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Odile Cazas [*] **, Nine M.-C. Glangeaud-Freudenthal**

* Correspondence should be adressed to: Odile Cazas <ao.cazas@wanadoo.fr >

Abstract
SUMMARY

Until fairly recently, mentally ill mothers were separated from their new-borns because of the potential danger to the baby. Over the past 50 years, however, we have learned more about the perinatal period, with the development of child psychiatry and interest in maternal postpartum disorders. This knowledge has led psychiatric departments to develop new ways to provide care without separating mentally ill mothers from their babies.

Joint full-time admissions began in Great Britain in 1948. The first Mother-Baby Unit (MBU) in France opened in 1979 and in Belgium in 1990. In 2003, there are 17 MBUs in France and 3 in Belgium.

From 1995 to 1998, Odile Cazas and Nine Glangeaud, working with a group of child and adult psychiatrists and psychologists, adapted the English Marcé Checklist to the French and Belgian health and child protective systems and added items useful for research.

MESH Keywords Adult ; Belgium ; Depression, Postpartum ; Female ; France ; History, 20th Century ; History, 21st Century ; Humans ; Infant ; Infant, Newborn ; Mental Disorders ; diagnosis ; therapy ; Mother-Child Relations ; Mothers ; psychology ; Postnatal Care ; history ; organization & administration ; Psychiatric Department, Hospital ; history ; organization & administration ; Psychiatric Status Rating Scales ; Rooming-in Care ; history ; organization & administration

Author Keywords Mother Baby Unit, Marcé checklist, postpartum disorders.

INTRODUCTION

The development of joint mother-baby hospitalisations in France dates from a little more than 20 years ago and has taken place in a very particular context. Until fairly recently, mentally ill mothers were separated from their new-borns, mainly because of the potential danger to the baby (Howard LM, 2000). This attitude has changed – slowly but radically – in response to discoveries over the past 50 years in very diverse disciplines that touch the perinatal period: psychiatry, paediatrics, experimental psychology, developmental psychology, ethology and psychoanalysis.

The new information comes from two sources: mother and child.

About the baby

Clinical observation uncovered aspects of infancy that were previously unknown. Spitz (1946) and Bowlby (1958) demonstrated the impact on the child's cognitive, psychic and emotional development of affective deprivation and separations, even when brief, of mother and child. The competencies of new-borns – including their capacity for communication and interactions with adults – were discovered (Brazelton, 1973), along with the attachment process (Bowlby, 1958 ; Ainsworth et al, 1978 ; Lebovici, 1983). The relationship between the infant and the primary caregiver appears to be of vital importance to the infant's emotional development.

About the mother

There has been a renewal of interest in postpartum disorders. Mental illnesses associated with childbirth were an early theme of modern psychiatry. In 1858, more than 150 years ago, Louis Victor Marcé, a French psychiatrist who was Esquirol's student (Esquirol, 1838), published his book "Treatise on the psychoses of pregnant women, and newly delivered and nursing mothers". Marcé is today considered the founding father of "perinatal psychiatry". Our English colleagues rediscovered him, and Channi Kumar gave his name to the first multidisciplinary Perinatal Society, founded in 1980, the – our – Marcé Society. A French-speaking Marcé group was founded in 1998 (Glangeaud, 2003).

After Marcé, perinatal psychiatry barely advanced at all in Europe until the second half of the 20th century, when new findings were reported and some theoretical tools developed:

- - 1956, "Primary maternal preoccupation" by Winnicott (1956)

- - 1961, “The mother and child in postpartum psychosis” by Racamier, a French psychiatrist and psychoanalyst. He occasionally admitted mothers and their babies together into an adult psychiatric department, on the grounds, he said, that “optimal therapy is impossible without the presence of the infant”. (Racamier et al, 1961)

- - 1962, Bion wrote about the mother’s “capacity for reverie” and how she “contains” the baby's emotions and anxieties (Bion, 1962).

- - 1968, Pitt published “Atypical depression following childbirth”, the first description of postnatal depression and ‘the Blues’ (Pitt, 1968).

