MALE PARTNERS OF WOMEN ADMITTED TO MBUS IN THE UK: A SURVEY OF AVAILABLE PSYCHOSOCIAL AND PSYCHOLOGICAL INTERVENTIONS

Beth Turner[1], Charlotte Garrett[1] and Anja Wittkowski1[2*]

[1]School of Health Sciences, the University of Manchester, [2]Greater Manchester Mental Health NHS Foundation Trust

[*]**Corresponding Author:** Anja Wittkowski, The University of Manchester, Faculty of Biology, Medicine and Health, School of Health Sciences, Division of Psychology and Mental Health, 2nd Floor Zochonis Building, Brunswick Street, Manchester M13 9PL, Tel: 0161 306 0400, Email: Anja.wittkowski@manchester.ac.uk

ABSTRACT

Objective: To explore the support currently offered to male partners of women admitted to specialist Mother and Baby Units (MBUs) in the United Kingdom (UK).

Background: In the UK, psychiatric MBUs offer dual admission for women experiencing severe mental illness and their newborn in order to improve maternal mental health and minimise disruption to the mother-infant bond. However, admission for many women also means separation from their partners, which could have a detrimental impact on the relationship between the woman and her partner, and the father-infant-bond. Current UK guidelines for managing mental health problems in pregnancy and the postnatal period recommend addressing the needs of partners, with MBU standards outlining the need to ensure that appropriate emotional, informational and practical support is offered. However, as there is a variety of ways in which support could be offered by MBUs and fathers have differing needs, the way in which this support is delivered may vary from unit to unit.

Method: As part of this questionnaire-based survey, 17 MBUs in the UK were contacted and asked to provide information on the psychological and/or psychological support interventions currently being offered by their service to male partners of patients. Information on barriers to and facilitators of offering support, together with aspirations for future support, was also collected.

Results: Ten (58%) MBUs completed the survey and provided information. The findings suggest that support was offered in a variety of ways by different members of staff, to partners on their own or to couples, or to

Citation: Turner B, Garrett C and Wittkowski A. Male partners of women admitted to MBUs in the UK: A survey of available psychosocial and psychological interventions. Women's Health Research [2017; 1(1): 25-36].

couples and their babies. Partner-level barriers included willingness to engage and other commitments such as work and childcare, while service-level barriers related to resources and staff training. Facilitators identified related to service resources and staff attitude towards support. Ideas for additional support included peer support groups, partner targeted information/skills groups and individual/couple therapy.

Conclusions: All of the MBUs who responded to the survey offered support to male partners. The findings capture the varied nature of interventions on offer across MBUs in the UK, which may reflect regional variations in patients' and their male partners' needs and staff preferences and training backgrounds.

Keywords: Mother and Baby units; psychological/psychosocial intervention; support; partner; father; service evaluation; survey

Introduction

It is widely recognised that the postnatal period is a time in which a woman's mental health can be compromised, with many disorders showing an increased rate of first presentation, exacerbation or relapse (1, 2). Some women experiencing severe postnatal mental health problems are admitted with their newborn to a psychiatric mother and baby units (MBUs) to minimise disruption to the mother-baby relationship (1, 3). However, separation from their partners during this time could impact negatively on the couple relationship and bond between the father and infant.

Research highlights the important role partners play in supporting women's mental health treatment and recovery (4, 5). The NICE guidelines for managing mental health problems in pregnancy and the postnatal period emphasise the importance of addressing the needs of partners to best support the treatment and recovery of the woman (1).

Although a woman's postnatal mental health problems can impact negatively on a man's wellbeing (6-9) and the quality of the relationship he has with his partner (10-11), findings from research into the impact of maternal mental health problems on the father-infant-relationship are mixed. For example, fathers can act as a buffer for adverse effects on the infant's wellbeing (12-13), yet findings also showed that maternal mental ill-health was associated with less positive interactions between father and child (14).

