Title: The role of the Health Visitor in supporting women with Postpartum Psychosis: a clinical review of the evidence

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Abstract: This article explores postpartum psychosis (PP), which is a severe and rare psychiatric condition affecting new mothers. Unlike other perinatal mental health conditions, and given it's rarity, it is proposed that health visitors' experience and understanding of PP may naturally be limited. Here, the condition is described in relation to the universal health visiting support offered under the high impact area of perinatal mental health, in order that health visitors gain further insight into the condition. Specifically, the prevalence and risk of PP are discussed, considering social inequality and how this may affect a mother's individual PP experience. Identification and treatment implications are subsequently discussed, prior to an exploration of collaborative practice in relation to the condition of PP. A lack of research is identified with the suggestion of qualitative research around PP recommended. The article concludes with reflective questions through which health visitors might explore their own practice.

Acknowledgements: The author would like to thank the Queen's Nursing Institute (QNI) for awarding an education grant to fund the work which contributed to this article

Conflicts of Interest: The author declares no conflict of interest

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Abstract

This article explores postpartum psychosis (PP), which is a severe and rare psychiatric condition affecting new mothers. Unlike other perinatal mental health conditions, and given it’s rarity, it is proposed that health visitors’ experience and understanding of PP may naturally be limited. Here, the condition is described in relation to the universal health visiting support offered under the high impact area of perinatal mental health, in order that health visitors gain further insight into the condition. Specifically, the prevalence and risk of PP are discussed, considering social inequality and how this may affect a mother’s individual PP experience. Identification and treatment implications are subsequently discussed, prior to an exploration of collaborative practice in relation to the condition of PP. A lack of research is identified with the suggestion of qualitative research around PP recommended. The article concludes with reflective questions through which health visitors might explore their own practice.

Keywords

Perinatal; Mother; Health Visiting; Postpartum; Psychosis

Key Points

- Postpartum psychosis is a rare condition, but the risk is increased significantly in maternal and family
- history of bipolar or postpartum psychosis
- The Healthy Child Programme antenatal visit is an ideal time for health visitors to consider factors
- which may increase a mother’s risk of PP
- Fathers are identified being negatively affected by PP and would benefit from extra support
- There is a need for more research into women’s lived experiences of PP
- Action on Postpartum Psychosis as a charity offers peer support to mothers, fathers, and further
- information is available on their website https://www.app-network.org/

Introduction

Perinatal mental illness is considered to cover the duration of pregnancy through to 12 months postnatally (NHS England, NHS Improvement, National Collaborating Centre for Mental Health, 2018), and maternal mental health is a high impact area for Health Visitors (Public Health England [PHE], 2016). The rationale for assessment, identification and intervention exists in relation to both mother and child. Notably, the 'Saving Lives, Improving Mothers' Care' 2019 report identifies maternal suicide as the most significant form of maternal death between six weeks and one year after birth (MBRRACE-UK, 2019). As such, early identification and intervention is vital. Current health guidance reflects this, with the National Institute for Health and Care Excellence (NICE, 2014 updated 2020) providing professionals with guidance on promoting 'antenatal and postnatal mental health' in mothers.

Universal support for maternal mental health:

A universal approach of enquiring around maternal mental health and wellbeing during routine appointments is also recommended (NICE, 2016), with health visitors assessing maternal mental health in both the antenatal and the postnatal period (PHE, 2016). Perinatal depression is a common type of mental illness, with an international systematic review estimating prevalence at 12% (Woody et all 2017). Accordingly, current assessment tools are validated in relation to assessing this, such as the Edinburgh Postnatal Depression Scale (EPDS), and the Patient Health Questionnaire (PHQ-9). These allow Health Visitors to universally screen mothers during each child health review until their baby is at least 12 months old. Postpartum Psychosis (PP) however, is less routinely assessed and there is no known assessment tool universally used when health visitors support women with perinatal mental health, meaning it is less easily identified. Further, given the rarity of the condition, many health visitors have never encountered it, resulting in a gap in professional knowledge.

