Postpartum psychosis and management: a case study

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Title Page

Postpartum Psychosis and Management: A Case study

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Table 1. Risk factors for Postpartum Psychosis

High level risk Factors (Tinkelman, Hill and Deligiannidis, 2017)	Previous PP Pre-existing psychotic illness (Bipolar disorder) Previous psychotic episode Discontinued psychotropic medication Family history of severe mental illness
Intermediate level risk factors (Perry et al, 2016)	Caesarean section Obstetric complications (particularly Pre-eclampsia) Genetic variations Sleep deprivation
Other risk factors (Perry et al, 2016)	Primiparity (Di Florio et al, 2014) Maternal age above 35 years Puerperal stress Immigrant population (Davis, 2017) Autoimmune disorders e.g. Autoimmune thyroiditis (Bergink, Gibney and Drexhage, 2014), and Systemic Lupus Erythematosus (Ganjekar et al, 2018)

Table 2: Screening questionnaires

Screening questionnaire	Content
Whooley Questions (Bosanquet et al, 2016)	During the past month, have you often been bothered by feeling down, depressed or hopeless? Yes or no During the past month, have you been bothered by little interest or pleasure in doing things? Yes or no
Generalised Anxiety Disorder 7-item (GAD-7) (Spitzer et al, 2006)	Explores emotional well-being over past 2 weeks
Edenborough Postnatal Depression Score (EDPS) (Cox, Holden, Sagovsky, 1987)	Explores emotional well-being over past 7 days.

Table 3: Rights of Medicines Management

1	Right patient
2	Right medication
3	Right dose
4	Right route
5	Right time (to avoid missed doses and overdosing)
6	Right of the woman to know information of the drug
7	Right documentation
8	Right to refuse
9	Right storage of medicine
The expiry date, need for the medication, and any possible contraindications (such as drug allergies) must be checked prior to administration (NMC, 2007).	

Table 4. Resources for midwives

Resource	Content	Website
Royal College of Psychiatrists Perinatal Mental Health services (2015): Recommendations for the provision of services for childbearing women	This report details the needs of women suffering from mental health in the UK, in addition to the expertise and facilities these women have a right to access within local geographical distances. Midwives can gain an understanding of the needs of women suffering from PMH issues.	-
Maternal Mental Health Alliance: Awareness Education Action (2018b)	This is a network of organisations across the UK dedicated to quality mental health care for women during pregnancy and the postpartum period. It holds important resources for midwives and other healthcare professionals for understanding the challenges and needs around PMH, and hosts online training for professional PMH education (website above). A map which details the locality of all 17 MBU in the UK and expresses the availability of PMH services for women, is also available here.	https://maternalmentalhealthalliance.org/ https://www.maternalmentalhealth.org.uk/resources/training/
Postpartum Support international (2018)	This is a comprehensive global organisation that hosts conferences on postpartum mental health, while offering information, guidance and social support for professionals, service users and their partners	www.postpartum.net/learn-more/postpartum-psychosis/

	about postpartum psychosis. It also offers online training and professional tools, such as screening questionnaires, and holds an alliance for women of colour in PMH.	
Mosaic blog post (2017), hosted by Wellcome Postpartum Psychosis: I'm afraid how you'll judge me as a mother and a person, by Catherine Carver	This blog post is a touching personal documentation of a woman's experience with postpartum psychosis and details the role that staff have in tackling stigma of mental health. It enables staff to better understand and empathise with the experiences the woman suffered, which will lead to more compassionate care.	https://mosaicscience.com/story/post-partum-psychosis-birth-mental-health-babies/
Toxbase (2018)	This is an online resource, commissioned by Public Health England, for healthcare professionals detailing the potentially dangerous outcomes from use of certain drugs and their overdose. A mobile app version is also available, allowing for rapid access to information.	www.Toxbase.org
Lactmed (2018) – Toxnet	Lactmed offers information on the safety of a drug for breast feeding. It details a drugs effect on the infant, its amount in breastmilk, and its effect on lactation itself. This is a useful resource for midwives in not only growing their knowledge base, but for rapid access to pharmaceutical	www.toxnet.nlm.nih.gov/newtoxnet/lactmed.htm

	knowledge when access to a specialist pharmacist is challenging.	