Ample research thus demonstrates that postpartum disorders interfere with optimal mothering (Beetschen et al, 1978 ; Cazas et al, 1999). In the postpartum period, many mentally ill mothers have difficulty responding to their infants' cues. These disorders frequently cause the separation of mother and baby (Howard, 2000). In this situation, dilemmas arise for each member of the dyad:

- - How can a woman become a mother if her baby is not physically present?

- - How can a baby become attached to her mother, if it is not the mother who is providing her daily care?

Concern about these issues led mental health units in some countries to develop new ways to provide care for the mentally ill mother without separating her from her baby. The full-time mother- baby unit is one setting among many others; one aspect of a broader approach to perinatal services.

HISTORY OF JOINT MOTHER-BABY ADMISSIONS IN EUROPE

Chronologically, for historical reasons, Great Britain has pioneered in the perinatal area. This began in the very particular setting of England after the Second World War. The evacuation that moved children out of London during the Blitz revealed the harmful effects of separating families (Bowlby et al, 1956). Thereafter it became routine practice to admit mothers and young children together to paediatric hospitals.

This practice facilitated the first joint psychiatric admission of a mother and baby, in 1948, for a woman suffering from non-psychotic depression. Gradually, in the years that followed, women with all kinds of mental illnesses related to childbearing were admitted (Main, 1958 ; Baker et al, 1961) to special units set up in adult psychiatric departments (Kumar, 1995 , 1997 ; Oates, 1996).

In France, joint full-time admissions first took place in 1960; they were only occasional and in only one psychiatric hospital near Paris – Racamier's patients, as we noted above. The first dedicated Mother Baby Unit was opened in 1979 in Créteil, near Paris, in a child psychiatry unit: 3 beds, 3 cots (Isserlis et al, 1980). A year later, the next opened in another Paris suburb, Villejuif, in a general psychiatric department (Cazas et al, 1990 ; Cazas, 2002). More units opened over the next two decades – most recently in 2002. There are currently 17 MBUs in France – 6 in the Paris area and 11 scattered around the rest of the country (Sutter et al, 1998). Three MBUs in Belgium have been providing joint full-time hospitalisation since the 1990s but one closed last year.

The paper by Glangeaud et al in this issue describes the distribution of the diagnoses of the women admitted to these units. The MBUs may admit very disturbed women in acute severe depressive, manic or other psychotic episodes. The mother would have been admitted in any case, either with or without her baby. In some units, the baby is not admitted until the acute stage of the mother's illness has passed, that is, not until the mother can pay a minimal level of attention to the baby.

Maternity units may be alerted to the mother's illness by a dysfunction in the mother-child interaction and early disturbances in attachment and refer the pair to a specialised MBU. Mothers may suffer from personality disorders, “borderline, narcissistic” disorders with parenting difficulties, histories of affective deprivation and/or sexual abuse as children, and milder sub- syndromic depression. The latter is relatively frequent during the postpartum period, even though most cases are not considered to require hospitalisation. Nevertheless, they may have an impact on the mother's interaction with the baby (Murray, 1992).

Characteristics of MBUs in France and Belgium

The style and philosophy of management and the length of stay vary greatly throughout France and Belgium, both for joint admissions and for post-discharge arrangements (Glangeaud et al in this issue). Practices differ from unit to unit. The observation may focus more on the mother, the baby or their interaction. All are administratively associated with a general psychiatric, child psychiatric or paediatric unit.

Practical setting: Staff and location

The size of the units ranges from 2 to 15 beds, 2 – 15 cots, that is, 8 to 15 dyad admissions a year by unit, for 150 joint admissions a year in France, and 20 in Belgium (Glangeaud et al in this issue). The largest MBUs, with 6 or more beds, justify a separate unit, with multidisciplinary specialists and specially trained staff. Some smaller MBUs have their own designated nurse but can also draw on the nurses from the main ward when necessary. The nurse needs appropriate training, special skills and understanding to be able to care for the women and the babies at this period of their lives. Others provide "facilities", that is, occasional mother and baby beds without any special nurse for the baby. The implicit assumption is that some baby care will be performed by the staff when the mother cannot.

Some MBUs take the form of an annexe to a general psychiatry ward or a child psychiatry unit: a few rooms are set aside. One MBU in France and one in Belgium are located in paediatric hospitals. Some are located in purpose-built units separate from the psychiatric ward, sometimes near a paediatric department or a maternity hospital. One is located in an urban mixed-use building rather than a hospital. One unit in France and one in Belgium also admit partners and older children. One unit admits women during pregnancy and after childbirth.