Prevalence and risk of PP

When identifying PP, prevalence and risk factors are important to consider for health visitors, particularly at the antenatal review (PHE, 2016). The lack of current assessment tool may be in part because the prevalence is much lower overall, since the risk for the general population is considered around 1 in 1000 (VanderKruik et all 2017). Yet, research demonstrates that risk rises to 50% (or 1 in 2) when the mother has Bipolar type I, alongside a family history of severe postpartum episodes (DiFlorio et all 2013). Family history is therefore highly significant (Jones & Craddock, 2001), and screening for this would be useful in routine reviews, particularly the antenatal visit. Being a first-time mother, and suffering complicated deliveries, have also been associated with PP (Blackmore et all 2006), meaning that whilst the condition cannot be predicted, an awareness of history on the part of health visitors may indicate a higher level of risk.

Social factors and PP

Accordingly, the health visitor approach, which focuses on identifying and minimising health inequalities in order to promote child health, prioritises maternal and family mental health as a high impact area (PHE, 2016) due to the potential impact on the child and family. With postnatal depression, for instance, high economic status is associated with a decreased prevalence of PND (Cena et all 2021). In contrast, for PP the overall figure is global (VanderKruik et all 2017), and consistent across a range of international nations of varied ethnicity/economic development. PP is also unrelated to personality type (Perry et al. 2019). As such, it appears biologically determined, so social risk factors-such as unsuitable living conditions or poverty-which health visitors usually take into account, are not relevant when screening for PP specifically. They should of course be considered in relation to the family's wider situation, in accordance with the SCPHN standards around tackling inequalities (Nursing and Midwifery Council [NMC], 2022). This is a current limitation to health visitors' care of women with PP.

Identification of PP

There is limited time to identify and assess for the condition within the health visitors' current service. Onset is sudden, with literature suggesting that PP usually presents in the first two weeks after birth (Bergink et al. 2015), meaning that by the point of new birth health visiting visit (before 14 days), a woman may already be very unwell. This is relevant for health visitors, since PP is a severe condition which inhibits functioning (Burgerhout et al. 2017), and which may subsequently impact on parenting ability to meet infant needs. Ultimately, PP is considered a 'psychiatric emergency' (Raza & Raza, 2021). In relation to health visiting care, however, it is not possible to separate the condition of PP from the wider family situation due to the focus on public health, and so this requires ongoing consideration.

In particular, PP has the potential to cause social inequality, and so it is necessary to consider symptoms when planning a care approach. Despite psychosis often being associated with schizophrenia, PP is a mood disorder often linked to Bipolar Affective disorder (DiFlorio et al. 2013), which underpins the symptomology. Many mothers exhibit mania, depression, or a mixed mood state (Bergink et al. 2016), but can also include confusion, hallucinations and delusions (DiFlorio et al. 2013). Due to symptom severity, medication is commenced as soon as possible (Bergink et al. 2015).

Treatment of Postpartum Psychosis

Treatment of PP includes a pharmacological approach. Antipsychotic medication is a medication used perinatally (NICE, 2014), but it is not without complex considerations in terms of reduction of symptoms, against side effects and risks. It is unethical to conduct research such as Randomised Controlled Trials (RCTs) in pregnancy and during breastfeeding due to potential harm (which includes denying evidenced benefits) to mother and child, who are historically excluded from research trials (Weld et al. 2022), which limits the data around harm to infants. Thus, mothers should follow medical advice. Though, even in the instance psychiatrists may encourage ongoing breastfeeding whilst taking prescribed medication, stopping breastfeeding may be considered necessary by the mother herself. However, this also limits the benefits of breastfeeding for mother and baby. For mothers, it can lower the risk of breast cancer (Anstey et al. 2017), and exclusive breastfeeding is associated with losing weight (Jarlenski et al. 2014). In the case that weight gain affects a mother’s self-esteem, this has the potential to restore confidence. For infants, breastfeeding is linked to lower risk of childhood obesity (Arenz et al. 2004), and reduced risk of allergies and asthma (Oddy, 2017). For these and other reasons, the World Health Organization [WHO] recommend breastfeeding exclusively for the first six months of life and then alongside foods for two years (WHO, 2020). A further limitation of taking psychotropic medication is around co-sleeping, which is considered unsafe in the case of sedating medications (The Lullaby Trust, 2021). As such, there is a balance to be considered when decision making professionally.