Abstract

Postpartum (or Puerperal) Psychosis (PP) is an acute mood disorder requiring close specialist care. It is a disorder little understood and rare in its occurrence but with devastating consequences. This work retrospectively describes the case study of a 26 year old woman who suffered postpartum psychosis following the birth of her first child. A critical appraisal of the care received follows this, focusing specifically on the postnatal period where she was most affected. It was found that critical information was not unearthed at the initial booking appointment, nor were her presenting symptoms recognised in a timely manner; detailing a need for greater training among midwives and care givers regarding early recognition and referral for PP.

Keywords

Postpartum Psychosis; Puerperal Psychosis, Perinatal Mental Health, Mental health Nursing, Mood Disorder.

Key points

Due to negative stigma and taboo, women may feel shame in admitting risk factors for mental health vulnerability. PP is a postnatal emergency and requires urgent specialist attention that is prompt and timely managed. Preventing separation of mother and baby is key to recovery, as is inclusion of the partner and family. Care must be given within the context of the woman's life and culture, while targeting the family as a whole.

Introduction

Postpartum (puerperal) psychosis (PP) is a severe mood disorder characterised by acute onset manic or affective psychosis (Dias and Jones, 2016), usually within 2 weeks after childbirth (Norhayati et al, 2015). This may be overlapped with depression and often fluctuates before full recovery is achieved (Dias and Jones, 2016). Symptoms include agitation, insomnia, thought processes that are eccentric, deviated and disorganised, with delusions and hallucinations, the content of which revolves around the neonate's safety (Vanderkrui et al, 2017). PP is considered a psychiatric emergency due to its high risk of suicide and infanticide (Nahar et al, 2017), it also increases risk of later developing non-gestational psychosis (particularly bipolar disorder) and PP after a subsequent pregnancy (Vanderkrui et al, 2017). It is the most severe mental illness of the perinatal period, defined as between pregnancy and 1 year post-delivery (Dias and Jones, 2016).

With an incidence rate of 1:1000 births (Tinkelman, Hill and Deligiannidis, 2017), and the reduced capacity of women to consent; conducting research and collecting data is challenging (Davis, 2017). Hence, PP aetiology remains poorly understood, however, a reduction in oestrogen levels after delivery and/or increased endocrine sensitivity may be to blame (Davis, 2017).

The present document will explore a case of PP, with particular focus on care of the woman and inclusion of her partner. This will incorporate a critical appraisal of the role of the midwife and the multidisciplinary team (MDT), including mental health professionals. Recommendations for improved care will then follow, and finally a conclusion of the points made and reflective questions for thought provocation are presented.

Case study

A woman of 26 years, pseudonymously named Sarah, had a forceps delivery at 41 weeks +4 days for failure to progress, this accompanied liquor with thin meconium and an estimated blood loss of 500mls. Her male infant was born healthy, with no complications and remained with her.

She was low risk at booking and was taking ferrous fumarate for pre-existing anaemia, and had no personal or family history of mental illness. However, a member from the mental health team later noted that she had a brother with severe learning disabilities and that she rented a room with her husband in a five bedroom house which was shared with other couples.

Though employed as a nurse and speaking good English, Sarah had an eastern European interpreter at booking. Her parents and family, who she communicated with often, remained in Eastern Europe after her migration several years ago. Her husband speaks much less English and required interpreting assistance.

Antenatally, small symphysio fundal height (SFH) measurements, and an episode of reduced fetal movements (RFM) caused her anxiety. After delivery she was discharged to community midwife care on day 1. At day 11 the midwife noticed Sarah's strange behavioural change and advised hospital attendance but she declined. A day later her husband brought her to Accident and Emergency (A+E) as she presented with confusion, disorientation and fever.

