Methylphenidate, lis-dexamphetamine, atomoxetine, melatonin
2. Cortese, S., Adamo, N., Del Giovane, C., et al. (2018). Comparative efficacy and tolerability of medications for attention-deficit hyperactivity disorder in children, adolescents, and adults: a systematic review and network meta-analysis. *The Lancet. Psychiatry*, *5*(9), 727–738.
3. Kooij, J., Bijlenga, D., Salerno, L., (2019). Updated European Consensus Statement on diagnosis and treatment of adult ADHD. *European Psychiatry: The Journal of the Association of European Psychiatrists*, *56*, 14–34.
4. Young, S., Adamo, N., Ásgeirsdóttir, B. B., Branney, P., et al. (2020) Females with ADHD: An expert consensus statement taking a lifespan approach providing

guidance for the identification and treatment of attention-deficit/ hyperactivity disorder in girls and women. *BMC psychiatry*, *20*(1), 404.

Day 2: Monday 20th September 2021

Day 2	Topic	Speakers
13.15-14.45	Autistic Spectrum Disorders in women	Dr Judy Eaton
14.45-15.00	BREAK	
15.00-16.30	Autistic Spectrum Disorders in women	Dr Judy Eaton

Intended learning objectives:

At the end of day 2 participants will be able to:

1. Identify how Autism can present in women
2. Demonstrate a clear understanding of common comorbidities with Autism and how these can be evaluated
3. Formulate the type of support that may benefit women who have Autism in the perinatal period.

Reading

Essential reading

1. Green, R. M., Travers, A. M., Howe, Y. & McDouglas, C. J., (2019). Women and Autism Spectrum Disorder: Diagnosis and Implications. *Current Psychiatry Reports*, 21:22, https://doi.org/10.1007/s11920-019-1006-3
2. Went, H. E., (2016). I didn't fit the stereotype of autism: A qualitative analysis of women's experiences relating to diagnosis of an Autism Spectrum Condition and mental health. Thesis submitted as part fulfilment for the degree of Doctor of Clinical Psychology. University of Exeter.
3. Gould, J., (2017). Towards understanding the under-recognition of girls and women on the autism spectrum. *Autism*, vol 21 (6) 703 – 705.

Recommended reading

1. Women and Girls with Autism Spectrum Disorder: Understanding Life Experiences from Early Childhood to Old Age, by Sarah Hendrick, published by Jessica Kingsley Publishers.
2. A Guide to Mental Health Issues in Girls and Young Women on the Autism Spectrum: Diagnosis, Intervention and Family Support, by Judy Eaton, published by Jessica Kingsley Publishers

Day 3: Tuesday 28th September 2021

Day 3	Topic	Speakers
1.15 - 2.45	Partners of women with lived experience of perinatal mental illness	Dr Sally Wilson and partners from Action on Postpartum Psychosis

2.45-3.00	BREAK	
3.00 – 4.30	Assessment and signposting for partners and fathers	Dr Lucinda Green

Intended learning objectives:

At the end of day 3 participants will be able to:

1. Understand the effect of a woman's perinatal mental illness on her partner.
2. Describe approaches to assessment and care for partners who have mental health problems in the perinatal period.

Reading

Essential reading

1. Lever Taylor, B., Billings, J., Morant, N., Bick, D., & Johnson, S. (2019). Experiences of how services supporting women with perinatal mental health difficulties work with their families: a qualitative study in England. *BMJ Open*, 9(7):e030208.

Recommended reading

1. Hanley, J. & Williams, M. (2019) Fathers and perinatal mental health. A Guide for recognition, treatment and management. Routledge.
2. Ruffell, B., Smith, D.M. & Wittkowski, A J. (2019) The Experiences of Male Partners of Women with Postnatal Mental Health Problems: A Systematic Review and Thematic Synthesis. *Child Fam Stud.*;28: 2772–2790.
3. Williams, M. (2020) Fathers reaching out-why dads matter. https://maternalmentalhealthalliance.org/wp-content/uploads/MARK_WILLIAMS_FATHERS_REACHING_OUT_PMH_REPORT10_SEP_2020.pdf

Day 4: Friday 15th October 2021

Day 4	Topic	Speakers
13.15-14.45	Couple and family interventions in the perinatal period	Dr Phil Arthrington
14.45-15.00	BREAK	
15.00-16.30	Couple and family interventions in the perinatal period	Dr Phil Arthrington

Intended learning objectives:

At the end of day 4 participants will be able to:

1. Describe the contribution that couple and family interventions can make to perinatal mental health services.
2. Identify key challenges faced by families during the perinatal period and how key systemic concepts can aid in making sense of these difficulties.
3. Discuss some of the main barriers to working with families in the perinatal period and how these may be overcome in your service.

Reading

Essential reading

1. Hunt, C. (2006). When baby brings the blues: Family therapy and postnatal depression. *Australian and New Zealand Journal of Family Therapy*, 27(4), 214-220.

Recommended reading

1. Arthington, P. (in press). Mighty oaks from little acorns grow: Why beginnings matter. Context, 172, pp.xxxxx. Warrington: AFT.
2. Barker, S. (2019). Perinatal mental health and working with families. In N. Evans (Ed), Family Work in Mental Health: A Skills Approach. Keswick: M&K Publishing. pp. 67-82.
3. Cluxton-Keller, F., & Bruce, M.L. (2018). Clinical effectiveness of family therapeutic interventions in the prevention and treatment of perinatal depression: A systematic review and meta-analysis. *PLoS ONE*, 13(6): e0198730.

Day 5: Friday 5th November 2021

Day 5	Topic	Speakers
09.15-10.45	Compassionate Leadership	Dr Lucinda Green and Dr Nic Horley
10.45-11.00	BREAK	
11.00-12.30	Compassionate Leadership	Dr Lucinda Green and Dr Nic Horley
12.30-13.15	LUNCH	
13.15-14.45	Compassionate Leadership	Dr Lucinda Green and Dr Nic Horley
14.45-15.00	BREAK	
15.00-16.30	Compassionate Leadership	Dr Lucinda Green and Dr Nic Horley

Intended learning objectives:

At the end of day 5 participants will be able to:

1. Understand the advantages of compassionate leadership approaches for leaders and teams
2. Understand the theoretical underpinnings of compassion focussed ideas
3. Recognise the importance of self-compassion
4. Be familiar with compassion focussed activities that can be used with their teams

Reading

Essential reading

1. West, M., Eckert, R., Collins, B., &Chowla, R. (2017) Caring to Change. How compassionate leadership can stimulate innovation in health care. The King's Fund

Recommended reading

1. Conversano, C., Ciacchini, R., Orrù, G., Di Giuseppe, M., Gemignani, A., & Poli, A. (2020). Mindfulness, Compassion, and Self-Compassion Among Health Care Professionals: What's New? A Systematic Review. *Frontiers in psychology*, 11, 1683. https://doi.org/10.3389/fpsyg.2020.01683.
2. de Zulueta P. C. (2015). Developing compassionate leadership in health care: an integrative review. *Journal of healthcare leadership*, 8, 1–10.
3. Gilbert, P.I & Basran, J. (2018). Imagining One's Compassionate Self and Coping with Life Difficulties. *EC Psychology and Psychiatry*, 7, 971-978.
4. Heaversedge, J. & Halliwell, E.(2012) The Mindful Manifesto. Hay House UK Ltd.
5. Neff, KD, Knox, MC, Long, P, Gregory, K. (2020) Caring for others without losing yourself: An adaptation of the Mindful Self-Compassion Program for Healthcare Communities. *J Clin Psychol*. 76, 1543– 1562.
6. NHS England (2014) Building and Strengthening Leadership: Leading with Compassion.

Day 6: Wednesday 17th November 2021

Day 6	Topic	Speakers
09.15-10.45	Infertility, fertility treatment and psychological implications	Suzanne Dark
10.45-11.00	BREAK	
11.00-12.30	Infertility, fertility treatment and psychological implications	Suzanne Dark
12.30-13.15	LUNCH	
13.15-14.45	Infertility, fertility treatment and psychological implications	Suzanne Dark and Dr Lucinda Green
14.45-15.00	BREAK	
15.00-16.30	Infertility, fertility treatment and psychological implications	Suzanne Dark and Dr Lucinda Green

Intended learning objectives:

At the end of day 6 participants will be able to:

1. Describe and recognise the psychological consequences of infertility and fertility treatment
2. Understand the role of the counsellor in the infertility clinic and the other care and support available for women having fertility treatment.
3. Discuss the risk of mental health problems associated with infertility and fertility treatment

Reading

Essential reading

1. Bhat, A., & Byatt, N. (2016). Infertility and perinatal loss: when the bough breaks. Current psychiatry reports, 18(3), 31.

Recommended reading

1. Bronya Hi-Kwan Luk & Alice Yuen Loke (2015) The Impact of Infertility on the Psychological Well-Being, Marital Relationships, Sexual Relationships, and Quality of Life of Couples: A Systematic Review, *Journal of Sex & Marital Therapy*, 41:6, 610-625,
2. Doyle, M., & Carballedo, A. (2014). Infertility and mental health. *Advances in Psychiatric Treatment*, 20(5), 297-303.
3. Golombok, S. (2015) Modern families: Parenting and children in new family forms. Cambridge University Press.
4. McCluskey G & Gilbert P. Implications counselling for people considering donor-assisted treatment. Fully updated version. British Infertility Counselling Association: 2015.
5. De Berardis, D., Mazza, M., Marini, S., Del Nibletto, L., Serroni, N., Pino, M. C., Valchera, A., Ortolani, C., Ciarrocchi, F., Martinotti, G., & Di Giannantonio, M. (2014). Psychopathology, emotional aspects and psychological counselling in infertility: a review. *La Clinica terapeutica*, 165(3), 163–169.
6. Ebdrup, N. H., Assens, M., Hougaard, C. O., Pinborg, A., Hageman, I., & Schmidt, L. (2014). Assisted reproductive technology (ART) treatment in women with schizophrenia or related psychotic disorder: a national cohort study. *European journal of obstetrics, gynecology, and reproductive biology*, 177, 115–120.
7. Pasch, L. A., Holley, S. R., Bleil, M. E., Shehab, D., Katz, P. P., & Adler, N. E. (2016). Addressing the needs of fertility treatment patients and their partners: are they informed of and do they receive mental health services?. Fertility and sterility, 106(1), 209–215.e2.
8. Patel, A., Sharma, P., & Kumar, P. (2018). Role of Mental Health Practitioner in Infertility Clinics: A Review on Past, Present and Future Directions. *Journal of Human Reproductive sciences*, 11(3), 219–228.
9. Szkodziak, F., Krzyżanowski, J., & Szkodziak, P. (2020). Psychological aspects of infertility. A systematic review. *The Journal of international medical research*, 48(6), 300060520932403.
10. Vikström, J., Josefsson, A., Bladh, M., & Sydsjö, G. (2015). Mental health in women 20-23 years after IVF treatment: a Swedish cross-sectional study. *BMJ open*, 5(10), e009426.

