

Mother and baby admissions: survey of resources

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This paper describes a questionnaire survey of facilities for joint admission of mothers and babies to psychiatric hospitals.

Development of mother and baby units

Units to admit psychiatrically ill mothers with their babies to psychiatric hospitals were pioneered following Main's description (1958) of the treatment of mothers with their children at the Cassel Hospital. Particular interest in puerperal psychosis and disorders of bonding and attachment led to units usually providing for babies below six or 12 months. Suggesting older infants should also be admitted, Main referred to the benefits in admitting parents to paediatric wards with ill children, and described how toddlers had been admitted with their mothers at the Cassel. Another early unit at Banstead Hospital cared for schizophrenic mothers with their babies and found that joint admissions lead to faster recovery, lower relapse rates and more babies continuing to live with their mothers (Baker *et al.*, 1961).

Joint admission can also be used as an opportunity for mothers to learn how to live with and enjoy their children, (Grunebaum *et al.* (1963). Leupker (1972), in a follow-up study, found that mothers whose babies had been admitted with them described the baby's presence as having been important in their recovery and in building their confidence as mothers. Concerns about the safety of babies on psychiatric wards were expressed by nursing staff in van der Walde's and colleagues' study (1968) of the introduction of joint admissions to one hospital but over the study period these concerns decreased and staff morale generally improved.

A survey conducted in 1979–1981 of resources to admit mothers and babies in one region (Kumar *et al.*, 1986) found a need for planning and coordination of services by region. Consideration of day and community care was suggested, as well as regional and national registers of facilities. Discussion about operational policies for these was lacking and problems for the family in general (such as when there was an older child) were noted.

Aware of difficulties in this area of practice, we were interested to find out whether facilities had progressed and to consider the provision of other facilities for families on psychiatric admission wards.

The study

A questionnaire was devised to ask about the existence of mother and baby units, local resources to treat mothers and babies and physical resources to help the family to keep in contact with the patient at the time of admission (for example, family visiting rooms).

Comments about local services, problems and plans for future development were invited and the policy documents concerning mother and baby units in existence were requested.

This questionnaire was sent to the senior nurse manager of the psychiatric units of 120 hospitals in six regions in the south of England and in Wales. One reminder was sent to non responders.

Findings

One hundred and three replies were received, a response rate of 86%. Ten hospitals were discovered not to have acute psychiatric wards and so were excluded from analysis. The range of response for the different regions was between 69% and 95%. Mother and baby units existed at 38 hospitals.

Regional resources for admitted mothers and their babies

Of the 93 hospitals that admit acute psychiatric patients, most were able to arrange admission for a mother with her baby; 59 used a designated mother and baby unit on site or by transferring the patient, 36 used general psychiatric wards for the mother with baby either lodged there or on a paediatric ward (some hospitals used both types as required). Eight hospitals were unable to arrange any admissions for a mother and baby. (See Table I).

Two regions had no regional units; in one of these, three hospitals reported themselves unable to arrange any mother and baby admissions. Five hospitals in Regions 2, 3 and 4 which do have regional units were unable to arrange admissions; there were many comments from Regions 2, 3 and 4 about difficulties in transferring patients to the Regional units because of delays (two hospitals), unit full (five hospitals), strict admission criteria (one hospital), and unit too far away (one hospital).

TABLE I
Resources for admission of mothers with babies by Region

Type of unit	Number of hospitals using each type of unit by Region					
	1	2	3	4	5	6
Mother and baby unit on site	5	6	9	8	4	6
District unit	2	2	0	1	0	3
Regional unit	0	4	4	4	0	1
Psychiatric ward	2	6	2	8	5	4
Psychiatric and paediatric wards	2	2	3	0	1	3
Other	1	0	0	0	0	1
Unable to arrange admission	3	1	3	1	0	0

TABLE II
Details of larger mother and baby units

Number of beds	Specific staff employed for unit	Number of admissions in one year
5	4 nursery nurses	Not given
8	8 psychiatric nurses	40
8	3 psychiatric nurses	
	1 nursery nurse	20
8	1 nursery nurse	20-30
6	7 psychiatric nurses	
	1 art therapist	45-50

Details of facilities provided

There was a clear distinction in the results between large mother and baby units (with five or more beds) and the small units. In fact there was a less clear difference between facilities provided by smaller, designated units and the facilities in hospitals that 'made do' using general beds.