She was then seen by a member of the PMH team who suspected a psychotic episode, they then liaised with specialist PMH midwives (SPMHM) and obstetricians as there was some debate over which pathway Sarah should be treated on. She was admitted to the postnatal ward (PNW), treated with antibiotics and Paroxetine, until she was later transferred to a mother and baby unit (MBU) on day 24.

Literature and Discussion

PP includes psychoses that occurs within the postpartum period (de Witte et al, 2018). This is devastating to the woman and her family (Nahar et al, 2017), due to its occurrence at a crucial time in a family's life (Doucet, Letourneau and Blackmore, 2012). There is an associated high risk but rare incidence of suicide, filicide or infanticide (Degner, 2017). Women are also noted to have a reduced relatability to the infant (Doucet, Letourneau and Blackmore, 2012). In light of these risks, the partner of the woman can often be overwhelmed, which can lead to marital disruption, particularly if the PP is not well understood, which in turn affects the parent-infant relationship (Wyatt et al, 2015).

Role of the Midwife

The midwife is therefore key in detecting deviations from the norm and making appropriate timely referrals to relevant specialists (Cantwell, Gray and Knight, 2017). This leads to effective MDT input by way of co-operative interprofessional communication (Murray-Davis, Marshall and Gordon, 2011). The Nursing and Midwifery Council's (NMC) code (2018) concurs; by stipulating the importance of prioritising the patient and protecting safety while providing sensitive, compassionate care. Midwives have a pivotal role in advocating for the woman's wishes and be a point of contact for safety, support and continuity, particularly in cases of complex social and mental health (Bayrampour, Hapsari and Pavlovic, 2018).

An example of ineffective recognition of mental decline, is when Sarah's community midwife (CMW) visited her on day 11 at home, and encountered her acting agitated and restless, while expressing distorted thoughts and anxiety around 'overheating' her baby due to a fever she believed she had, particularly as she was breastfeeding. The midwife documented the strange behaviour and recorded her temperature as no abnormalities detected (NAD). Sarah was advised to go to hospital which was declined, but the midwife failed to escalate the situation by communicating to a

specialised professional such as the SPMHM, as soon as possible. This was not safe practice or dutiful, as monitoring for signs and symptoms of mental illness is an important midwifery role (National Institute for Health and Care Excellence (NICE), 2014), particularly as early detection allows for effective PP management and maximises the safety of mother and infant (Nahar et al, 2017).

However, the rarity of PP (Vanderkrui et al, 2017), may render midwives lacking sufficient experience to confidently recognise its signs and symptoms (Noonan et al, 2017), hence consistent training (Cantwell, Gray and Knight, 2017) should be provided by healthcare institutions and SPMHMs to raise and maintain competence (Maternal Mental Health Alliance (MMHA), National Institute for the Prevention of Cruelty to Children (NSPCC), and Royal College of Midwives (RCM), 2013). However, midwives are expected to update and maintain their own knowledge (NMC, 2015). Furthermore, human factors, such as the midwife's psychological process (Derickson et al, 2015), may have contributed to fear and apprehension of informing Sarah's disordered behaviour to a specialist, for fear of raising a false alarm and appearing inadequate. Healthcare institutes can cultivate 'psychological safety' by being aware of human factors, which enables courage to communicate across MDT hierarchies (Aranzamendex, Janes and Toms, 2015).

The CMW's lack of action did not fulfil the midwives' role in protecting women's dignity (NMC, 2015), as evidenced by Sarah's husband bringing her to A+E the next day in a state of pyrexia and confusion. In particular; shouting and baring her breasts while massaging them. Effective timely referral to the SPMHM, leading to robust risk assessments could have avoided this (Cantwell, Gray and Knight, 2017). Moreover, continuity of care throughout her perinatal experience was not provided and likely due to staff shortages, however this probably impeded the development of a trusting relationship between Sarah and midwifery staff (NMC, 2015), discouraging Sarah from communicating concerns, and inhibiting knowledge of Sarah's usual behaviour, hence delaying sensibilities in recognising her decline earlier (Cantwell, Gray and Knight, 2017).