Day 7: Friday 3rd December 2021

Day 7	Topic	Speaker
09.15-10:45	Premenstrual Syndrome and menopause	Dr Michael Craig
10:45-11:00	BREAK	
11.00-12.30	Premenstrual syndrome and menopause	Dr Michael Craig

Intended learning objectives:

At the end of day 7 participants will be able to:

1. Discuss the management of Premenstrual Syndrome with women who have co-existing mental health problems.
2. Describe the impact of the menopause on women's mental health.
3. Understand the management of menopause related mood symptoms.

Reading

Essential reading

1. Green LJ, O'Brien PMS, Panay N, Craig M on behalf of the Royal College of Obstetricians and Gynaecologists. Management of premenstrual syndrome (2016) *BJOG* ; DOI: 10.1111/1471-0528.14260.

Recommended reading

1. Craig, M. C., Sadler, C., & Panay, N. (2019). Diagnosis and management of premenstrual syndrome. *Practitioner*, 263(1824), 15-19.
2. Clow A & Smyth N (2020). Stress and Brain Health: Across the Life Course. *International Review of Neurobiology* Volume 150, 2-246

Day 8: Friday 10th December 2021

Day 8	Topic	Speakers
9.15-10.45	Implementing the NHS Long Term Plan - expanding perinatal mental health services and extending to 2 years postnatal.	Dr Giles Berrisford
10.45-11.00	BREAK	
11-12.30	Implementing the NHS Long Term Plan - expanding perinatal mental health services and extending to 2 years postnatal.	Dr Giles Berrisford

Intended learning objectives:

At the end of day 8 participants will be able to:

1. Define potential criteria for women who will be eligible for perinatal mental health services once the NHS Long Term Plan is fully implemented.
2. Describe approaches to implementing the NHS Long Term plan in perinatal mental health services.

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Royal College of Psychiatrists - Perinatal Psychiatry Masterclass Programme

New Consultants

The aims of this masterclass programme are to:

- enable and support new consultants in perinatal psychiatry in their assessment, understanding and management of complex clinical work
- encourage participants to integrate current evidence into clinical practice
- develop self-reflection skills
- support leadership development
- emphasise the importance of the perspectives of women, infants, partners and families throughout the perinatal pathway
- improve patient safety
- improve the experience of women and families in perinatal mental health services.

The following key issues are fundamental aspects of perinatal mental health care and will be discussed and considered throughout the programme:

- safeguarding children and adults
- culture and difference
- collaborative working with women, partners and families
- women's own experience of perinatal mental disorders and care
- legal issues

Dates:
Each day will start at 9.15am and finish at 4.30pm.

Date	**Themes**
11 September 2020	Introductions; The National Picture; Assessment and communication
8 October 2020	Lived experience, co-production, partners
2 November 2020	The infant
3 November 2020	Risk and Safeguarding adults and children
3 December 2020	Prescribing in the perinatal period

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11 January 2021	Personality Disorder
11 February 2021	Legal and Forensic
12 February 2021	Pre-pregnancy Counselling, pre-birth planning; addictions
15 March 2021	Eating Disorders; pregnancy loss, infertility and complex pregnancy related issues
22 April 2021	Leadership and service development

Programme

Learning objectives and reading lists will be provided before each day.

Each session within the day will have a didactic component and small group work/discussion.

Facilitators: Dr Liz McDonald and Dr Lucinda Green and Dr Clare Dolman (on Day 2)

Day 1: Friday 11th September 2020

Day 1	Topic	Speakers
09.15-10.45	Introduction to the masterclass programme and to each other. What do you hope to achieve by your participation?	Dr Liz McDonald Dr Lucinda Green
10.45-11.00	BREAK	
11.00-12.30	The National Picture: where are we now? what is your role?	Dr Giles Berrisford
12.30-13.15	LUNCH	
13.15-14.45	How does the perinatal frame of mind inform our assessments?	Dr Liz McDonald
14.45-15.00	BREAK	
15.00-16.30	Formulating and communicating assessments	Dr Lucinda Green

Intended learning objectives:

At the end of day 1 participants will be able to:

8. Demonstrate an understanding of how the case for perinatal mental health service expansion was made
9. Apply this understanding to the development of services in wave 1 and wave 2 of the Five Year Forward View
10. Evaluate the proposed changes to perinatal mental health services outlined in the NHS Long Term Plan and consider how these service developments can be implemented.
11. Describe the range of factors that can affect a woman's mental health in the perinatal period and her experience of pregnancy and parenting.
12. Summarise, formulate and communicate assessments to enable women, families and professionals to understand the factors which have contributed to her mental health problems, associated risks and/or her risk of developing a perinatal mental illness.

Reading

Essential reading

1. NHS England (2016) The Five Year Forward View for Mental Health
2. NHS England (2019) The NHS Long Term Plan

Recommended reading

1. Bauer A, Knapp M, Adelaja B (2016). Best Practice for perinatal mental health care: the economic case. PSSRU. London School of Economics.
2. NHS England (2016) Better Births: Improving outcomes of maternity services in England - A Five Year Forward View for maternity care.
3. Royal College of Psychiatrists 2018) *Framework for Routine Outcome Measurement in Perinatal Psychiatry*. College Report CR126.

Day 2: Thursday 8th October 2020

Day 2	Topic	Speakers
09.15-10.45	What does the literature tell us about women's experience of care and treatment in the perinatal period?	Dr Clare Dolman
10.45-11.00	BREAK	
11.00-12.30	What could have improved my experience of care in the perinatal period? Group: what can I do in my service to improve the care of women?	Kathryn Grant Rachael Buabong
12.30-13.15	LUNCH	
13.15-14.45	Co-production in PMH services. My experience.	Rosie Lowman
14.45-15.00	BREAK	
15.00-16.30	What is the experience of the partner? As support to the woman, own needs and building a relationship with the infant.	Dr Henry Fay

Intended learning objectives:

At the end of day 2 participants will be able to:

1. Demonstrate an awareness of the barriers to care for women in the perinatal period
2. Understand the factors influencing women's decision-making around pregnancy and childbirth
3. Recognise how healthcare professionals can improve the experience of women and families receiving perinatal mental healthcare
4. Understand the benefits of involving women and partners in co-producing perinatal mental health services.
5. Recognise the effect of a woman's perinatal mental illness on her partner.

Reading

Essential reading

1. Dolman, C., Jones, I., & Howard, L. M. (2013). Pre-conception to parenting: a systematic review and meta-synthesis of the qualitative literature on motherhood for women with severe mental illness. *Archives of women's mental health*, *16*(3), 173–196.
2. Lever Taylor, B., Billings, J., Morant, N., Bick, D., & Johnson, S. (2019). Experiences of how services supporting women with perinatal mental health difficulties work with their families: a qualitative study in England. *BMJ open*, *9*(7), e030208.

Recommended reading

1. Dolman, C., Jones, I. R., & Howard, L. M. (2016). Women with bipolar disorder and pregnancy: factors influencing their decision-making. BJPsych open, 2(5), 294–300.
2. Lever Taylor, B., Kandiah, A., Johnson, S., Howard, L. M., & Morant, N. (2020). A qualitative investigation of models of community mental health care for women with perinatal mental health problems. Journal of mental health (Abingdon, England), 1–7. Advance online publication.
3. Lever Taylor, B., Mosse, L., & Stanley, N. (2019). Experiences of social work intervention among mothers with perinatal mental health needs. Health & social care in the community, 27(6), 1586–1596.
4. Megnin-Viggars O, Symington I, Howard LM, Pilling S. Experience of care for mental health problems in the antenatal or postnatal period for women in the UK: a systematic review and meta-synthesis of qualitative research. *Arch Womens Ment Health*. 2015;18(6):745-759.
5. Millett, L., Taylor, B. L., Howard, L. M., Bick, D., Stanley, N., & Johnson, S. (2018). Experiences of Improving Access to Psychological Therapy Services for Perinatal Mental Health Difficulties: a Qualitative Study of Women's and Therapists' Views. *Behavioural and cognitive psychotherapy*, *46*(4), 421–436.
6. Royal College of Obstetricians and Gynaecologists (2017) Maternal mental health women's voices.
7. Sambrook Smith, M., Lawrence, V., Sadler, E., & Easter, A. (2019). Barriers to accessing mental health services for women with perinatal mental illness: systematic review and meta-synthesis of qualitative studies in the UK. BMJ open, 9(1), e024803.
8. Watson H, Harrop D, Walton E, Young A, Soltani H. A systematic review of ethnic minority women's experiences of perinatal mental health conditions and services in Europe. *PLoS One*. 2019;14(1):e0210587.

Day 3: Monday 2nd November 2020

Day 3	Topic	Speakers
09.15-10.45	Assessment of the mother-infant relationship in clinical practice.	Dr Maddalena Miele

10.45-11.00	BREAK	
11.00-12.30	Assessment of the mother-infant relationship in clinical practice	Dr Maddalena Miele
12.30-13.15	LUNCH	
13.15-14.45	The evidence base for interventions with parents and infants in the perinatal period.	Dr Jane Barlow
14.45-15.00	BREAK	
15.00-16.30	Parent-Infant psychotherapy	Dr Amanda Jones

Intended learning objectives:

At the end of day 3 participants will be able to:

1. Understand the key ways in which perinatal mental health problems can affect the ability of women to interact with their infant
2. Demonstrate a basic knowledge of the current clinical approaches to assessing parent-infant relationships
3. Describe the basic principles of attachment theory and the neurobiology of parenting
4. Outline the determinants of a sensitive parent-infant interaction
5. Understand the key ways in which parent-infant interaction during the postnatal period influences the later capacity of the infant for emotion regulation
6. Examine some of the key evidence-based methods of working dyadically, with mothers experiencing perinatal mental health problems, to support the interaction with the baby.

Reading

Essential reading

1. Laulik, S., Chau, S., Browne, K., & Allam, J. (2013). The link between personality disorder and parenting behaviors: A systematic review. Aggression and Violent Behavior 18(6), 644–655.
2. Royal College of Psychiatry (2018). Framework for Routine Outcome Measures in Perinatal Psychiatry CR216. London: RCP.
3. Van Ijzendoorn, M.H., Schuengel, C., Bakermans-Kranenburg, M.J. (1999). Disorganized attachment in early childhood: meta-analysis of precursors, concomitants, and sequelae. *Developmental Psychopathology,*11(2), 225-49.