Postpartum Psychosis and the fathers’ needs

Reid et al. (2017) found that fathers suffer emotional strain whilst simultaneously experiencing the positive emotions of just becoming a father, when their partners are in an MBU. Similarly, Boddy et al. (2017) described a period of shock and confusion in fathers whose partners suffered PP. This indicates a complexity around father wellbeing. Given that depression is also a symptom of PP (DiFlorio et al. 2013), it is useful to consider that there is an acknowledged link between maternal postnatal depression and depression in fathers (Goodman, 2008). Potential forms of support for fathers include father mental health charities such as Dads Matter UK, and the Paternal Mental Health Alliance. On a universal level, the NHS Long Term Plan (2019) outlined a plan to support partners and families when offering perinatal mental healthcare to mothers, but at the time of writing, there is no universal service offered to fathers (Williams, 2020). This is an evidenced area requiring future development both in terms of Health Visiting and wider service provision, in particular due to fathers being known to experience perinatal depression (Davenport et al. 2022).

Limitations around evidence-based practice for PP

Evidence Based Practice (EBP), a concept outlined by Sackett et al. (1996) incorporates the clinician's expertise, the best available evidence, and the experience of the patient. Yet, there are limitations around the availability of a sufficient research base for mothers experiencing postpartum psychosis. Most existing research on PP, as identified here, is in relation to prevalence, risk and associations for PP. Such quantitative evidence and systematic reviews are considered robust, and sit higher in the research hierarchy (Polit & Beck, 2012). But whilst these are useful, the voice of the patient is less represented in current research, and also more dated (see for example Robertson & Lyons, 2003) meaning that when using evidence to support practice, it is difficult to know how women feel with PP in relation to the support from their health visitors. As such, further qualitative research exploring lived experiences of women with PP receiving health visiting support for their perinatal mental health, would meet this gap in knowledge.

Another limitation is in safeguarding practices. Diflorio et al. (2013) outlined complications related to safeguarding in PP, which include risk of suicide in the mother. Around suicide risk, PHQ-9 is a validated assessment tool, used by health visitors, which screens for thoughts of suicide. Calear et al. (2019) however, acknowledges that disclosing suicidal ideation is more likely when an individual experiences less suicide stigma, which is difficult to determine. A further finding is that for some people who do disclose suicidal ideation, they find the response of others unhelpful (Calear et al. 2019). As such, a supportive trusting relationship, with good understanding of how to react to a mother's disclosure of suicidal feelings, would be of potential benefit. In light of this evidence, it would be beneficial if this involved signposting, immediate crisis care, and utilisation of existing support networks with consent.

Collaboration and future planning

Given the perinatal period is considered to end around twelve months postpartum according to the NHS England, NHS Improvement, National Collaborating Centre for Mental Health (2018) guidance for perinatal care, then prior to this point plans of care should be made going forwards. Some women with continuing illness may be referred onwards to the Early Intervention in Psychosis (EIP), or community mental health (CMH) teams, to offer further support. This provides continuity of care, though in the case of sudden relapse, most mental health crisis teams are available out of hours. Further, given that PP is a severe mental health condition, rehospitalisation is also possible in an MBU within the postpartum period. Collaboration may also extend more broadly in the future, for instance with funded nursery hours, parenting courses and Early Help support. Regarding signposting families for peer support, Action on Postpartum Psychosis offers both peer support for mothers, fathers, and training on PP for professionals including health visitors. However, from birth to five, the professional best placed to support a family where perinatal mental health is threatening the environment, parenting capacity, or child development, is the health visitor, due to their universal, public health approach to child health (PHE, 2016).

This article has focussed on the clinical condition of postpartum psychosis, in terms of the prevalence and risk for mothers. It has been observed that many health visitors have not encountered PP because it is a rare condition. Consequently, the presentation of PP in terms of symptoms and it’s relation to bipolar affective disorder have been outlined. The identification of PP through risk and symptoms, and also the treatment of PP, have also been explored. It has been noted that whilst there is a strong evidence base for the condition of PP, there remains a lack of qualitative, lived experience based data on which to base health visiting care. Furthermore, there are identified implications for fathers when the mother suffers PP, demonstrating a wider family need arising from the condition for which health visitors are ideally placed to meet.

Reflective Questions

1. What information might a health visitor use in order to consider a mother’s risk of PP during an antenatal visit?
2. What health visiting support might a mother need following discharge home from an MBU?
3. Give an example of collaborative working in perinatal mental health from your own professional experience
4. Think of a safeguarding implication of PP on the family and what you might do to mediate this risk
5. Reflect on the needs of the father and how he might be supported both during an MBU admission and after his partner returns home with his child

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