Review of postnatal notes from day 0 and at discharge on day 1 did not describe Sarah's emotional well-being, her adaptation to motherhood or her competence at recognising her infant's needs. They were inadequate in providing an immediate

postnatal baseline of her mental health. The Whooley questions (Table 2) were asked and answered NAD, however, their design favours false positives (Bosanquet et al, 2016). Alternative questions (Table 2) were not considered. Instead documentation encompassed Sarah's physical health, and though important, absence of mental well-being documentation (NICE, 2014) insinuates its exclusion from midwifery care.

Care by Mental Health Staff

At A+E, a mental health nurse (MHN) specialist, extracted a highly detailed psychosocial history, in order to individualise risk and provide care that contextualises Sarah's culture and individuality (Di Florio et al, 2014). A family history of learning disability and a challenging housing situation were discovered, Sarah may not have confessed this at booking due to negative stigma or shame (Davis et al, 2018). Midwives and SPMHMs (MMHA, NSPCC and RCM 2013) need to challenge this stigma by open communication and education, to prevent secrecy and misplaced shame (Vanderkrui et al, 2017). The couple rented a room in a five bedroom house along with four other couples, whom two were recently postnatal. This may signal poverty and stress; leading to mental health vulnerability. Sarah's housing situation is also a mental health risk factor as maintaining functional relationships with other families within a confined, shared space is a stressful and difficult feat, particularly as the home is meant to be a space of relaxation (Franks, Crozier and Penhale, 2017). However, living with other families could be a display of effective community; where families of less means assist each other to transition into motherhood and collectively raise their young, as exemplified by women who birth within prison (Al-Maliki et al, 2012).

The MHN was effective in creating a comprehensive biopsychosocial picture, which aided direction of management by highlighting risk factors (Table 1) (NICE, 2014). However, spousal neglect was evident by employing Sarah as interpreter and not a professional, this proved futile (she repeated her own disjointed thoughts) and was highly improper due to her compromised cognition (Mannion and Slade, 2014). Though priority of Sarah is necessary, targeting the family holistically is needed for full recovery (Glangeaud-Freudenthal, Howard and Sutter-Dallay, 2014), and for prevention of long term sequelae to the infant (Thippeswamy et al, 2017). Partners of PP women report fear, confusion and anger, while being reluctant help-seekers;

contributing to stress and marital collapse (Wyatt et al, 2015). Midwives should provide affirmational support while informing and educating the family to increase understanding of the illness; enabling all to cope with the associated stress and guide the partner to help the patient, whose support is crucial to recovery (Doucet, Letourneau and Blackmore, 2012).

The MHN specialist also discovered Sarah's antenatal anxiety over the small SFH and RFM, despite normal growth scans, and a non-suspicious CTG. Though the midwives discharged Sarah with warnings to return if RFM repeated, they did not document any reassurance given, or note her anxiety. Considering the growing evidence that maternal stress leads to negative neonatal outcomes (Zijlmans, Risken-Walraven and de Weerth, 2015), midwives here were therefore not effective in monitoring PMH risk (NICE, 2014). Reiteration of this disregard occurred in the intrapartum notes where Sarah grew anxious at sighting thin meconium in her amniotic fluid, midwives did not document informing her of the normalcy of this occurring in postdates pregnancies (England, 2014), and gave no reassurance. Midwives may have assumed that due to Sarah's nursing background, she would have health-based knowledge, thereby not require as much information or psychological support. This violates a tenant of practice (NMC, 2018) to not discriminate between patients and provide quality care, including information, to all.

Sleep deprivation may have contributed to Sarah's development of PP as she was working night shifts before commencing maternity leave, which was compounded by gestational sleep disruption and postnatal insomnia. Though no reports associate night shift work with postpartum psychosis (Aiken et al, 2016), evidence of sleep deprivation's culpability with postpartum mental illness and PP aetiology exist (Lawson et al, 2015). Midwives did not take note of this aspect of Sarah's employment, hence they inadequately screened Sarah's physical and mental well-being antenatally and postnatally, this is important as the information could have alerted staff to a potential PMH risk (NICE, 2014).