Recommended reading

1. Madigan, S., Bakermans-Kranenburg, MJ., Van Ijzendoorn, M.H., Moran, G., Pederson, D.R., & Benoit, D. (2006). Unresolved states of mind, anomalous parental behavior,

and disorganized attachment: a review and meta-analysis of a transmission gap. Attachment and Human Development, 8(2), 89–111.
2. Music G. *Nurturing Natures (2017). Attachment and Children's Emotional, Sociocultural and Brain Development*. 2nd Edition. London: Routledge.
3. O'Hara, L., Smith, E.R., Barlow, J., Livingstone, N., Herath, N.I.N.S., Wei, Y., Spreckelsen, T.F., & Macdonald, G. (Forthcoming). Video feedback for improving parental sensitivity and child attachment. Cochrane Library.
4. P.O. Svanberg , J. Barlow & W. Tigbe (2013) The Parent–Infant Interaction Observation Scale: reliability and validity of a screening tool, Journal of Reproductive and Infant Psychology, 31:1, 5-14.
5. Schore, A.N. (2001). The effects of early relational trauma on right brain development, affect regulation, and infant mental health. Infant Mental Health Journal, 22, 201-269.
6. Stein A, Pearson RM, Goodman SH, et al. Effects of perinatal mental disorders on the fetus and child. *Lancet*. 2014;384(9956):1800-1819.

Day 4: Tuesday 3rd November 2020

Day 4	Topic	Speakers
09.15-10.45	What have we learned from women who have died from psychiatric causes in the perinatal period?	Dr Roch Cantwell
10.45-11.00	BREAK	
11.00-12.30	Violence towards women in the perinatal period.	Dr Hind Khalifeh
12.30-13.15	LUNCH	
13.15-14.45	Safeguarding infants and children in the context of maternal mental disorder	Dr Lucinda Green
14.45-15.00	BREAK	
15.00-16.30	Safeguarding infants and children in the context of maternal mental disorder	Dr Lucinda Green

Intended learning objectives:

At the end of day 4 participants will be able to:

9. Describe the epidemiology of self-harm and suicide in the perinatal period.
10. Describe the distinctive clinical features of maternal suicide.
11. Recognise risk in relation to maternal suicide and apply this to clinical assessment.
12. Understand the evidence base regarding the extent and impact of domestic violence / abuse in the perinatal period
13. Understand the evidence base regarding interventions for domestic violence/ abuse including for domestic violence/abuse in the perinatal period.

14. Demonstrate skills in enquiring about and responding to domestic violence/abuse disclosures by women under the care of perinatal mental health services
15. Describe the factors highlighted in child serious case reviews which can affect children's safety and wellbeing and increase the risk of abuse and neglect.
16. Recognise how perinatal mental health services, working effectively in partnership with a range of professionals, can ensure child safeguarding concerns are identified early and that effective care, treatment and support for women and families can reduce the risk of harm to infants and children.

Reading

Essential reading

1. Oates M & Cantwell R (2011) Deaths due to psychiatric causes. Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer 2006-2008. *British Journal of Obstetrics and Gynaecology*, 118 (s1), 132-142.
2. Cantwell R, Knight M, Oates M, Shakespeare J on behalf of the MBRRACE-UK mental health chapter writing group (2015) Lessons on maternal mental health. In Knight M, Tuffnel D, Kenyon S, Shakespeare J, Gray R, Kyrinczuk JJ (Eds.) on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care – Surveillance of maternal deaths in the UK 2011-13 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2015: p22-41.
3. Cantwell R, Youd E and Knight M on behalf of the MBRRACE-UK mental health chapter-writing group (2018) Messages for mental health. In Knight M, Bunch K, Tuffnell D, Jayakody H, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014-16. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2018: p42-60.
4. Department for Education (2018). *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*. London: HM Government
5. Howard, L. M., Oram, S., Galley, H., Trevillion, K., & Feder, G. (2013). Domestic violence and perinatal mental disorders: a systematic review and meta-analysis. *PLoS medicine*, *10*(5), e1001452.
6. Hahn, C. K., Gilmore, A. K., Aguayo, R. O., & Rheingold, A. A. (2018). Perinatal Intimate Partner Violence. *Obstetrics and gynecology clinics of North America*, *45*(3), 535–547.

Recommended reading

1. Department for Education (2020) *Complexity and challenge: a triennial analysis of serious case reviews 2014-2017*. London: Department for Education.

2. Hammond J, Lipsedge M. Assessing Parenting Capacity in Psychiatric Mother and Baby Units: A case report and review of literature. *Psychiatr Danub*. 2015;27 Suppl 1: S71-S83.
3. Johannsen BMW et al (2016) All-cause mortality in women with severe postpartum psychiatric disorders. American Journal of Psychiatry, 173, 635-642.
4. Johannsen et al (2020) Self-harm in women with postpartum mental disorders. Psychological Medicine, 50, 1563-1569.
5. Khalifeh, H., Hunt, I.M., Appleby, L., Howard, L.M. (2016) Suicide in perinatal and non-perinatal women in contact with psychiatric services: 15 year findings from a UK national inquiry. Lancet Psychiatry. 3(3), pp. 233-242.
6. Khalifeh, H., Moran, P., Borschmann, R., Dean, K., Hart, C., Hogg, J., Osborn, D., Johnson, S., & Howard, L. M. (2015). Domestic and sexual violence against patients with severe mental illness. *Psychological medicine*, *45*(4), 875–886.
7. Lysell H et al (2018) Maternal suicide: register based study of all suicides occurring after delivery in Sweden 1974-2009. PLoS ONE, 13(1): e0190133.
8. Smithson, R., and Gibson, M. Less than human: a qualitative study into the experience of parents involved in the child protection system. *Child & Family Social Work*. 2017;22:565–574.
9. Webinar: https://www.solacewomensaid.org/free-webinar-series-supporting-survivors-during-covid-19

Day 5: Thursday 3rd December 2020

Day 5	Topic	Speaker
09.15-09.50	Prescribing anti-depressant medication in the perinatal period: how do we translate evidence into practice?	Prof Ian Jones
09:50-10:45	Prescribing anti-psychotic medication and mood stabilisers in pregnancy and breastfeeding	Dr Angelika Wieck
10:45-11:00	BREAK	
11.00-12.30	Case discussions and examples of prescribing medication in pregnancy and breastfeeding	Dr Angelika Wieck Prof Ian Jones
12.30-13.15	LUNCH	
13.15-14.45	How do we interpret the evidence in relation to prescribing in pregnancy? Workshop: participants will review and discuss selected literature.	Dr Angelika Wieck Prof Ian Jones
14.45-15.00	BREAK	
15.00-16.30	How do we interpret the evidence in relation to prescribing in pregnancy? Workshop: participants will discuss how they talk about risk/benefit analysis when supporting women with decision making.	Dr Angelika Wieck Prof Ian Jones

Intended learning objectives:

At the end of day 5 participants will be able to:

4. Understand the kinds of methodological problems that hamper research into the reproductive safety of psychotropic drugs and be able to take these into account when interpreting peer-reviewed publications
5. Be familiar with currently available evidence on the reproductive safety of the main psychotropic drugs, resources that provide high quality evidence updates and current influential prescribing guidance
6. Be able to apply current evidence and general principles for the pharmacological management of pregnant and breastfeeding women to clinical scenarios.

Reading

Essential reading

1. McAllister-Williams, R. H., Baldwin, D. S., Cantwell, R. et al (2017). British Association for Psychopharmacology consensus guidance on the use of psychotropic medication preconception, in pregnancy and postpartum. *Journal of psychopharmacology (Oxford, England)*, *31*(5), 519–552.
2. National Institute for Health and Care Excellence (2014). Antenatal and Postnatal Mental Health - Clinical Management and Service Guidance. Clinical Guideline 192.
3. MHRA: Valproate use by women and girls (2018). www.gov.uk/guidance/valproate-use-by-women-and-girls

Recommended reading

1. Jones, I., Chandra, P. S., Dazzan, P., & Howard, L. M. (2014). Bipolar disorder, affective psychosis, and schizophrenia in pregnancy and the post-partum period. *Lancet (London, England)*, *384*(9956), 1789–1799.
2. Wieck A & Jones IR (2020) Psychotropics in pregnancy and lactation. In: Seminars in Clinical Psychopharmacology. Haddad PM, Nutt DJ (eds.). RCPsych/Cambridge University Press.
3. Wieck A, Abel KMA (2016) Sexual, reproductive and antenatal care of women with mental illness. In: Comprehensive Women's Mental Health (DJ Castle and KM Abel, eds). Cambridge University Press, Cambridge.

Day 6: Monday 11th January 2021

Day 6	Topic	Speaker
09.15-10.45	Personality Disorder and its implications for Maternal Mental Health and Parenting Part 1	Dr Gwen Adshead
10.45-11.00	BREAK	
11.00-12.30	Personality Disorder and its implications for Maternal Mental Health and Parenting Part 2	Dr Gwen Adshead

12.30-13.15	LUNCH	
13.15-14.45	Psychological interventions for women with personality disorder in the perinatal period. Part 1	Dr Nic Horley
14.45-15.00	BREAK	
15.00-16.30	Psychological interventions for women with personality disorder in the perinatal period. Part 2	Dr Nic Horley

Intended learning objectives:

At the end of day 6 participants will be able to:

1. Demonstrate an understanding of personality function and dysfunction
2. Understand how personality function may become disordered in pregnancy and postnatally
3. Appreciate the importance of assessment and treatment of personality disorder by perinatal mental health services
4. Understand the different psychological therapies for women with personality disorder and their use during the perinatal period
5. Outline the psychological interventions which can support the parent-infant relationship for women with personality disorder and their infants.

Reading

Essential reading

1. Blankley, G., Galbally, M., Snellen, M., Power, J. and Lewis, A.J., (2015). Borderline personality disorder in the perinatal period: early infant and maternal outcomes. Australasian Psychiatry, 23(6), pp.688-692.
2. Hudson, C., Spry, E., Borschmann, R. et al . (2017). Preconception personality disorder and antenatal maternal mental health: A population-based cohort study. Journal of affective disorders, 209, pp.169-176.
3. Mikulincer, M. and Florian, V., (1999). Maternal-fetal bonding, coping strategies, and mental health during pregnancy–the contribution of attachment style. Journal of Social and Clinical Psychology, 18(3), pp.255-276.
4. Petfield, L., Startup, H., Droscher, H., & Cartwright-Hatton, S. (2015). Parenting in mothers with borderline personality disorder and impact on child outcomes. *Evidence-based mental health*, *18*(3), 67–75.

Recommended reading

1. Hobson, R.P., Patrick, M., Crandell, L., Garcia-Perez, R. and Lee, A., (2005). Personal relatedness and attachment in infants of mothers with borderline personality disorder. Dev Psychopathol, 17(2), pp.329-347.

2. Porcerelli, J.H., Huth-Bocks, A., Huprich, S.K. and Richardson, L., (2016). Defense mechanisms of pregnant mothers predict attachment security, social-emotional competence, and behavior problems in their toddlers. American Journal of Psychiatry, 173(2), pp.138-146.
3. Risholm Mothander, P., Furmark, C., & Neander, K. (2018). Adding "Circle of Security - Parenting" to treatment as usual in three Swedish infant mental health clinics. Effects on parents' internal representations and quality of parent-infant interaction. *Scandinavian journal of psychology*, *59*(3), 262–272
4. Smith-Nielsen, J., Steele, H., Mehlhase, H., Cordes, K., Steele, M., Harder, S. and Væver, M.S., (2015). Links among high EPDS scores, state of mind regarding attachment, and symptoms of personality disorder. Journal of Personality Disorders, 29(6), pp.771-793.
5. Wilson, H., & Donachie, A. L. (2018). Evaluating the Effectiveness of a Dialectical Behaviour Therapy (DBT) Informed Programme in a Community Perinatal Team. *Behavioural and cognitive psychotherapy*, *46*(5), 541–553.