Two units are open only during the week. On Friday evening, mother and child, together or not, must leave; they may stay with the extended family, or on a psychiatric or a paediatric ward, at a foster home or with a foster care family. They return on Monday morning. Length of stay in the different units is reported in another paper in this issue, by Glangeaud et al.

The status and management of MBUs

The status of MBUs in France and Belgium is precarious for a variety of reasons: money, interest of doctors, the children's status, size of the unit, etc. Perinatal psychiatric services have limited resources. Two MBUs closed down completely for a few years, mainly but not only for financial reasons. Both are again operational, although one has been converted into a less costly day-care hospital.

The survival of these units also depends on the continuing interest of a particular consultant or department chief; and the unit may close when that person leaves. These units are the fruit of local decisions: human and institutional resources available at a given moment, a doctor with a special interest, and a hospital director sensitive to the problem. So far, their creation has not involved any overall vision or real assessment of needs; this explains their totally random distribution throughout the country. Today, however, perinatal care has become an official public health priority in France, and MBUs should thus become a part of a general policy, a network built up around the birth process.

Another issue, also related to costs, is the status of children on the ward. Sometimes the baby is considered a patient, just as the mother is, and the national health insurance fund accordingly provides reimbursement for both. In those cases, experts in infant care and early mother-infant relationships work at the unit and care for the children. In other MBUs, set up in adult psychiatric departments, the infants are often considered "healthy relatives" who simply accompany their ill mother. They are not patients themselves, but simply a vital component of their mothers' treatment. There is then no funding available for their health care. Moreover, other difficulties may arise, because the nurses must divert time and effort from other duties to care for the mother and baby.

In France most units are run by child psychiatrists, often psychoanalysts by training, and very concerned about the quality of the mother-infant bond. Some units are managed by adult general psychiatrists, as in England. Three are jointly administered by two psychiatrists, one specializing in children and the other in adults.

Elsewhere in the world

Joint mother-baby hospitalisation in psychiatric units remains relatively rare outside the United Kingdom (see paper in this issue by Salmon et al), Australia (see paper in this issue by Buist et al; Barnett, 1996) and New Zealand (see paper in this issue by Wilson et al). There are some MBUs in Europe outside France and Belgium: one in the Netherlands since 1995 (Klompenhouwer et al, 1991), and another in Germany since 1999 (Deneke, 1999 ; Nicolaï et al, 2002). A unit will also be opening shortly in Luxembourg. Such units have opened only very rarely in the United States (Wisner et al, 1996) and Canada (Stewart, 1989), and, as far as we know, they have all closed, for financial reasons (related to budgets, inadequate health insurance reimbursement, and malpractice insurance rates).

Why has this care arrangement taken root in Great Britain, and then later in France, Belgium, Australia and New Zealand, but not spread elsewhere? The reason is not clear, since the prevalence of postpartum disorders does not differ among countries. Part of the explanation may be the absence of controlled clinical trials of this type of management and thus the lack of evidence of its superiority over the traditional psychiatric admission of the mother alone. In any case, most often, mothers, families, and caregivers express great satisfaction with this experience (Brockington, 1996).

THE HISTORY OF THE FRENCH VERSION OF THE MARCé CHECKLIST

MBUs must evaluate the services they provide. This means that they must introduce into their practice standardised files that record common variables that are both easy to use and useful, in order to set up sufficiently large cohorts. This requires collaboration between clinical departments and research teams.

At the 1996 meeting of the Marcé Society in London, Louis Appleby and Trevor Friedman presented the Marcé Clinical Checklist, which became the framework for a national system of data collection on mother and baby admissions in Great Britain.

With the consent of L. Appleby and the advice of C. Kumar, N. Glangeaud, a researcher in psychology and Odile Cazas, a psychiatrist for adults – translated this questionnaire into French and adapted it for use in France and Belgium (Glangeaud-Freudenthal and al, 1999). This translation was discussed and modified at monthly meetings of a group of colleagues working in French and Belgian MBUs (Glangeaud-Freudenthal et al in this issue). It was decided to retain all the series of items found in the English version, because a common instrument facilitates international comparisons.