Interprofessional working

The MHN specialist then performed her role well in communicating to PMH, obstetric and midwifery staff; who then orchestrated a PNW side room for Sarah's readmission and privacy. This was a good display of communication across MDTs and

interprofessional collaboration in the best interests for the woman (Murray-Davis, Marshall and Gordon, 2011). Sarah's history was then handed over to maternity staff and a MHN was stationed with her to monitor her condition and protect her safety (NMC, 2015). Sarah's sister-in-law stayed throughout the readmission; providing key support in caring for the infant and ensuring breastfeeding continued (Wyatt et al, 2015). Though these actions are a midwife's duty (Posmontier, 2010), staff shortages and time restrains make it difficult to provide the complete attention required. Therefore, priority in recruiting more midwives and retaining them, by ensuring a work culture that promotes staff wellbeing and happiness, is needed for effective and safe midwifery care (Aquino et al, 2016).

Good interprofessional collaboration was also seen when the obstetric and PMH teams communicated about Sarah's management (Murray-Davis, Marshall and Gordon, 2011), as hesitance to choose a sepsis or a mental illness pathway presided. Initially a sepsis pathway was chosen, but later changed after further discourse between the two clinical teams, electing the consultant PMH psychiatrist as the lead clinician. Upon the change, the PMH midwife and other midwifery staff were informed, exemplifying model communication across an MDT (Murray-Davis, Marshall and Gordon, 2011). The SPMHM held an important office of acting as a co-ordinator of care and advocate for the women (Posmontier, 2010), which was vital considering Sarah's vulnerable mental capacity.

Kalanithi (2016) reports dangerous power dynamics and tugs of control between clinical teams, impeding interprofessional communication and collaboration. This has detrimental effects on patients' health and safety, via egocentrically motivated decision making. The good communication seen in Sarah's case makes this occurrence unlikely, however, it remains a barrier to effective interprofessional working, as is lack of trust, respect, patient centred work ethic and understanding of each other's professional role (Aquino et al, 2016).

Sarah's management started with antibiotics to treat her infection, followed by oral paroxetine for mood stabilisation. This is in line with best practice which recommends stabilising physical health, before treating mental health (NICE, 2014). Following the Department of Constitutional affairs' code of practice (2007), midwives first assumed

Sarah had capacity to consent, which was gained before medicine administration, in concordance with local and NMC standards (2007) (see Table 3).

As an immunological role in PP pathogenesis is well documented (de Witte et al, 2018), it is important to ascertain an infection with a sepsis bundle screen which was performed in Sarah's case and proved positive. Infection may have been missed earlier when Sarah complained of fever to her CMW, despite a normal temperature reading. Raised monocyte and microglia inflammatory activation patterns are thought to be biomarkers of PP (Bergink, Gibney and Drexhage, 2014), screening for these may be performed in the future, as could scanning for structural cortical changes in women with PP (Fuste et al, 2017). However, screening women with MRI scans, even those women at risk (see Appendix 1), is unlikely to be cost effective due to the rarity of PP incidence (Dias and Jones, 2016).

Throughout her 12 day readmission, Sarah's mental health fluctuated between recovery and decline, this follows PP's natural history, which, without proper clinical knowledge, can result in repeated discharge and readmission of the patient (Cantwell, Gray and Knight, 2017). This did not happen with Sarah due to co-ordinated MDT efforts, however, her decline dived into dangerous waters as Sarah mentioned thoughts of killing her child and was declining medication. Despite Sarah's right to refuse medication (NMC, 2007), the risk to safety induced the midwives and MHN to document and communicate this promptly; resulting in the PMH and obstetric teams' presence.