Day 7: Thursday 11th February 2021

Day 7	Topic	Speaker
09.15-10:45	Joint working between forensic and perinatal psychiatry	Dr Olivia Protti
10.45-11.00	BREAK	
11.00-12.30	Murderous Mothers- feticide, neonaticide, infanticide, filicide – what does the perinatal psychiatrist need to know?	Dr Gwen Adshead
12.30-13.15	LUNC H	
13.15-14.45	Mental Health Law, Mental Capacity and the Court of Protection: issues in the perinatal period	Mr Alex Ruck Keene, Barrister Dr Livia Martucci
14.45-15.00	BREAK	
15.00-16.30	Advance Directives in the perinatal period	Dr Lucy Stephenson

Intended learning objectives:

At the end of day 7 participants will be able to:

1. Recognise the relevant legal frameworks and to formulate a legally informed advance decision making document with women in the perinatal period

2. Describe upcoming reforms to the Mental Health Act and the impact on advance decision making in the perinatal period

3. Distinguish between ethical/moral issues and legal frameworks and how to approach them separately

4. *Please note: ILOs from Gwen Adshead, Sumi Ratnam and Olivia Protti will be added to your group website*

Reading

Essential reading

1. Brockington I (1998) Infanticide (chapter 8) Motherhood and Mental Health.
2. Owen, G. S., Gergel, T., Stephenson, L. A., Hussain, O., Rifkin, L., & Keene, A. R. (2019). Advance decision-making in mental health - Suggestions for legal reform in England and Wales. *International journal of law and psychiatry*, *64*, 162–177.
3. Stephenson, L. A., Gergel, T., Ruck Keene, A., Rifkin, L., & Owen, G. (2020). The PACT advance decision-making template: preparing for Mental Health Act reforms with co-production, focus groups and consultation. *International journal of law and psychiatry*, *71*, 101563.
4. Welldon Estela V. (1992) Mother, Madonna, whore: The idealization and denigration of motherhood.

Recommended reading

1. Flynn, S. M., Shaw, J. J., & Abel, K. M. (2013). Filicide: mental illness in those who kill their children. *PloS one*, *8*(4), e58981.
2. Hindley, G., Stephenson, L. A., Ruck Keene, A., Rifkin, L., Gergel, T., & Owen, G. (2019). "Why have I not been told about this?": a survey of experiences of and attitudes to advance decision-making amongst people with bipolar. *Wellcome open research*, *4*, 16.
3. Ruck Keene, A. et al (2020) Carrying out and recording capacity assessments. 39 Essex Chambers. www.39essex.com/mental-capacity-guidance-note-brief-guide-carrying-capacity-assessments/
4. Ruck Keene, A. et al (2020) Determining and recording best interests. 39 Essex Chambers. www.39essex.com/mental-capacity-guidance-note-best-interests-july-2020/
5. Thornicroft, G., Farrelly, S., Szmukler, G., Birchwood, M., Waheed, W., Flach, C., Barrett, B., Byford, S., Henderson, C., Sutherby, K., Lester, H., Rose, D., Dunn, G., Leese, M., & Marshall, M. (2013). Clinical outcomes of Joint Crisis Plans to reduce compulsory treatment for people with psychosis: a randomised controlled trial. *Lancet (London, England)*, *381*(9878), 1634–1641.
6. Case comments: Re AB (Termination of pregnancy) - https://www.39essex.com/cop_cases/re-ab-termination-of-pregnancy/
7. Case comments: GSTT& SLAM vR –
8. Report of an independent inquiry into the care and treatment of Daksha Emson and her daughter Freya: www.simplypsychiatry.co.uk/sitebuildercontent/sitebuilderfiles/deinquiryreport.pdf
9. Vivian Gamor Serious Case Review – *to be circulated*

Day 8: Friday 12th February 2021

Day 8	Topic	Speaker
09.15-10.45	Pre-pregnancy Counselling	Dr Maddalena Miele

10.45-11.00	BREAK	
11.00-12.30	Pre-birth Planning	Dr Lucinda Green
12.30-13.15	LUNCH	
13.15-14.45	Working with and understanding women with substance dependence and misuse in the perinatal period. Part 1	Dr Emily Finch
14.45-15.00	BREAK	
15.00-16.30	Working with and understanding women with substance dependence and misuse in the perinatal period. Part 2	Dr Emily Finch

Intended learning objectives:

At the end of day 8 participants will be able to:

4. Understand the range of factors which should be discussed during the preconception consultation and the rationale for these
5. Have a framework to share the outcome of the consultation in a meaningful and sensitive way to women and their partners, highlighting risks, protective factors and the risks and benefits of treatments.
6. Understand how to organise and chair a perinatal mental health pre-birth planning meeting to ensure that the woman, her partner and other family members and the relevant professionals have a shared understanding of any concerns, needs and risks as well as the woman and family's strengths.
7. Develop effective perinatal mental health care plans collaboratively with women, partners, other carers and professionals.
8. Understand the issues encountered in measuring how common substance misuse in pregnancy is.
9. Explore ways to identify substance misuse in pregnancy
10. Understand what interventions are available to reduce the harm from substance misuse in pregnancy

Reading

Essential reading

1. Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health – *page 220 pregnancy section* - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf
2. Pre-conception advice: Best Practice Toolkit for Perinatal Mental Health Service (2019) Pan-London Perinatal Mental Health Networks. www.healthylondon.org/wp-content/uploads/2019/05/Pre-conception-advice-Best-Practice-Toolkit-for-Perinatal-Mental-Health-Services.pdf
3. Pre-Birth Planning: Best Practice Toolkit for Perinatal Mental Health Services (2019) Pan-London Perinatal Mental Health Networks.

https://www.healthylondon.org/wp-content/uploads/2019/01/Pre-birth-planning-guidance-for-Perinatal-Mental-Health-Networks.pdf

Recommended reading

1. Marlow, S., & Finch, E. (2016). Women and addiction. In D. Castle & K. Abel (Eds.), Comprehensive Women's Mental Health (pp. 174-196). Cambridge: Cambridge University Press.
2. Shawe, J. Steegers, E.A.P., Verbiest, S. (Eds) (2020). Preconception Health and Care: A Life Course Approach. Springer.
3. WHO (2014). Guidelines for the identification and management of substance use disorders in pregnancy. https://www.who.int/publications-detail/9789241548731
4. Wilson CA, Finch E, Kerr C, Shakespeare J. (2020) Alcohol, smoking, and other substance use in the perinatal period. *BMJ*. 369:m1627.

Day 9: Monday 15th March 2021

Day 9	Topic	Speaker
09.15-10.45	Eating Disorders: presentation, assessment, care and treatment in the perinatal period	Dr Catia Acosta
10.45-11.00	BREAK	
11.00-12.30	Eating Disorders: presentation, assessment, care and treatment in the perinatal period	Dr Catia Acosta
12.30-13.15	LUNCH	
13.15-14.45	Pregnancy loss, infertility and trauma	Dr Lucinda Green Dr Sarah Finnis
14.45-15.00	BREAK	
15.00-16.30	Complex pregnancy related presentations	Dr Lucinda Green Dr Sarah Finnis

Intended learning objectives:

At the end of day 9 participants will be able to:

5. Screen for and identify women who have a diagnosis of an eating disorder in the perinatal period.
6. Assess women who have eating disorders in the perinatal period, including assessment of the risk to the woman, the foetus and the infant and requesting physical investigations and discussing risk concerns with women.
7. Devise a perinatal mental health care plan for a woman who has an eating disorder in the perinatal period, in partnership with the woman, the eating disorder service and other relevant professionals.
8. Understand the factors which contribute to birth trauma (PTSD)

9. Understand how pregnancy related trauma and loss can affect women and partners.
10. Demonstrate knowledge and understanding of the challenges and complexities for women and partners associated with assisted conception.

Reading

Essential reading

3. NICE (2017). Eating disorders: recognition and treatment.
4. Acosta, C., Treasure, J. (2015) Eating Disorders: Overview and Management in Women. Current progress in obstetrics and gynaecology, volume 3. Ed: Studd J, Tan SL.
5. Daugirdaitė, V., van den Akker, O., & Purewal, S. (2015). Posttraumatic stress and posttraumatic stress disorder after termination of pregnancy and reproductive loss: a systematic review. *Journal of pregnancy*, *2015*, 646345.
6. Bhat, A., & Byatt, N. (2016). Infertility and Perinatal Loss: When the Bough Breaks. *Current psychiatry reports*, *18*(3), 31.

Recommended reading

5. Bye, A., Shawe, J., Bick, D., Easter, A., Kash-Macdonald, M., & Micali, N. (2018). Barriers to identifying eating disorders in pregnancy and in the postnatal period: a qualitative approach. *BMC pregnancy and childbirth*, *18*(1), 114.
6. Christiansen D. M. (2017). Posttraumatic stress disorder in parents following infant death: A systematic review. *Clinical psychology review*, *51*, 60–74.
7. Easter, A., Treasure, J., & Micali, N. (2011). Fertility and prenatal attitudes towards pregnancy in women with eating disorders: results from the Avon Longitudinal Study of Parents and Children. *BJOG : an international journal of obstetrics and gynaecology*, *118*(12), 1491–1498.
8. Farren, J., Jalmbrant, M., Ameye, L., Joash, K., Mitchell-Jones, N., Tapp, S., Timmerman, D., & Bourne, T. (2016). Post-traumatic stress, anxiety and depression following miscarriage or ectopic pregnancy: a prospective cohort study. *BMJ open*, *6*(11), e011864.
9. Fogarty, S., Elmir, R., Hay, P. *et al.* (2018).The experience of women with an eating disorder in the perinatal period: a meta-ethnographic study. *BMC Pregnancy Childbirth* 18, 121.
10. Hunter, A., Tussis, L., & MacBeth, A. (2017). The presence of anxiety, depression and stress in women and their partners during pregnancies following perinatal loss: A meta-analysis. *Journal of affective disorders*, *223*, 153–164.
11. Kitzinger, S (2006) Birth Crisis. Routledge.