Mother and baby units with at least five beds

There were five of these units which had specially designated, trained staff and more than 20 admissions per year (see Table II). It was interesting to note the range of specific staff thought to be required, i.e. one nursery nurse for an eight bedded unit, a six bedded unit had seven psychiatric nurses and one art therapist. The total number of admission per year to these five units was 150-170.

Smaller mother and baby units

Of these 31 units, most were two bedded (17 units), nine were one bedded, two were three bedded and

two were four bedded. One of these units was part of a family and children's unit with high staffing levels and a different rationale; (the aim was to treat the family rather than the resource being considered for one patient). Of the other 30 units based in adult services, only three could call upon specific staff and these were only employed from agencies as required.

The total number of admissions to each of these units was usually low. Fifteen had less than five admissions a year, eight units had five to ten admissions a year and four had 10-20 admissions a year, so that the number of admissions per bed per year varied from 0.5 to 9. Looking at the minimal estimate of admissions per year, these smaller units accounted for about 140 admissions per year over the six regions.

Many comments from these units were about the lack of specifically trained staff and the unit diverting staff resources away from other patients. There were many comments concerning units with no specific funding and many designated units simply consisted of a cot and a wash basin. Respondents queried the safety of babies on psychiatric wards (12 comments). Others mentioned specific problems with older, more mobile babies, financial cutbacks, blocking of beds by other patients and difficulties with case management in the longer term.

Two small designated units were closed because of staff shortages and financial restraints.

Other types of provisions

Babies were admitted to the psychiatric ward with mother at 25 hospitals and at 11 hospitals the baby was admitted to the paediatric ward. There were examples of flexible use of existing services to cope with the problem of treating a mother and her baby. One hospital admits babies if necessary and can use the staff crèche to care for children of patients, another treat mother and baby as day patients. Three hospitals described no difficulty in admitting to adult psychiatric wards which are well provided with single rooms and staff. Liaison with child psychiatry enabled families to be admitted to a child psychiatric unit in one hospital. Three hospitals have new units planned, two of which will provide for admission of the family when necessary.

Diagnoses

Of the 38 designated mother and baby units, 35 replies to a question concerning the diagnostic admission criteria for their unit: 100% said they would admit mothers with psychoses; 25 units (66%) those with personality disorder; 26 units (68%) those with neurosis; but only 13 units (34%) said they would admit a patient with drug and alcohol dependence.

In Region 5, no mothers with drug and alcohol dependency could be admitted with their baby.

Facilities for family visits

It was enquired whether privacy for the psychiatric patient to see their family was available. All patients in single rooms were able to do so when their mental state permitted. At ten hospitals all rooms were single; in seven hospitals nearly all (90–100%) the beds were in single rooms; in seven hospitals 50–90% were single; in 36 hospitals 20–50% were single; and in 30 up to 19% were single. There were seven hospitals with no room for family visits where less than 10% of the patients had single rooms and two hospitals had no single rooms.

There were rooms other than their own room in which the patient could see visitors in 73 of the 93 hospitals.

Facilities for involvement of the family in therapeutic aspects of the patient care

In 83 of the hospitals there was space available for interviewing families. If the relatives needed accommodation, 22 said they could arrange beds for distressed relatives and 31 for a relative for therapeutic purposes.

Comment

Facilities are generally available for joint admission of mothers with their babies for psychiatric treatment. It was worrying that so many units are currently strained for resources. In particular, comments backed up the questionnaire findings that few had specifically trained or appointed staff. Two units were actually closed because of lack of staff. Another striking feature was the division between small and large units, five beds seeming to be the critical size, in that units with five or more beds were more likely to have specifically trained staff and had less complaints concerning funding.

The psychiatric literature mostly contains information from larger units and so decisions as to whether to set up many small local or fewer large units cannot be based on research evidence.

Transferring patients to regional units created problems by separating them from their families and local psychiatric services. Some regional units were often full and thus other hospitals experienced difficulties caring for these patients.