Some items nonetheless had to be modified to adapt them to the organization of mental health services and the laws governing mother-baby hospital admissions. Child protection agencies and children's courts are different in France and Britain, and these differences can affect care in MBUs, especially when a baby is separated from its very mentally ill mother (Durand et al, 2000 , Lerminiaux, 2000). The underlying concepts include the balance between the child's best interests (including development, safety and welfare) and the rights of the biological parents, and the formalities involved in each country for foster care and adoption (Daguerre, 1999).

Some items were added to collect additional information that seems to us important to the mother's psychopathology.

- Psychological theory attributes an important role to the line of filiation, with inter-generational elements in the formation of the self (Lebovici, 1992). When a child is born, mother and father set out to seek their own history; the child they once were. The child is perceived by the parents across the conflicts they once had with their own parents. For this reason, we systematically ask the mother questions about her own childhood and adolescence: quality of maternal care (foster care, placement within the extended family; adoption), important life events and trauma, such as parental separation, severe physical or mental disease, or death, and harm to the child, through neglect, and abuse.

- Dysfunction of mother-baby interaction was added to the list of primary purposes of admission, as it can be a reason for admission in France and in Belgium.

- Mother's pathology is more detailed and we have added a separate code for an “acute transitory delusional episode”, the French “bouffée délirante aigue” option not offered in the existing classifications that, we feel, do not allow clear coding for the acute mixed atypical postpartum psychosis commonly seen by those who treat severe postpartum disorders.

- In addition to the informal English Marcé list of maternal pathologies, we also collect the maternal psychiatric diagnosis according to the International Classification of Diseases (ICD 10), which is widely used for health service statistics in Europe and Australia.

- Questions about substance abuse now clearly distinguish alcohol, drugs, and tobacco, because their outcomes can differ widely.

- In the part of the questionnaire about “Harm to the child”, we differentiate child neglect from child abuse, which may arise in a different context and may lead to different or more urgent decisions to protect the child.

- Information is collected about the partner and/or the baby's father if different from the partner, about traumatic events in his childhood, his own pathology, with questions similar to those described above for the baby's mother (Poinso et al, 1998).

Sixteen of the 20 French and Belgian MBUs began in 1999 to complete this French version of the Marcé Clinical Checklist for every joint admission and contribute to the Franco-Belgian Marcé data collection (see some analysis of this data base in the paper from Glangeaud et al in this issue).

As we are especially interested in the mother-baby interaction, we have also added an instrument to assess the baby, so that we can also focus on the baby; otherwise the mother's disorder may be so salient that it prevents the nurses from seeing the baby. The observation of mother-baby interactions has therefore become a large part of the work of the nursing staff, and an instrument has been developed to collect these observations weekly (Durand et al, 1999). This child file was presented in 1998 at a biennial Marcé Society meeting in Iowa. It has since been discussed further and revised by a working group of psychiatrists, child psychiatrists, psychologists and researchers working in MBUs. It has been tested in several French and Belgian MBUs. Six units use it routinely at this time and results were discussed in a workshop at the 2002 WAIMH biennial meeting in Amsterdam. (abstracts unpublished as yet).

IN CONCLUSION

Joint full time mother baby admissions have been developed in France and Belgium following Great Britain, since more than 20 years, as a specific and original reply to mental illnesses associated with childbirth. This arrangement prevents separation of the infant from her mother even mentally ill, while providing welfare, safety and continuous care for the baby. It allows her cognitive, psychic and emotional development.

Joint admissions require tact, a good evaluation of potential danger, multidisciplinary knowledge and appropriate training for the team. Practicing this type of management needs a rigorous assessment of provided services. The product of a standardized file in two parts, the French version of the Marcé checklist and the French child file became a common instrument to MBUs. The aim of these files – mother and baby - is to:

- - Provide a national audit of facilities that offer joint mother and baby admission and to enable comparison among centres.
- - Develop a large data set to support research and audit in postpartum disorders.
- - Carry out multi-site collaborative research on prevention and treatment
- - Establish an appropriate broader national plan for managing postpartum psychiatric disorders.

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