12. Koert E, Malling GMH, Sylvest R, et al. Recurrent pregnancy loss: couples' perspectives on their need for treatment, support and follow up. *Hum Reprod*. 2019;34(2):291-296.
13. Martínez-Olcina, M., Rubio-Arias, J. A., Reche-García, C., Leyva-Vela, B., Hernández-García, M., Hernández-Morante, J. J., & Martínez-Rodríguez, A. (2020). Eating Disorders in Pregnant and Breastfeeding Women: A Systematic Review. *Medicina (Kaunas, Lithuania)*, *56*(7), 352.
14. McCluskey, G. and Gilbert, P. (2015) Implications counselling for people considering donor-assisted treatment. Fully updated version. BICA Publications.
15. Pearson G. *The Burden of Choice: Collected stories from parents facing a diagnosis of abnormalities during pregnancy*. Dormouse Press: 2013
16. Quagliata E (Ed.). (2013) *Becoming Parents and Overcoming Obstacles: Understanding the Experience of miscarriage, premature births, infertility and postnatal depression*. Karnac Books.
17. Svanberg, E. (2019) Why Birth Trauma Matters. Pinter & Martin.
18. The Lancet (2020). Eating disorders: innovation and progress urgently needed. *Lancet (London, England)*, *395*(10227), 840.
19. Van Der Kolk, B. (2015) The Body Keeps the Score: Mind, Brain and Body in the Transformation of Trauma. Penguin.

Day 10: Thursday 22nd April 2020

Day 10	Topic	Speaker
09.15-10.45	How to talk with commissioners.	Dr David Bridle
10.45-11.00	BREAK	
11.00-12.30	Compassionate Leadership within Perinatal Mental Health Teams.	Dr Lucinda Green
12.30-13.15	LUNCH	
13.15-14.45	The Long Term Plan – implications for leadership and service development	Participants and facilitators
14.45-15.00	BREAK	
15.00-16.30	Going forward: reflections on the course and the application of what has been learned to clinical practice and service development.	Participants and facilitators

Intended learning objectives:

At the end of day 10 participants will be able to:

1. Improve your understanding of the commissioning of services and the changes happening with this
2. Develop your perspectives on relating to those who control/manage/influence the resourcing decisions for services
3. Understand what you can bring in your leadership role as a consultant psychiatrist to constructively contribute to those decisions

4. Identify approaches to implementing the NHS Long Term Plan within perinatal mental health services
5. Understand the advantages of compassionate leadership approaches for leaders and teams
6. Recognise the importance of self-compassion
7. Plan changes to their own clinical practice and services as a result of learning on the course

Reading

Essential reading

2. West, M., Eckert, R., Collins, B., &Chowla, R. (2017) Caring to Change. How compassionate leadership can stimulate innovation in health care. The King's Fund
3. https://www.kingsfund.org.uk/publications/what-commissioning-and-how-it-changing
4. https://www.kingsfund.org.uk/publications/integrated-care-systems-explained

Recommended reading

7. Conversano, C., Ciacchini, R., Orrù, G., Di Giuseppe, M., Gemignani, A., & Poli, A. (2020). Mindfulness, Compassion, and Self-Compassion Among Health Care Professionals: What's New? A Systematic Review. *Frontiers in psychology*, *11*, 1683. https://doi.org/10.3389/fpsyg.2020.01683.
8. de Zulueta P. C. (2015). Developing compassionate leadership in health care: an integrative review. *Journal of healthcare leadership*, *8*, 1–10.
9. Neff, KD, Knox, MC, Long, P, Gregory, K. (2020) Caring for others without losing yourself: An adaptation of the Mindful Self-Compassion Program for Healthcare Communities. *J Clin Psychol.* 76, 1543– 1562.
10. NHS England (2014) Building and Strengthening Leadership: Leading with Compassion
11. https://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model/
12. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan-june-2019.pdf

Royal College of Psychiatrists - Perinatal Psychiatry Masterclass Programme

SAS Psychiatrists

The aims of this masterclass programme are to:

- enable and support SAS doctors in perinatal psychiatry and other services for women of child-bearing potential in their assessment, understanding and management of complex clinical work
- encourage participants to integrate current evidence into clinical practice
- develop self-reflection skills
- emphasise the importance of the perspectives of women, infants, partners and families throughout the perinatal pathway
- improve patient safety
- improve the experience of women and families during the perinatal period and within perinatal mental health services.

The following key issues are fundamental aspects of perinatal mental health care and will be discussed and considered throughout the programme:

- safeguarding children and adults
- culture and difference
- collaborative working with women, partners and families
- women's own experience of perinatal mental disorders and care
- legal issues

Themes

Day 1	Introductions The National Picture Assessment and communication
Day2	Lived experience, co-production, partners
Day 3	Mental disorders in the perinatal period
Day 4	The infant
Day 5	Risk and Safeguarding adults and children
Day 6	Personality Disorder

Day 7	Prescribing in the perinatal period
Day 8	Pre-pregnancy Counselling, pre-birth planning. Addictions
Day 9	Eating Disorders Pregnancy loss, infertility and complex pregnancy related issues
Day 10	Mental Health law, Mental Capacity, Court of Protection. Advance Directives.

Programme:

Each day will be facilitated by Dr Liz McDonald and Dr Lucinda Green.
Dr Clare Dolman will also facilitate on Day 2.
Learning objectives and reading lists will be provided before each day.
Each session within the day will have a didactic component and small group work/discussion.

Course dates

Each day will start at 9.15am and finish at 4.30pm.

Group 1	**Group 2**
• Thursday 10th September 2020 • Friday 2nd October 2020 • Monday 9th November 2020 • Tuesday 10th November 2020 • 10th December 2020 • Thursday 8th January 2021 • Monday 1st February 2021 • Tuesday 2nd February 2021 • Friday 19th March 2021 • Friday 23rd April 2021	• Friday 25th September 2020 • Tuesday 13th October 2020 • Monday 16th November 2020 • Tuesday 17th November 2020 • Friday 11th December 2020 • Thursday 14th January 2021 • Monday 22nd February 2021 • Tuesday 23rd February 2021 • Friday 19th March 2021 • Monday 19th April 2021

Day 1:

Day 1	**Topic**	**Speaker**
09.15-10.45	Introduction to the masterclass programme and to each other. What do you hope to achieve by your participation?	Dr Liz McDonald Dr Lucinda Green
10.45-11.00	BREAK	
11.00-12.30	The National Picture: where are we now? what is your role?	Dr Giles Berrisford
12.30-13.15	LUNCH	
13.15-14.45	How does the perinatal frame of mind inform our assessments?	Dr Liz McDonald

14.45-15.00	BREAK	
15.00-16.30	Formulating and communicating assessments	Dr Lucinda Green

Intended learning objectives:

At the end of day 1 participants will be able to:

13. Demonstrate an understanding of how the case for perinatal mental health service expansion was made
14. Apply this understanding to the development of services in wave 1 and wave 2 of the Five Year Forward View
15. Evaluate the proposed changes to perinatal mental health services outlined in the NHS Long Term Plan and consider how these service developments can be implemented.
16. Describe the range of factors that can affect a woman's mental health in the perinatal period and her experience of pregnancy and parenting.
17. Summarise, formulate and communicate assessments to enable women, families and professionals to understand the factors which have contributed to her mental health problems, associated risks and/or her risk of developing a perinatal mental illness.

Reading

Essential reading

3. NHS England (2016) The Five Year Forward View for Mental Health
4. NHS England (2019) The NHS Long Term Plan

Recommended reading

4. Bauer A, Knapp M, Adelaja B (2016). Best Practice for perinatal mental health care: the economic case. PSSRU. London School of Economics.
5. NHS England (2016) Better Births: Improving outcomes of maternity services in England - A Five Year Forward View for maternity care.
6. Royal College of Psychiatrists 2018) *Framework for Routine Outcome Measurement in Perinatal Psychiatry*. College Report CR126.

Day 2

Day 2	**Topic**	**Speaker**
09.15-10.45	What does the literature tell us about women's experience of care and treatment in the perinatal period?	Dr Clare Dolman
10.45-11.00	BREAK	
11.00-12.30	What could have improved my experience of care in the perinatal period?	Kathryn Grant Rachael Buabeng

	Group: what can I do in my service to improve the care of women?	
12.30-13.15	LUNCH	
13.15-14.45	Co-production in PMH services. My experience.	Rosie Lowman
14.45-15.00	BREAK	
15.00-16.30	What is the experience of the partner? As support to the woman, own needs and building a relationship with the infant.	Henry Fay

Intended learning objectives:

At the end of day 2 participants will be able to:

6. Demonstrate an awareness of the barriers to care for women in the perinatal period
7. Understand the factors influencing women's decision-making around pregnancy and childbirth
8. Recognise how healthcare professionals can improve the experience of women and families receiving perinatal mental healthcare
9. Understand the benefits of involving women and partners in co-producing perinatal mental health services.
10. Recognise the effect of a woman's perinatal mental illness on her partner.

Reading

Essential reading

3. Dolman, C., Jones, I., & Howard, L. M. (2013). Pre-conception to parenting: a systematic review and meta-synthesis of the qualitative literature on motherhood for women with severe mental illness. *Archives of women's mental health*, *16*(3), 173–196.
4. Lever Taylor, B., Billings, J., Morant, N., Bick, D., & Johnson, S. (2019). Experiences of how services supporting women with perinatal mental health difficulties work with their families: a qualitative study in England. *BMJ open*, *9*(7), e030208.

Recommended reading

9. Dolman, C., Jones, I. R., & Howard, L. M. (2016). Women with bipolar disorder and pregnancy: factors influencing their decision-making. BJPsych open, 2(5), 294–300.
10. Lever Taylor, B., Kandiah, A., Johnson, S., Howard, L. M., & Morant, N. (2020). A qualitative investigation of models of community mental health care for women

with perinatal mental health problems. Journal of mental health (Abingdon, England), 1–7. Advance online publication.
11. Lever Taylor, B., Mosse, L., & Stanley, N. (2019). Experiences of social work intervention among mothers with perinatal mental health needs. Health & social care in the community, 27(6), 1586–1596.
12. Megnin-Viggars O, Symington I, Howard LM, Pilling S. Experience of care for mental health problems in the antenatal or postnatal period for women in the UK: a systematic review and meta-synthesis of qualitative research. *Arch Womens Ment Health*. 2015;18(6):745-759.
13. Millett, L., Taylor, B. L., Howard, L. M., Bick, D., Stanley, N., & Johnson, S. (2018). Experiences of Improving Access to Psychological Therapy Services for Perinatal Mental Health Difficulties: a Qualitative Study of Women's and Therapists' Views. *Behavioural and cognitive psychotherapy*, *46*(4), 421–436.
14. Royal College of Obstetricians and Gynaecologists (2017) Maternal mental health women's voices.
15. Sambrook Smith, M., Lawrence, V., Sadler, E., & Easter, A. (2019). Barriers to accessing mental health services for women with perinatal mental illness: systematic review and meta-synthesis of qualitative studies in the UK. BMJ open, 9(1), e024803.
16. Watson H, Harrop D, Walton E, Young A, Soltani H. A systematic review of ethnic minority women's experiences of perinatal mental health conditions and services in Europe. *PLoS One*. 2019;14(1):e0210587.

