

Reports from the colleges

The Margaret Oates Mother and Baby Unit in East London

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In recent years it has been increasingly recognised that addressing the mental health needs of new mothers with psychiatric problems is an important challenge for both mental health and maternity services. Approximately 3% of new mothers require specialist mental health services; but pregnancy-related mental health services have, until recently, been given a low priority despite suicide being the leading cause of maternal death in the UK.

Women with a previous history of mental health problems are most vulnerable during pregnancy and following childbirth: approximately two-thirds of women admitted postnatally to mother and baby units have a past psychiatric history. Many women develop their first episode of severe mental illness post-partum and have an increased risk of admission in the first week following childbirth. In the UK, 2 in 1000 women are admitted post-delivery with severe mental illnesses such as schizophrenia and bipolar affective disorder, clustering in the first month after delivery. Relapse rates in women with untreated bipolar affective disorder are high in the antenatal and postnatal period. Puerperal psychosis accounts for admissions to psychiatric units for 1 in 1000 delivered women and these women have a 50% risk of relapse following subsequent births.

Severe mental disorder and its associated significant impairment in social and personal functioning can lead to the mother being unable to care effectively for herself and her children.¹ Maternal mental disorder can also affect the social, cognitive and physical health and development of children.

Both NICE guidelines² and key policy documents³⁻⁵ state that:

Women who need inpatient care for a mental disorder within 12 months of childbirth should normally be admitted to a specialist Mother and Baby Unit (MBU), unless there are specific reasons for not doing so.

Mother and baby units recognise that separating mothers and babies is both undesirable and potentially harmful to mother, baby, and the mother-baby relationship, that specialist treatment skills are required e.g. drug treatments in pregnancy and breast-feeding, that specialist assessment and intervention may be required in relation to mother-infant interaction and parenting and that individuals with severe illness do better when under the care of specialist teams.

The first mother and baby units in the UK were established at Shenley Hospital and at Binstead Hospital in 1959. Nearly 50 years later, perinatal mental health services remain patchy and development is still uncoordinated throughout the UK. A recent survey identified 19 mother and baby units but most women are still admitted without their babies if they break down in the postnatal period.

The inner city boroughs that East London Foundation Trust serves have the highest (and continuing to rise) birth rates in the country, in conjunction with high rates of deprivation, diversity and high psychiatric morbidity. Nationally 20% of women who give birth were born outside the UK. In East London this figure is 46%.

The mother and baby unit at the Homerton Hospital was opened in 1995 and provides a service for mentally ill women and their infants from City and Hackney, Tower Hamlets and Newham. It was initially opened as a four bed/four cot annexe to an acute psychiatric ward for women. By 2002 the unit had been separated from the acute ward but over the following years there were weaknesses that needed to be addressed e.g. the small number of beds did not meet local need or NICE guideline recommendations for size of unit required to concentrate expertise and provide a regional service, there was minimal capacity to respond to the need for emergency admissions, there was a need for substantial

improvement in the physical environment in order to meet modern standards of comfort, privacy and dignity as well as a need to improve the clinical facilities. As a consequence in 2010 the East London Foundation Trust developed and opened a modern, state of the art 10 bed/10 cot unit to provide a key service for vulnerable mothers and babies at a critical stage in their lives.

The unit provides specialist management of women who develop acute post-partum psychosis or severe non-psychotic illness, management of pregnant and post-partum women with pre-existing chronic mental illness, assessment of risk to infants in the context of significant acute maternal mental illness and appropriate facilitation and enhancement of the mother–infant relationship where the mother suffers from severe mental illness or has difficulties in caring for the infant.

The unit admits unwell pregnant women who are over 32 weeks gestation in order to offer adequate, appropriate and safe psychiatric and maternity care. The unit is located on a general hospital site and has close physical and clinical links with both maternity and paediatric services providing women and their infants with holistic and seamless care.

Seventy percent of women admitted to the unit come from ethnic minorities and many of the women admitted have overwhelming social and environmental stressors. The service has a compassionate, culturally sensitive awareness that puts the individual at the heart of planning, provision of treatment, recovery and preparation for life in her and her infant's family and community. Interpreting services are widely used as many women who have acquired English as a second language find it difficult to communicate in English when very unwell. Many women do not have any skills in English and assessment through interpreters is required. Non-verbal therapies are vitally important for aiding women to express their thoughts, feelings and experiences.

The unit has 10 large, comfortable rooms all with en-suite facilities. Two of the rooms have been designed to cater for mothers with complex mental health needs who may require more intensive supervision and assessment and containment of risk. This facility is unique and ensures that those who are in most need of the facility have prompt access and admission.

One room has been designed to support women with physical disabilities and there is a specially designed room to support women with twins. Breast-feeding is encouraged and supported and bottle-feeding mothers can prepare milk in a well equipped milk kitchen. The activities of daily living (ADL) kitchen provides opportunities for women to prepare food for themselves and others on the unit while also providing a safe assessment area. There

is a specially designed infant's bathroom which enables mothers to bathe their babies easily and safely. The large, landscaped, courtyard garden ensures that mothers and their infants have access to fresh air, a play area, seating, exercise space, herbs, flowers and shrubs. There are quiet and communal areas, therapeutic rooms and a large occupational therapy room to allow women access to a wide variety of internal spaces.

