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Treatment – Mother–infant inpatient units

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Infants of parents with psychiatric disorders may be particularly vulnerable and have a higher risk of developing psychiatric disorders in adulthood. Until the second half of the 20th century, women and infants were cared for separately. Today, hospitalisation of women with their babies in psychiatric mother–baby units enables psychiatric care of women and promotion of parent–infant interactions and child development. The distribution of psychiatric mother–baby units around the world, as well as within countries, varies strongly. Reasons for this may be related to the absence of national perinatal mental health policies related to psychiatric mother–baby unit location, differences in sources of referral for admission, and criteria for psychiatric mother–baby unit admission. Two principal national epidemiologic studies, in England and in France and Belgium, have described issues related to discharge from

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such care, as have smaller local studies, but no epidemiologic studies have yet demonstrated that joint inpatient psychiatric mother–baby unit care is cost-effective compared with separate care.

Joint admission to an inpatient mother-baby unit after childbirth

During the postpartum period, women may experience mental health problems. Postpartum depression is the most frequent postpartum pathology (affecting one in every 10 women) [1] (see chapter by O'Hara and Wisner on the definition, description and aetiology of perinatal illness in this issue). Most women with postpartum depression do not need psychiatric inpatient care, but admission for such care may be required for women who present a first episode, or a relapse, of a severe psychiatric disorder such as postpartum psychosis, manic disorder, major depressive episodes, or both, or schizophrenia [2]. Women's mental health problems and stress during pregnancy may affect the fetus (see chapter by Glover on maternal depression, anxiety and stress during pregnancy and child outcome in this issue), and postpartum mental health problems or psychiatric disorders may lead to severe bonding difficulties that negatively affect the child's psychoaffective development [3] (see chapter by Guedeney et al. on mother–infant relationship psychotherapy in this issue).

Full-time (24-h a day) psychiatric mother–baby units (MBU) admit women with severe mental health problems or disorders. They require two different types of expertise. The first in treating women with psychiatric disorders, and the second in child care and development. Caregivers in these clinical settings face especially complex situations, in which women are mothering infants who are especially vulnerable owing to pregnancy risk factors (pregnancy with psychotropic medications, poor pregnancy care, and lifestyle), maternal mental health symptoms, and genetic vulnerability. Care in an MBU may lessen the effect of maternal problems on the child's development. Remaining with their babies during psychiatric treatment should prevent the potential detrimental effects to the baby of separation from the mother, and the effects this separation could have on the mother's self-confidence. Most women admitted with their babies are pleased that they need not be separated from their child while receiving care in an MBU [4], a finding that confirms 'the central importance women with severe mental illness assign to motherhood' reported by Dolman et al. [5] in a systematic review of the literature.

As early as 1992, the Royal College of Psychiatrists in the UK recommended as good practice that mothers be admitted together with their infant to special designated mother and baby facility whenever possible, and if domiciliary or day hospital management is not possible [6]. In 2007, however, Joy and Saylan [7] reported in a Cochrane review that only a few articles described joint mother and baby inpatient admissions to psychiatric MBUs [4,8–15]. Also, in 2007, The National Institute of Clinical Health and Excellence guideline GC45 for England and Wales [16] recommended that 'women who need inpatient care for mental disorder within 12 months of childbirth should normally be admitted to a specialised MBU, unless there are specific reasons for not doing so'. Both single-centre and national epidemiologic studies describe the risk factors associated with a lack of improvement in women's mental health and mothering abilities [17–20].

History of psychiatric mother–baby units

Howard [21] notes in her historical review that 'in the first half of the 20th century, women with postpartum psychotic disorders were routinely separated from their babies, whether they were cared for at home or in asylums. Treatment of mothers with their infants started in the 1950s'. She adds that changes in practice, especially in the development of mother and baby units, are most likely attributable to a combination of factors. These include improvements in psychiatric treatment of postpartum psychosis, changes in the nature of asylums, family structures resulting in a lack of surrogate care, change in government policy, and the development of social psychiatry and the increase in women psychiatrists.

Cazas and Glangeaud-Freudenthal [22] suggest that the negative attitude towards joint admissions over the past 50 years has changed in response to new discoveries in diverse disciplines: psychiatry, paediatrics, experimental psychology, developmental psychology, ethology, and psychoanalysis.