Day 3:

Day 3	Topic	Speaker
09.15-10.45	Depression in the perinatal period	Dr Lucinda Green
10.45-11.00	BREAK	
11.00-12.30	Bipolar Affective Disorder and Post-partum Psychosis	Prof Ian Jones Dr Liz McDonald
12.30-13.15	LUNCH	
13.15-14.45	Schizophrenia in women	Dr Liz McDonald
14.45-15.00	BREAK	
15.00-16.30	OCD and anxiety disorders in the perinatal period	Dr Lucinda Green

Intended learning objectives:

At the end of day 3 participants will be able to:

1. Describe the prevalence and symptoms of a range of mental disorders in the perinatal period, including Perinatal Depression, Postpartum Psychosis and Perinatal OCD.
2. Understand the complexity than can exist when assessing and treating women who have depression and anxiety disorders in the perinatal period.

3. Recognise the reasons for identifying women early in pregnancy who have a history of Bipolar Disorder, Schizophrenia or other psychoses, and/or a high risk of Postpartum Psychosis, and ensuring there is a comprehensive multiagency plan for each woman and family's care.

Reading

Essential reading

1. Bergink, V., Rasgon, N., & Wisner, K. L. (2016). Postpartum Psychosis: Madness, Mania, and Melancholia in Motherhood. *The American journal of psychiatry*, *173*(12), 1179–1188.
2. Challacombe, F. L., Bavetta, M., & De Giorgio, S. (2019). Intrusive thoughts in perinatal obsessive-compulsive disorder. *BMJ (Clinical research ed.)*, *367*, l6574.
3. Di Florio A &Jones IR. (2019) Postpartum Depression. *BMJ Best Practice*.
4. Forde R, Peters S, Wittkowski A. Recovery from postpartum psychosis: a systematic review and metasynthesis of women's and families' experiences [published online ahead of print, 2020 Feb 4]. *Arch Womens Ment Health*. 2020;10.1007/s00737-020-01025-z.

Recommended reading

1. Ayers S, Bond R, Bertullies S, Wijma K. The aetiology of post-traumatic stress following childbirth: a meta-analysis and theoretical framework. *Psychol Med*. 2016;46(6):1121-1134.
2. Connellan, K., Bartholomaeus, C., Due, C., & Riggs, D. W. (2017). A systematic review of research on psychiatric mother-baby units. *Archives of women's mental health*, *20*(3), 373–388.
3. Di Florio, A., Forty, L., Gordon-Smith, K., Heron, J., Jones, L., Craddock, N., & Jones, I. (2013). Perinatal episodes across the mood disorder spectrum. *JAMA psychiatry*, *70*(2), 168–175.
4. Di Florio, A., Gordon-Smith, K., Forty, L., Kosorok, M. R., Fraser, C., Perry, A., Bethell, A., Craddock, N., Jones, L., & Jones, I. (2018). Stratification of the risk of bipolar disorder recurrences in pregnancy and postpartum. *The British journal of psychiatry : the journal of mental science*, *213*(3), 542–547.
5. Ding, X.X., Wu, Y.L., Xu, S.J., et al. (2014) Maternal anxiety during pregnancy and adverse birth outcomes: a systematic review and meta-analysis of prospective cohort studies. J Affect Disord. 159, pp. 103-110.
6. Glangeaud-Freudenthal, N. M., Sutter-Dallay, A. L., Thieulin, A. C., Dagens, V., Zimmermann, M. A., Debourg, A., Amzallag, C., Cazas, O., Cammas, R., Klopfert, M. E., Rainelli, C., Tielemans, P., Mertens, C., Maron, M., Nezelof, S., & Poinso, F. (2013). Predictors of infant foster care in cases of maternal psychiatric disorders. *Social psychiatry and psychiatric epidemiology*, *48*(4), 553–561.

7. Guintivano, J., Manuck, T., & Meltzer-Brody, S. (2018). Predictors of Postpartum Depression: A Comprehensive Review of the Last Decade of Evidence. *Clinical obstetrics and gynecology*, *61*(3), 591–603.
8. Jarde, A., Morais, M., Kingston, D., Giallo, R., MacQueen, G. M., Giglia, L., Beyene, J., Wang, Y., & McDonald, S. D. (2016). Neonatal Outcomes in Women With Untreated Antenatal Depression Compared With Women Without Depression: A Systematic Review and Meta-analysis. *JAMA psychiatry*, *73*(8), 826–837.
9. Rusner, M., Berg, M., Begley, C. (2016) Bipolar disorder in pregnancy and childbirth: a systematic review of outcomes. BMC Pregnancy Childbirth. 16(1), p. 331.
10. Slomian, J., Honvo, G., Emonts, P., Reginster, J. Y., & Bruyère, O. (2019). Consequences of maternal postpartum depression: A systematic review of maternal and infant outcomes. *Women's health (London, England)*, *15*, 1745506519844044.
11. Svanberg E. (2019) Why Birth Trauma Matters. Pinter & Martin Ltd.
12. Zhong, Q.Y., Gelaye, B., Fricchione, G.L., Avillach, P., Karlson., EW., Williams, M.A. (2018) Adverse obstetric and neonatal outcomes complicated by psychosis among pregnant women in the United States. BMC Pregnancy Childbirth. 18(1), p. 120.

Day 4:

Day 4	**Topic**	**Speaker**
09.15-10.45	Assessment of the mother-infant relationship in clinical practice.	Dr Maddalena Miele
10.45-11.00	BREAK	
11.00-12.30	Assessment of the mother-infant relationship in clinical practice.	Dr Maddalena Miele
12.30-13.15	LUNCH	
13.15-14.45	The evidence base for interventions with parents and infants in the perinatal period.	Dr Jane Barlow
14.45-15.00	BREAK	
15.00-16.30	Parent-infant psychotherapy *please note both MCSAS1 and MCSAS2 will attend this seminar on 10th November 2020	Dr Amanda Jones

Intended learning objectives:

At the end of day 4 participants will be able to:

7. Understand the key ways in which perinatal mental health problems can affect the ability of women to interact with their infant
8. Demonstrate a basic knowledge of the current clinical approaches to assessing parent-infant relationships

9. Describe the basic principles of attachment theory and the neurobiology of parenting
10. Outline the determinants of a sensitive parent-infant interaction
11. Understand the key ways in which parent-infant interaction during the postnatal period influences the later capacity of the infant for emotion regulation
12. Examine some of the key evidence-based methods of working dyadically, with mothers experiencing perinatal mental health problems, to support the interaction with the baby.

Reading

Essential reading

4. Laulik, S., Chau, S., Browne, K., & Allam, J. (2013). The link between personality disorder and parenting behaviors: A systematic review. Aggression and Violent Behavior 18(6), 644–655.
5. Royal College of Psychiatry (2018). Framework for Routine Outcome Measures in Perinatal Psychiatry CR216. London: RCP.
6. Van Ijzendoorn, M.H., Schuengel, C., Bakermans-Kranenburg, M.J. (1999). Disorganized attachment in early childhood: meta-analysis of precursors, concomitants, and sequelae. *Developmental Psychopathology,*11(2), 225-49.

Recommended reading

7. Madigan, S., Bakermans-Kranenburg, MJ., Van Ijzendoorn, M.H., Moran, G., Pederson, D.R., & Benoit, D. (2006). Unresolved states of mind, anomalous parental behavior, and disorganized attachment: a review and meta-analysis of a transmission gap. Attachment and Human Development, 8(2), 89–111.
8. Music G. *Nurturing Natures (2017). Attachment and Children's Emotional, Sociocultural and Brain Development*. 2nd Edition. London: Routledge.
9. O'Hara, L., Smith, E.R., Barlow, J., Livingstone, N., Herath, N.I.N.S., Wei, Y., Spreckelsen, T.F., & Macdonald, G. (Forthcoming). Video feedback for improving parental sensitivity and child attachment. Cochrane Library.
10. P.O. Svanberg , J. Barlow & W. Tigbe (2013) The Parent–Infant Interaction Observation Scale: reliability and validity of a screening tool, Journal of Reproductive and Infant Psychology, 31:1, 5-14.
11. Schore, A.N. (2001). The effects of early relational trauma on right brain development, affect regulation, and infant mental health. Infant Mental Health Journal, 22, 201-269.
12. Stein A, Pearson RM, Goodman SH, et al. Effects of perinatal mental disorders on the fetus and child. *Lancet*. 2014;384(9956):1800-1819.

Day 5:

Day 5	Topic	Speaker

09.15-10.45	What have we learned from women who have died from psychiatric causes in the perinatal period?	Dr Roch Cantwell
10.45-11.00	BREAK	
11.00-12.30	Violence towards women in the perinatal period.	Dr Hind Khalifeh
12.30-13.15	LUNCH	
13.15-14.45	Safeguarding infants and children in the context of maternal mental disorder.	Dr Lucinda Green
14.45-15.00	BREAK	
15.00-16.30	Safeguarding infants and children in the context of maternal mental disorder.	Dr Lucinda Green

Intended learning objectives:

At the end of day 5 participants will be able to:

17. Describe the epidemiology of self-harm and suicide in the perinatal period.
18. Describe the distinctive clinical features of maternal suicide.
19. Recognise risk in relation to maternal suicide and apply this to clinical assessment.
20. Understand the evidence base regarding the extent and impact of domestic violence / abuse in the perinatal period
21. Understand the evidence base regarding interventions for domestic violence/ abuse including for domestic violence/abuse in the perinatal period.
22. Demonstrate skills in enquiring about and responding to domestic violence/abuse disclosures by women under the care of perinatal mental health services
23. Describe the factors highlighted in child serious case reviews which can affect children's safety and wellbeing and increase the risk of abuse and neglect.
24. Recognise how perinatal mental health services, working effectively in partnership with a range of professionals, can ensure child safeguarding concerns are identified early and that effective care, treatment and support for women and families can reduce the risk of harm to infants and children.

Reading

Essential reading

7. Oates M & Cantwell R (2011) Deaths due to psychiatric causes. Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer 2006-2008. *British Journal of Obstetrics and Gynaecology*, 118 (s1), 132-142.
8. Cantwell R, Knight M, Oates M, Shakespeare J on behalf of the MBRRACE-UK mental health chapter writing group (2015) Lessons on maternal mental health. In Knight M, Tuffnel D, Kenyon S, Shakespeare J, Gray R, Kyrinczuk JJ (Eds.) on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care – Surveillance of maternal deaths in the UK 2011-13 and lessons learned to inform maternity care from the UK

and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2015: p22-41.

9. Cantwell R, Youd E and Knight M on behalf of the MBRRACE-UK mental health chapter-writing group (2018) Messages for mental health. In Knight M, Bunch K, Tuffnell D, Jayakody H, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014-16. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2018: p42-60.
10. Department for Education (2018). *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*. London: HM Government
11. Howard, L. M., Oram, S., Galley, H., Trevillion, K., & Feder, G. (2013). Domestic violence and perinatal mental disorders: a systematic review and meta-analysis. *PLoS medicine*, *10*(5), e1001452.
12. Hahn, C. K., Gilmore, A. K., Aguayo, R. O., & Rheingold, A. A. (2018). Perinatal Intimate Partner Violence. *Obstetrics and gynecology clinics of North America*, *45*(3), 535–547.