Staff in the unit represent the diversity present in the community and this contributes to supporting the complex needs of the patient group. The multi-disciplinary team is reflective, dedicated, cohesive, compassionate and mindful of the many needs of the mother and her infant. The team includes RMNs, nursery nurses, social therapists, occupational therapist, psychologists, parent–infant psychotherapists, pharmacist, dance therapist, art therapist, midwife, trainee psychiatrists and consultant psychiatrist.

Registered mental nurses (RMNs) and nursery nurses are present on the unit 24 hours a day. They receive specialist training in perinatal mental health. Each woman has an allocated primary nurse and each infant an allocated nursery nurse. They work closely with the patient, family, community-based staff (maternity, social services, mental health, primary care) and the unit multi-disciplinary team in planning and providing individualised care for the mother and infant. Social therapists support the work of nurses in providing care and actively engaging patients in their daily programmes.

There are clear safeguarding policies in place. Nursery nurses work directly with the mothers and infants ensuring that the infants' needs for safety, wellbeing, nutrition, sleep, play, stimulation and good physical and mental health are assessed and addressed. Women and their infants are encouraged and supported to retain their links with the community and from the earliest time possible are escorted for walks, shopping and assessment outside of the hospital environment. Fathers have regular access to the unit and are supported in addressing their own psychological needs and how best to help their partners.

The parent–infant psychotherapist from the acute stage of illness offers a series of therapeutic consultations as assessment and clinical intervention. The mother and infant are seen together and the father often joins the sessions. The focus of the intervention is on the growing bond and attachment between the mother and infant which has been disrupted by the mental illness of the mother. As a consequence of the disruption the baby may need help in re-establishing its connection with its mother and supportive work may be needed to re-build the mother's confidence as a mother to her baby. The therapist supports the mother, father and baby

towards understanding both these disrupted processes and emotionally supports them to feel confident in remaking this connection together.

Each week there is an afternoon where the mothers and infants participate in a mother and baby therapeutic group within the ward setting. They sit together with the parent–infant therapist on a level for playing with babies and are helped to make connections through the use of toys and linking words and movements. Particular attention is given to the babies experience within the groups. Behaviour that supports the mother–baby relationship is reinforced and the babies are helped to enjoy other babies in the baby-centred, fluid and playful atmosphere.

The midwife provides both antenatal and postnatal care to women on the unit. She is also available for discussion on all antenatal and postnatal issues and problems, such as formulating a birth plan, advice on maternity benefits, physical health checks, breastfeeding advice, neonatal feeding problems, advising on sleep and enables access to antenatal physiotherapy. She contributes to the work of the multidisciplinary team and attends the weekly patient meetings.

The occupational therapist organises and runs a comprehensive and dynamic therapies programme where meaningful activity on the ward facilitates optimal individual function and provides structure to the day. Each infant has a lifestory book created by his/her mother to document development and progress when on the unit while also providing a photographic record of the people who provided care.

The art therapist uses art media as a primary mode of expression and communication. It is helpful for those who find it hard to express their thoughts and feelings verbally. The sessions take place in a group setting allowing the women the opportunity to share experiences and address issues in relating to others.

The dance movement psychotherapist uses movement, dance and the body towards supporting the woman's physical, emotional, cognitive and social integration and recovery. The weekly sessions use body orientation exercises, bonding and trust exercises and relaxation.

The psychologists contribute to assessment, formulation and treatment of each woman and are able

to work with significant levels of disturbance and are a core element of treatment on the unit. Most women have an average stay of 6–8 weeks therefore the focus is on comprehensive assessment and formulation making it possible to make well-informed recommendations about further psychological input once discharged.

Identifying the ongoing therapeutic needs of the mother is a crucial task in discharge planning and detailed recommendations that are both practical and specific are made to the community team.

Psychological therapy and interventions are offered as individual, family or couple depending on assessment of individual need. This may include offering individual work to the woman's partner.

Weekly meetings are held for each patient where the members of the team, the patient and her family review progress and future plans are discussed and developed. The consultant psychiatrist takes the clinical lead in the collaborative work of the unit where the individual patient and her infant and family are central.

The unit welcomes referrals from all areas of the UK and can be contacted on 0208 5108420.

REFERENCES

- 1 Howard LM. Fertility and pregnancy in women with psychotic disorders. *European Journal of Obstetrics, Gynecology and Reproductive Biology* 2005;119(1):3–10.
- 2 NICE (2007) *Antenatal and Postnatal Mental Health. NICE Guideline on Clinical Management and Service Guidance*. London: NICE, 2007.
- 3 Confidential Enquiry into Maternal Deaths. *Why Mothers Die*. CEMACH. 2000–2002.
- 4 Confidential Enquiry into Maternal and Child Health. *Saving Mothers Lives*. CMACE, 2003–2005.
- 5 Department of Health. *Women's Mental Health: into the mainstream*. London: DOH, 2002.

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