Sarah's mental capacity was assessed by two PMH psychiatrists in line with the code of practice (The Department for Constitutional affairs, 2007), she was then sectioned under the Mental Capacity Act (2005), but only after a joint MDT meeting passed to incorporate the input of all members, communicate understanding of the situation and create a plan of care. This was good clinical practice, as communication was made in a timely fashion and action was taken promptly, in order to protect the safety of mother and infant (NMC, 2015). Unfortunately, no documentation, within this context, relating to the partner or family members was made, insinuating their exclusion. This will further propagate their isolation, pain and distress (Wyatt et al, 2015).

<u>Transfer and care planning</u>

Discussions over transfer to a psychiatric unit was in motion with an aim for a MBU, however due to Sarah's PP severity, it was not known if a MBU would be suitable. After psychiatry staff asked Sarah's husband if he would be willing to care for the infant should separation from the mother occur, he agreed. However no discussion resumed over extending his leave from work to care for the infant, or help in organising childcare, infant feeding, and visits to his wife. Discussions for his financial, and emotional support to protect his own mental health did not occur either (Doucet, Letourneau and Blackmore, 2012). Additionally a translator was again not used, hence impeding effective communication and understanding (NMC, 2015), which is necessary for partners' confidence in staff (Davis et al, 2018). The PMH staff therefore assumed an over-simplified version of the husband caring for the infant and did not respect the degree of complexity that this accompanies. Furthermore, this is another example of staff not targeting the family as a whole (Glangeaud-Freudenthal, Howard and Sutter-Dallay, 2014) or providing sensitive care (NMC, 2018).

Eventually Sarah was transferred to a MBU on day 24 after assessment from MBU staff. This is best practice (Cantwell, Gray and Knight, 2017), as separation of the infant from the mother has detrimental effects on maternal recovery, mother-child bonding, and maternal parenting confidence (Glangeaud-Freudenthal, Howard and Sutter-Dallay, 2014). However, earlier transfer is preferred, as the PNW is not a suitable environment for management, treatment and full recovery from PP (Cantwell, Gray and Knight, 2017). This is due to PNW's lack of continuous mental health staff, cognitive behavioural therapy, and facilities in which to support maternal parenting and child bonding within the context of severe mental illness, which MBUs do accommodate (Glangeaud-Freudenthal, Howard and Sutter-Dallay, 2014), in addition to organising electroconvulsive therapy, which is recommended for PP women with catatonia (Tinkelman, Hill and Deligiannidis, 2017).

The delay may have been due to time restraints that occur when collaborating with clinical staff in a different locality, or because of uncertainty over Sarah's suitability for a MBU, but it is more likely that MBU bed shortages were to blame (as this was also documented). These bed shortages are linked to the high cost and long stay that MBU admissions accrue (Glangeaud-Freudenthal, Howard and Sutter-Dallay, 2014), but more heavily associated with the scarcity of MBUs (MMHA, 2018b). Despite four new MBUs opening in 2018/19 (MMHA, 2018b), more is needed for women to access local

specialist PMH care, even though stipulations for these services are already published (Royal College of Psychiatrists, 2015).

No more information is known after Sarah's transfer, however, upon full recovery, a joint meeting with the community health visitor, SPMHM (for advocacy and continuity), psychiatric team, pharmacist, GP and obstetric team will be needed with the inclusion of Sarah (Glangeaud-Freudenthal, Howard and Sutter-Dallay, 2014) and her husband if she consents (NICE, 2014). This will allow MBU-to-community discharge planning and ensure Sarah is well linked to the MBU and provided with good quality social support while at home (Glangeaud-Freudenthal, Howard and Sutter-Dallay, 2014). This is to maintain Sarah's mental health, help her in adjusting to autonomous parenthood and prevent psychiatric readmission (Doucet, Letourneau and Blackmore, 2012).