Recommended reading

10. Department for Education (2020) *Complexity and challenge: a triennial analysis of serious case reviews 2014-2017*. London: Department for Education.
11. Hammond J, Lipsedge M. Assessing Parenting Capacity in Psychiatric Mother and Baby Units: A case report and review of literature. *Psychiatr Danub*. 2015;27 Suppl 1: S71-S83.
12. Johannsen BMW et al (2016) All-cause mortality in women with severe postpartum psychiatric disorders. American Journal of Psychiatry, 173, 635-642.
13. Johannsen et al (2020) Self-harm in women with postpartum mental disorders. Psychological Medicine, 50, 1563-1569.
14. Khalifeh, H., Hunt, I.M., Appleby, L., Howard, L.M. (2016) Suicide in perinatal and non-perinatal women in contact with psychiatric services: 15 year findings from a UK national inquiry. Lancet Psychiatry. 3(3), pp. 233-242.
15. Khalifeh, H., Moran, P., Borschmann, R., Dean, K., Hart, C., Hogg, J., Osborn, D., Johnson, S., & Howard, L. M. (2015). Domestic and sexual violence against patients with severe mental illness. *Psychological medicine*, *45*(4), 875–886.
16. Lysell H et al (2018) Maternal suicide: register based study of all suicides occurring after delivery in Sweden 1974-2009. PLoS ONE, 13(1): e0190133.
17. Smithson, R., and Gibson, M. Less than human: a qualitative study into the experience of parents involved in the child protection system. *Child & Family Social Work*. 2017;22:565–574.
18. Webinar: https://www.solacewomensaid.org/free-webinar-series-supporting-survivors-during-covid-19

Day 6:

Day 6	Topic	Speaker
09.15-10.45	Personality Disorder and its implications for Maternal Mental Health and Parenting Part 1	Dr Gwen Adshead
10.45-11.00	BREAK	
11.00-12.30	Personality Disorder and its implications for Maternal Mental Health and Parenting Part 2	Dr Gwen Adshead
12.30-13.15	LUNCH	
13.15-14.45	Psychological interventions for women with personality disorder in the perinatal period. Part 1	Dr Nic Horley
14.45-15.00	BREAK	
15.00-16.30	Psychological interventions for women with personality disorder in the perinatal period. Part 2	Dr Nic Horley

Intended learning objectives:

At the end of day 6 participants will be able to:

6. Demonstrate an understanding of personality function and dysfunction
7. Understand how personality function may become disordered in pregnancy and postnatally
8. Appreciate the importance of assessment and treatment of personality disorder by perinatal mental health services
9. Understand the different psychological therapies for women with personality disorder and their use during the perinatal period
10. Outline the psychological interventions which can support the parent-infant relationship for women with personality disorder and their infants.

Reading

Essential reading

5. Blankley, G., Galbally, M., Snellen, M., Power, J. and Lewis, A.J., (2015). Borderline personality disorder in the perinatal period: early infant and maternal outcomes. Australasian Psychiatry, 23(6), pp.688-692.
6. Hudson, C., Spry, E., Borschmann, R. et al . (2017). Preconception personality disorder and antenatal maternal mental health: A population-based cohort study. Journal of affective disorders, 209, pp.169-176.
7. Mikulincer, M. and Florian, V., (1999). Maternal-fetal bonding, coping strategies, and mental health during pregnancy–the contribution of attachment style. Journal of Social and Clinical Psychology, 18(3), pp.255-276.

8. Petfield, L., Startup, H., Droscher, H., & Cartwright-Hatton, S. (2015). Parenting in mothers with borderline personality disorder and impact on child outcomes. *Evidence-based mental health*, *18*(3), 67–75.

Recommended reading

6. Hobson, R.P., Patrick, M., Crandell, L., Garcia-Perez, R. and Lee, A., (2005). Personal relatedness and attachment in infants of mothers with borderline personality disorder. Dev Psychopathol, 17(2), pp.329-347.
7. Porcerelli, J.H., Huth-Bocks, A., Huprich, S.K. and Richardson, L., (2016). Defense mechanisms of pregnant mothers predict attachment security, social-emotional competence, and behavior problems in their toddlers. American Journal of Psychiatry, 173(2), pp.138-146.
8. Risholm Mothander, P., Furmark, C., & Neander, K. (2018). Adding "Circle of Security - Parenting" to treatment as usual in three Swedish infant mental health clinics. Effects on parents' internal representations and quality of parent-infant interaction. *Scandinavian journal of psychology*, *59*(3), 262–272
9. Smith-Nielsen, J., Steele, H., Mehlhase, H., Cordes, K., Steele, M., Harder, S. and Væver, M.S., (2015). Links among high EPDS scores, state of mind regarding attachment, and symptoms of personality disorder. Journal of Personality Disorders, 29(6), pp.771-793.
10. Wilson, H., & Donachie, A. L. (2018). Evaluating the Effectiveness of a Dialectical Behaviour Therapy (DBT) Informed Programme in a Community Perinatal Team. *Behavioural and cognitive psychotherapy*, *46*(5), 541–553.

Day 7:

Day 7	**Topic**	**Speaker**
09.15-09.50	Prescribing anti-depressant medication in the perinatal period: how do we translate evidence into practice?	Prof Ian Jones
09.50-10.45	Prescribing anti-psychotic medication and mood stabilisers in pregnancy and breastfeeding	Dr Angelika Wieck
10.45-11.00	BREAK	
11.00-12.30	Case discussions and examples of prescribing medication in pregnancy and breastfeeding	Dr Angelika Wieck Prof Ian Jones
12.30-13.15	LUNCH	
13.15-14.45	How do we interpret the evidence in relation to prescribing in pregnancy? Workshop: participants will review and discuss selected literature.	Dr Angelika Wieck Prof Ian Jones
14.45-15.00	BREAK	

15.00-16.30	How do we interpret the evidence in relation to prescribing in pregnancy? Workshop: participants will discuss how they talk about risk/benefit analysis when supporting women with decision making.	Dr Angelika Wieck Prof Ian Jones

Intended learning objectives:

At the end of day 7 participants will be able to:

7. Understand the kinds of methodological problems that hamper research into the reproductive safety of psychotropic drugs and be able to take these into account when interpreting peer-reviewed publications
8. Be familiar with currently available evidence on the reproductive safety of the main psychotropic drugs, resources that provide high quality evidence updates and current influential prescribing guidance
9. Be able to apply current evidence and general principles for the pharmacological management of pregnant and breastfeeding women to clinical scenarios.

Reading

Essential reading

4. McAllister-Williams, R. H., Baldwin, D. S., Cantwell, R. et al (2017). British Association for Psychopharmacology consensus guidance on the use of psychotropic medication preconception, in pregnancy and postpartum. *Journal of psychopharmacology (Oxford, England)*, *31*(5), 519–552.
5. National Institute for Health and Care Excellence (2014). Antenatal and Postnatal Mental Health - Clinical Management and Service Guidance. Clinical Guideline 192.
6. MHRA: Valproate use by women and girls (2018). www.gov.uk/guidance/valproate-use-by-women-and-girls

Recommended reading

4. Jones, I., Chandra, P. S., Dazzan, P., & Howard, L. M. (2014). Bipolar disorder, affective psychosis, and schizophrenia in pregnancy and the post-partum period. *Lancet (London, England)*, *384*(9956), 1789–1799.
5. Wieck A & Jones IR (2020) Psychotropics in pregnancy and lactation. In: Seminars in Clinical Psychopharmacology. Haddad PM, Nutt DJ (eds.). RCPsych/Cambridge University Press.
6. Wieck A, Abel KMA (2016) Sexual, reproductive and antenatal care of women with mental illness. In: Comprehensive Women's Mental Health (DJ Castle and KM Abel, eds). Cambridge University Press, Cambridge.

Day 8:

Day 8	Topic	Speaker
09.15-10.45	Pre-pregnancy Counselling	Dr Maddalena Miele
10.45-11.00	BREAK	
11.00-12.30	Pre-birth Planning	Dr Lucinda Green
12.30-13.15	LUNCH	
13.15-14.45	Working with and understanding women with substance dependence and misuse in the perinatal period. Part 1	Dr Emily Finch
14.45-15.00	BREAK	
15.00-16.30	Working with and understanding women with substance dependence and misuse in the perinatal period. Part 2	Dr Emily Finch

Intended learning objectives:

At the end of day 8 participants will be able to:

11. Understand the range of factors which should be discussed during the preconception consultation and the rationale for these
12. Have a framework to share the outcome of the consultation in a meaningful and sensitive way to women and their partners, highlighting risks, protective factors and the risks and benefits of treatments.
13. Understand how to organise and chair a perinatal mental health pre-birth planning meeting to ensure that the woman, her partner and other family members and the relevant professionals have a shared understanding of any concerns, needs and risks as well as the woman and family's strengths.
14. Develop effective perinatal mental health care plans collaboratively with women, partners, other carers and professionals.
15. Understand the issues encountered in measuring how common substance misuse in pregnancy is.
16. Explore ways to identify substance misuse in pregnancy
17. Understand what interventions are available to reduce the harm from substance misuse in pregnancy

Reading

Essential reading

4. Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on

clinical management. London: Department of Health – *page 220 pregnancy section* - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

5. Pre-conception advice: Best Practice Toolkit for Perinatal Mental Health Service (2019) Pan-London Perinatal Mental Health Networks. www.healthylondon.org/wp-content/uploads/2019/05/Pre-conception-advice-Best-Practice-Toolkit-for-Perinatal-Mental-Health-Services.pdf
6. Pre-Birth Planning: Best Practice Toolkit for Perinatal Mental Health Services (2019) Pan-London Perinatal Mental Health Networks. https://www.healthylondon.org/wp-content/uploads/2019/01/Pre-birth-planning-guidance-for-Perinatal-Mental-Health-Networks.pdf

Recommended reading

5. Marlow, S., & Finch, E. (2016). Women and addiction. In D. Castle & K. Abel (Eds.), Comprehensive Women's Mental Health (pp. 174-196). Cambridge: Cambridge University Press.
6. Shawe, J. Steegers, E.A.P., Verbiest, S. (Eds) (2020). Preconception Health and Care: A Life Course Approach. Springer.
7. WHO (2014). Guidelines for the identification and management of substance use disorders in pregnancy. https://www.who.int/publications-detail/9789241548731
8. Wilson CA, Finch E, Kerr C, Shakespeare J. (2020) Alcohol, smoking, and other substance use in the perinatal period. *BMJ*. 369:m1627.