Five small units, that were well resourced with staff and single rooms, reported satisfaction with the situation. These results would indicate that research aimed at clarifying the level and type of staffing required by each unit and the outcome of patients leaving different types of unit is required to clarify whether units should be smaller and local, or larger and more specialised.

Considering family visits to patients, we focused on the resources around families with babies. It was clear

that for all patients in some hospitals there was little opportunity for privacy with visitors because there were few single rooms and no extra visitors' rooms. Re-establishing relationships with families who have been stressed by worries about the patient, and often troubled by aspects of the patient's behaviour, would seem to be an important part of the general rehabilitation process. Current developments in family therapy and community care reflect this, but simple resources were lacking. For all patients it would seem to be beneficial if their relatives could be admitted on occasion. From our replies, it would seem that in designing future sites it may be important to consider the specific provision of rooms where patients can see their families if this is not available in the ward. Tangari (1974) indicated better outcome when there is a good relationship between the hospital and the family and adequate facilities provided to help them; this is pertinent with current changes towards community care.

Only two units sent copies of their operational policy as requested; we hope this reflects clerical time involved rather than the lack of policy making. We would argue that despite the small numbers of beds at each, it is important that small units have a specific operational policy, as the figures show that around half of these admissions overall are to smaller units.

Mothers are at no less risk than the general population for most types of psychiatric illness, yet although all mother and baby units accepted patients with psychotic illness, other diagnostic groups were excluded. Alcoholism and related problems in girls and young women is increasing but only 34% of units would care for mothers with these problems.

Kumar (1986) suggested the setting up of a national register for mother and baby facilities; this survey reinforces the need for this. Clinicians treating an ill mother and baby have difficulty obtaining information about available services. More importantly, since over half of the admissions of mothers and babies are to small units, and the total number of admissions to mother and baby units nationwide are not very large, such a register would facilitate research access to a wider and more representative sample of patients and services. In addition, the register could be usefully linked with a few units that would also provide an information base from which standards of practice could be set. Monitoring of the quality and continuing development of services for mothers with their babies will remain necessary if the continuing problems are to be overcome.

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Why do patients occupy acute psychiatry beds? A pilot study

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The main aim of this pilot study was to identify factors influencing acute psychiatry bed use. The reasons for occupying a bed vary with time, so patients in the study were assessed on a weekly basis to monitor the changes in the factors thought to be responsible for continued stay. The reasons for bed occupancy also are often only known to those professionals directly involved in day to day care of patients, and it is suspected that the reasons often have little to do with manifest psychiatric illness. The reason for this study was to investigate this question.

The study

A census of the in-patients occupying acute admission beds in a psychiatric hospital in South London (Springfield Hospital) for three catchment area services was recorded during the ward round each week for ten consecutive weeks by a junior psychiatrist involved in the care of the patient. Information obtained included: name, hospital number, admission date, week of admission, name of consultant in charge, date of birth, sex, marital status, employment status, whether first psychiatric or first hospital admission, and whether the patient was formally detained. Clinical information was obtained each week concerning psychiatric symptoms, psychiatric management, social network, involved agencies and

accommodation, which were then recorded in coded form. On discharge, the disposal was recorded with total number of days in hospital. The patients present at the end of the study were followed up for discharge date and total number of days spent in hospital recorded where possible.

The study started on 22 January 1988, for two consultants' beds and after six weeks, to enlarge the sample, a third consultant's beds included. Consequently the period covered in the results is 16 weeks but occupancy status of each bed was observed for ten consecutive weeks.

Inter-rater reliability was established between the two clinicians by cross-rating ten patients during the ninth and tenth weeks of the 16 week period when minor differences were corrected.

Before the study began it was hypothesised that occupation of a bed would be for a combination of two or more of the following factors:

(a) *Medical reasons for admission*: meaning that the patient is in hospital to exclude or treat a medical condition; for example, he may have been admitted in a state of confusion and the possibility of a chest infection may be being investigated or treated.

(b) *Psychiatric*: the patient has been admitted because of a known psychiatric diagnosis. Alternatively, he is receiving a recognised psychiatric treatment in the form of medication, ECT, behaviour