Subsequently, a joint meeting for preconception counselling is needed (NICE, 2014) prior to MBU discharge with the couple (and hopefully a translator for the partner) and a psychiatrist or SPMHM. This is to inform the couple of the teratogenic effects of psychotropic medication she may need prophylactically in a second pregnancy, or that she may still be taking which should be administered alongside long acting reversible contraception (Cantwell, Gray and Knight, 2017). Breastfeeding should be encouraged throughout her care, but tact is required as to the choice of psychotropic drugs, as carbamazepine, clozapine and lithium are not suitable for breastfeeding, and Sarah should be made aware of their effects (NICE, 2014). If they have been prescribed while Sarah remains breastfeeding, documentation as to the reason is necessary, as is regular checks on the infant's renal function (NICE, 2014). Sodium valproate should not be considered for Sarah due to significant teratogenicity (NICE, 2014). In this way, tailored, individualised care planning is made for Sarah with consideration for her feeding choices and her new-born child (NICE, 2014).

This meeting also allows for informing Sarah and her husband of the high risk of PP recurrence after a subsequent pregnancy (Dias and Jones, 2016). Education on the signs and symptoms to be aware of should follow, along with how to escalate the situation effectively (Doucet, Letourneau and Blackmore, 2012), in order to access care quickly due to the rapid manifestation of PP and necessary early detection (Nahar et al, 2017). Given the context of partners being reluctant help seekers, this

information is especially important (Doucet, Letourneau and Blackmore, 2012). The couple would also be informed that the psychosis sustained, may be the first episode of a chronic mental disorder, such as bipolar disorder, which will require more specialist antenatal attention should they decide to conceive again (Glangeaud-Freudenthal, Howard and Sutter-Dallay, 2014). In this way, the couple are empowered by being included in their care and decision making process (NMC, 2015).

Recommendations for future practice

In future, priority in documenting the mental state of women and their relatability to the needs of their infant, including assessing emotional and verbal interactions with the child (NICE, 2014), should take place. Continuity of care should also be prioritised, in order to maintain trusting relationships with staff to inspire patients' confidence in them and patients' confidence to speak of their feelings and thoughts without fear (Posmontier, 2010). Training and education for midwives to detect PP early is also needed (Posmontier, 2010).

Conclusion

Due to the rapid and dangerous manifestations of PP (Norhayati et al, 2015), it is considered a psychiatric emergency (Kent, 2011), requiring prompt detection and urgent treatment (Cantwell, Gray and Knight, 2017). A complete biopsychosocial history must be taken at booking, to plan care that is individualised and contextualises the woman's beliefs, values and wishes (Noonan et al, 2017). This is impeded by stigma, taboo and misunderstandings attached to mental health, in addition to fear of being separated from their child, which drives reluctance to discuss it (Davis et al, 2018). PP is also distressing for partners and family who are necessary for recovery and support of the woman (Wyatt et al, 2015), midwives must provide them information and inclusion in order to cope (Doucet, Letourneau and Blackmore, 2012).

Midwives therefore have an integral role to play in PMH (Franks, Crozier and Penhale, 2017). This involves educating and empowering women to make their own choices, and actively participate in their own care (NMC, 2015). Moreover midwives are a necessary point of contact with the woman, enabling a trusting relationship to brew, which facilitates safe and compassionate care (NMC, 2015). This is executed by monitoring and documenting both the physical and mental state of the woman, while

making referrals to relevant specialists in a timely fashion (Noonan et al, 2017) and administering medications safely (NMC, 2007).

Effective interprofessional collaboration, by way of candid communication across an MDT, is essential for safe and comprehensive management of the woman (Bayrampour, Hapsari and Pavlovic, 2018), this requires trust, respect and knowledge of teams and individuals (Murray-Davis, Marshall and Gordon, 2011). Hence, facilitating good care, and dramatically reducing the risk of separation between mother and child by way of transfer to a MBU, which is best for recovery (NICE, 2014).

Reflective Questions

1. How best can midwives tackle taboo of PMH issues and postpartum psychosis?
2. Is it wise or ethical at booking to make known the possible severity of mental health disorders to women regardless of risk?
3. A pivotal role of the midwife is to advocate and support the woman, but should advocating for partners and family members in the context of severe mental health be an included midwifery role? If so, how best do we accomplish this?
4. Greater training is needed for midwives in understanding PP, but due to the rarity of its occurrence, how will lack of the midwife's experience impact care? And what role does it have in student midwife training?

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