Day 9:

Day 9	Topic	Speaker
09.15-10.45	Eating Disorders: presentation, assessment, care and treatment in the perinatal period	Dr Catia Acosta
10.45-11.00	BREAK	
11.00-12.30	Eating Disorders: presentation, assessment, care and treatment in the perinatal period	Dr Catia Acosta
12.30-13.15	LUNCH	
13.15-14.45	Pregnancy loss, infertility and trauma	Dr Sarah Finnis Dr Lucinda Green
14.45-15.00	BREAK	
15.00-16.30	Complex pregnancy related presentations	Dr Sarah Finnis Dr Lucinda Green

Intended learning objectives:

At the end of day 9 participants will be able to:

11. Screen for and identify women who have a diagnosis of an eating disorder in the perinatal period.
12. Assess women who have eating disorders in the perinatal period, including assessment of the risk to the woman, the foetus and the infant and requesting physical investigations and discussing risk concerns with women.
13. Devise a perinatal mental health care plan for a woman who has an eating disorder in the perinatal period, in partnership with the woman, the eating disorder service and other relevant professionals.
14. Understand the factors which contribute to birth trauma (PTSD)
15. Understand how pregnancy related trauma and loss can affect women and partners.
16. Demonstrate knowledge and understanding of the challenges and complexities for women and partners associated with assisted conception.

Reading

Essential reading

7. NICE (2017). Eating disorders: recognition and treatment.
8. Acosta, C., Treasure, J. (2015) Eating Disorders: Overview and Management in Women. Current progress in obstetrics and gynaecology, volume 3. Ed: Studd J, Tan SL.
9. Daugirdaitė, V., van den Akker, O., & Purewal, S. (2015). Posttraumatic stress and posttraumatic stress disorder after termination of pregnancy and reproductive loss: a systematic review. *Journal of pregnancy*, *2015*, 646345.
10. Bhat, A., & Byatt, N. (2016). Infertility and Perinatal Loss: When the Bough Breaks. *Current psychiatry reports*, *18*(3), 31.

Recommended reading

20. Bye, A., Shawe, J., Bick, D., Easter, A., Kash-Macdonald, M., & Micali, N. (2018). Barriers to identifying eating disorders in pregnancy and in the postnatal period: a qualitative approach. *BMC pregnancy and childbirth*, *18*(1), 114.
21. Christiansen D. M. (2017). Posttraumatic stress disorder in parents following infant death: A systematic review. *Clinical psychology review*, *51*, 60–74.
22. Easter, A., Treasure, J., & Micali, N. (2011). Fertility and prenatal attitudes towards pregnancy in women with eating disorders: results from the Avon Longitudinal Study of Parents and Children. *BJOG : an international journal of obstetrics and gynaecology*, *118*(12), 1491–1498.
23. Farren, J., Jalmbrant, M., Ameye, L., Joash, K., Mitchell-Jones, N., Tapp, S., Timmerman, D., & Bourne, T. (2016). Post-traumatic stress, anxiety and depression

following miscarriage or ectopic pregnancy: a prospective cohort study. *BMJ open*, *6*(11), e011864.

24. Fogarty, S., Elmir, R., Hay, P. *et al.* (2018).The experience of women with an eating disorder in the perinatal period: a meta-ethnographic study. *BMC Pregnancy Childbirth* 18, 121.
25. Hunter, A., Tussis, L., & MacBeth, A. (2017). The presence of anxiety, depression and stress in women and their partners during pregnancies following perinatal loss: A meta-analysis. *Journal of affective disorders*, *223*, 153–164.
26. Kitzinger, S (2006) Birth Crisis. Routledge.
27. Koert E, Malling GMH, Sylvest R, et al. Recurrent pregnancy loss: couples' perspectives on their need for treatment, support and follow up. *Hum Reprod*. 2019;34(2):291-296.
28. Martínez-Olcina, M., Rubio-Arias, J. A., Reche-García, C., Leyva-Vela, B., Hernández-García, M., Hernández-Morante, J. J., & Martínez-Rodríguez, A. (2020). Eating Disorders in Pregnant and Breastfeeding Women: A Systematic Review. *Medicina (Kaunas, Lithuania)*, *56*(7), 352.
29. McCluskey, G. and Gilbert, P. (2015) Implications counselling for people considering donor-assisted treatment. Fully updated version. BICA Publications.
30. Pearson G. *The Burden of Choice: Collected stories from parents facing a diagnosis of abnormalities during pregnancy.* Dormouse Press: 2013
31. Quagliata E (Ed.). (2013) *Becoming Parents and Overcoming Obstacles: Understanding the Experience of miscarriage, premature births, infertility and postnatal depression.* Karnac Books.
32. Svanberg, E. (2019) Why Birth Trauma Matters. Pinter & Martin.
33. The Lancet (2020). Eating disorders: innovation and progress urgently needed. *Lancet (London, England)*, *395*(10227), 840.
34. Van Der Kolk, B. (2015) The Body Keeps the Score: Mind, Brain and Body in the Transformation of Trauma. Penguin.

Day 10:

Day 10	**Topic**	**Speaker**
09.15-10.45	Mental Health Law, Mental Capacity and the Court of Protection: issues in the perinatal period	Mr Alex Ruck Keene, Barrister Dr Livia Martucci
10.45-11.00	BREAK	
11.00-12.30	Advance Directives in the perinatal period	Dr Lucy Stephenson
12.30-13.15	LUNCH	

13.15-14.45	Going forward: reflections on the course and the application of what has been learned to clinical practice	Dr Liz McDonald Dr Lucinda Green
14.45-15.00	BREAK	
15.00-16.30	Going forward: reflections on the course and the application of what has been learned to clinical practice	Dr Liz McDonald Dr Lucinda Green

Intended learning objectives:

At the end of day 10 participants will be able to:
1. Recognise the relevant legal frameworks and to formulate a legally informed advance decision making document with women in the perinatal period.
2. Describe upcoming reforms to the Mental Health Act and the impact on advance decision making in the perinatal period.
3. Distinguish between ethical/moral issues and legal frameworks and how to approach them separately.

Reading

Essential reading

5. Owen, G. S., Gergel, T., Stephenson, L. A., Hussain, O., Rifkin, L., & Keene, A. R. (2019). Advance decision-making in mental health - Suggestions for legal reform in England and Wales. *International journal of law and psychiatry*, *64*, 162–177.
6. Stephenson, L. A., Gergel, T., Ruck Keene, A., Rifkin, L., & Owen, G. (2020). The PACT advance decision-making template: preparing for Mental Health Act reforms with co-production, focus groups and consultation. *International journal of law and psychiatry*, *71*, 101563.

Recommended reading

10. Hindley, G., Stephenson, L. A., Ruck Keene, A., Rifkin, L., Gergel, T., & Owen, G. (2019). "Why have I not been told about this?": a survey of experiences of and attitudes to advance decision-making amongst people with bipolar. *Wellcome open research*, *4*, 16.
11. Ruck Keene, A. et al (2020) Carrying out and recording capacity assessments. 39 Essex Chambers. www.39essex.com/mental-capacity-guidance-note-brief-guide-carrying-capacity-assessments/

12. Ruck Keene, A. et al (2020) Determining and recording best interests. 39 Essex Chambers. www.39essex.com/mental-capacity-guidance-note-best-interests-july-2020/
13. Thornicroft, G., Farrelly, S., Szmukler, G., Birchwood, M., Waheed, W., Flach, C., Barrett, B., Byford, S., Henderson, C., Sutherby, K., Lester, H., Rose, D., Dunn, G., Leese, M., & Marshall, M. (2013). Clinical outcomes of Joint Crisis Plans to reduce compulsory treatment for people with psychosis: a randomised controlled trial. *Lancet (London, England)*, *381*(9878), 1634–1641.
14. Case comments: Re AB (Termination of pregnancy) - https://www.39essex.com/cop_cases/re-ab-termination-of-pregnancy/
15. Case comments: GSTT& SLAM vR - https://www.39essex.com/cop_cases/gstt-slam-v-r/

Appendix II

Perinatal Psychiatry Masterclass Programme 2022: A HEE funded programme for new Consultants in Perinatal Psychiatry.

The application process is now open: Applications will be received from the primary constituency (England) with provision made for applicants from the devolved nations and The Republic of Ireland; detailed below.

Health Education England has agreed to fund the Royal College of Psychiatrists to deliver a masterclass programme for *new* consultants in Perinatal Psychiatry. Consultants already working in Perinatal Psychiatry/PMH teams are also invited to attend. There are 25 places for consultants who are working in NHSE perinatal mental health teams and *who have not been through* a previous masterclass programme; the course is free to attend for these participants, as this initiative is being HEE funded to contribute to the ongoing development of clinical expertise and provision within PMH services.

The programme is being adapted to provide an additional eight places for consultants in Perinatal Psychiatry who work in the devolved nations (Scotland, Wales, Northern Ireland) and the Republic of Ireland. Each of these places will require funding for individual participants. Once applications have been received and applicants are deemed to meet the criteria for receiving a place, information will be given as to how this funding can be resourced within the appropriate nation.

The course involves ten days of active participation. Given recent changes to how we can deliver training and education, the majority if not all of the course will be delivered remotely with presentations, background reading, case discussions, and small group work. We have considerable experience in delivering training remotely, with positive feedback about the experience from participants. The classes will be facilitated by leaders and experts in the field.

The application process for the 33 places is now open. Successful applicants will be expected to attend ALL of the classes. One of the aims of the programme is to develop relationships between participants within the group in order to support future liaison, networking and peer support.

Applications are invited from psychiatrists who have taken up consultant perinatal psychiatrist posts in the last one to two years or who are about to take up new consultant posts in perinatal psychiatry by 2022. Individuals who meet these criteria and who have not had formal training in perinatal psychiatry (e.g. one year at ST4-6) will be given priority as will individuals who will be working in areas of need (i.e. areas where new services are developing where there are no training opportunities available). However, all applications will be considered.

The applications should include the following:

- Curriculum vitae
- A personal statement setting out why the individual consultant psychiatrist should be offered a place

- Confirmation that the individual applying will attend all the classes
- Support from the employing Trust to release the consultant for the training
- The **reference code MCNC2022**

Below are the programme dates. We have tried our best to keep the dates outside of school holidays.

1. 10th January 2022
2. 28th January 2022
3. 7th February 2022
4. 28th February 2022
5. 4th March 2022
6. 18th March 2022
7. 25th April 2022
8. 6th May 2022
9. 16th May 2022
10. 7th June 2022

Each day will start at 9.15am and finish at 4.30pm.

The content of the masterclasses will include service development, prescribing, safeguarding, infant mental health, forensic and legal issues in the perinatal period, personality dysfunction, lived experience and psychological therapies.

Please send applications to Perinataltraining2022@rcpsych.ac.uk

The application **deadline is the 22nd October 2022.** Successful applicants will be notified by 29th October 2022.

Please forward this email to all colleagues, perinatal mental health teams, and clinical networks who will know of psychiatrists eligible to apply. Please encourage colleagues who may benefit from this opportunity to make an application.

Please note that this opportunity is not for ST4-6 trainees or SAS psychiatrists. We can confirm that HEE will be funding us to deliver two five-day masterclass programmes for ST4-6 trainees in 2022 (January and October). These courses will be advertised separately.

Best wishes
Liz and Lucinda

Dr Liz McDonald MPhil FRCPsych DU. Dr Lucinda Green MA MRCPsych MSc.
Joint Clinical Leads for Perinatal Psychiatry Training RCPsych