Background

Women are at greater risk of developing a mental illness following childbirth than at any other time. The effects of post-natal mental illness can be devastating, and without adequate management, symptoms and associated impairment of functioning, can sometimes persist for years (Kowalenko, 2000). Although variable in severity, perinatal mental health problems are a leading cause of maternal mortality in the first postnatal year (Oates, 2003; PMMRC, 2013). Maternal mental health problems can have very disruptive effects on families by contributing to the breakdown of parental relationships and increasing the risk of concurrent paternal depression (Paulson & Bazemore, 2010; Cogill et al, 1986; Murray, 1992). Furthermore, this important transitional period in family life has immense impact upon the early development of relationships, parenting confidence and infant attachment. Early disruption of mother-infant interactions can have a long term adverse influence on developmental milestones, cognition and behavioural outcomes (Cogill et al, 1986; Murray, 1992) as well as attachment relationships (Lyons-Ruth et al, 1986).

Depression related to child-bearing can occur during pregnancy (antenatal depression), and after birth (postnatal depression) with estimates ranging from 12–20% of women giving birth affected, with a commonly reported estimate of 13% (Bennett et al, 2004; Josefsson et al, 2001; O’Hara & Swain, 1996). Evidences sourced from the Black Dog Institute estimates that around 5% suffer severe depression and, more rarely, postpartum psychosis – usually an affective psychosis – affects around 0.2% of women (BDI, 2014). The risk of a relapse of an existing psychiatric condition also increases in the months after childbirth (Oates, 2000).

It is therefore imperative that mentally ill caregivers, particularly primary attachment figures have access to effective treatment. Fortunately, most postnatal psychiatric illness can be managed with outpatient treatment, but in some cases the illness and associated risks can be severe enough to warrant admission to hospital.

It is now widely accepted that women requiring inpatient treatment have improved outcomes if accompanied by their babies. Admitting both mother and baby to hospital circumvents the possibility of women refusing inpatient treatment in order to avoid being separated from their children (Salmon et al, 2003) and is well demonstrated to be effective in treating perinatal illness (Wilson et al, 2004). Joint admission to a dedicated unit has been demonstrated to lead to improved parenting skills and help the woman gain increased confidence in her mothering role (Kumar et al, 1995). Joint admission constitutes an investment in the baby’s future health. National Institute for Health and Care Excellence (NICE) Guidelines recommend joint mother and baby admissions when hospitalisation is required for mentally ill mothers in the United Kingdom (NICE, 2014). Some Australian health care funders have portrayed mother-and-baby joint admission as being out of step with other contractual arrangements and industry standards, and there has, in the past, been a trend for care funder remuneration to exclude the accommodation of a baby as a ‘boarder’ during his or her mother’s stay. Such practice is at odds with optimal psychiatric practice and is not conducive to either the mother’s swift recovery or the future good health of her child. Such shifts in care funder remuneration practice may have serious implications for the provision of effective treatment of mothers and their children.
Recommendations

Given the weight of evidence in favour of joint admission, the Royal Australian and New Zealand College of Psychiatrist’s (RANZCP) position is:

- Early identification of maternal illness either antenatally or early in the postnatal period along with the development of safe and appropriate pathways to urgent care is appropriate. An understanding of the risks of the acute situation is always appropriate and co-working across maternal and paediatric services at primary, secondary and tertiary levels is likely to ensure better outcomes.
- Every effort must be made to ensure inter-team accuracy and timeliness of communication in such scenarios.
- Routine antenatal screening for risk factors associated with postnatal depression and serious mental illness should be implemented as part of the range of health services accessed by pregnant women (Oates et al, 2003) and after birth (NHMRC, 2011).
- Except in cases where the baby’s or the mother’s emotional or physical well-being may be jeopardised, it is best clinical practice that mother and baby remain together during treatment together, and that the involvement of other parents and/or caregivers is supported. To this end, all prospective care funders should be encouraged to incorporate mother-and-baby joint admission into industry standards. Further, there should be recognition by funders of the importance of mother-and-baby joint admission and adequate inpatient beds and facilities should be made available for this purpose.
- Fathers are at increased risk of also experiencing mental health problems at such times and should be supported (Gutierrez-Galve et al, 2015).
- The RANZCP supports admission to mother-and-baby psychiatric units with appropriately trained staff as best practice. General adult psychiatric facilities are not an appropriate environment for infants and do not have the requisite parenting facilities or specialist expertise. The RANZCP acknowledges however that admission to mother-and-baby psychiatric units is not always feasible in every jurisdiction across Australia and New Zealand currently.
- Further research on the mental health outcomes associated with admission onto mother-and-baby psychiatric units should be supported so as to strengthen practitioner understanding and evidence-based best practice.
- Following admission, and if indicated, follow-up into early childhood may assist optimising child development, parenting confidence and family functioning (Kowalenko et al, 2012).

This statement should be read in association with RANZCP Position Statement 56 ‘Children of Parents with a Mental Illness’.
References


Disclaimer

This information is intended to provide general guide to practitioners, and should not be relied on as a substitute for proper assessment with respect to the merits of each case and the needs of the patient. The RANZCP endeavours to ensure that information is accurate and current at the time of preparation, but takes no responsibility for matters arising from changed circumstances or information or material that may have become subsequently available.