To date, only three qualitative studies have explored the experiences of partners of MBU patients (5, 15-16). They explored the impact of MBU admission on fathers, highlighting the need to reduce feelings of uncertainty and anxiety (15) and to offer appropriate support (5) to enable them to support their partner optimally. The findings from these studies also emphasised that fathers wanted more information to better understand their partner's illness and support their partner's recovery (15-16) and to increase their sense of mastery and assist their coping (5). The studies also highlighted the role of the MBU in the father's acquisition of skills and knowledge relating to the caregiving role (5, 15). Furthermore, support needs may reflect parenting experience: first-time fathers may require support with the transition to fatherhood (5, 17), whereas men who already have children may need support with 'keeping the family together' (15).

Current UK guidelines for perinatal mental health recommend addressing the needs of partners (1-2), with recent MBU standards outlining the need to ensure that appropriate emotional, informational and practical support is offered to enhance the partner's understanding and participation in the woman's care and promote their bond with the infant (18). This may be addressed by MBUs offering psychosocial support to male partners, and/or assessing their mental wellbeing to signpost them to relevant services. As there is no detailed information on the type of support being offered to date, the current study aimed to gain better insight into what support had been offered to male partners by MBUs in the UK in order to share information on current practices. The survey asked about what support had been offered by MBUs and by whom. It also explored barriers to and facilitators of offering support and any additional support MBUs would like to be able to offer.

Material and methods

The survey

After gaining approval from the Trust's National Health Service (NHS) audit department, a questionnaire was devised which asked open ended questions covering the following topics: 1) the service (i.e.., number of beds, ward team structure, primary diagnoses of ward population and average length of stay), 2) the psychosocial and/or psychological support offered to partners (i.e., type, delivery, development, structure and facilitator.), 3) future plans for support (i.e., type and delivery of support) and 4) perceived barriers to and facilitators of delivering support of this nature.

Procedure and data analysis

At the time of data collection there were 17 MBUs in the United Kingdom (UK). All MBUs were included in the study, and were contacted by telephone and email between September 2016 and February 2017, with information about the survey. Responses were gathered and summarised using descriptive statistics.

Results

Of the 17 MBUs contacted, ten (58%) replied. Surveys were completed by ward managers, senior nurses, clinical psychologists, an assistant psychologist and a consultant psychiatrist. The mean number of beds across these units was 7, with a range of 5 to 10 beds. The average length of stay was around 6 weeks (ranging from 4 to 8 weeks).

The reported psychological difficulties leading to MBU admission covered a broad spectrum of mental health presentations and diagnoses (as first episode or relapses), including postpartum psychosis, schizophrenia and schizoaffective disorder, bipolar disorder, postpartum depression, anxiety disorders and personality disorders. The MBUs reported a high number of co-morbidities within presentations, and some applied exclusion criteria for diagnoses of personality disorder, substance use and/or intellectual disability.

The findings relating to interventions are described below, including details pertaining to the type of support or intervention offered, and the delivery of the interventions.

Table 1. Type of support offered by the ten participating MBUs

	N interventions (Offered by *n* MBUs)
Psychosocial	
1:1 session	12 (10)
Admission pack	9 (9)
Telephone support	6 (6)
Mother and baby groups	5 (5)
Support group	4 (4)
Carer's assessment	3 (3)
Ward round	3 (3)
Care Planning	2 (2)
Carer's story book	1 (1)
Dads' library	1 (1)
Psychological	
Couples therapy	4 (4)
Couple and baby therapy	1 (1)
Couples mindfulness	1 (1)
Individual therapy	1 (1)

Type of interventions offered

Table 1 displays information on the 14 interventions that were offered across the ten MBUs, consisting of ten psychosocial interventions and four psychological interventions. The most frequently offered psychosocial interventions were face-to-face support sessions (23%), information packs (17%), and telephone support (11%). The most frequently offered psychological intervention was couple therapy (8%), offered by four MBUs.

Details of interventions offered across the MBUs

Table 2 displays details on the interventions offered across the participating MBUs. A total of 53 interventions were delivered across the ten MBUs (range = 2-11, mean = 5.3). Six MBUs offered interventions that aimed at providing emotional, informational and practical support (60%), with the others offering support that covered only some of these areas (40%). Of the 53 interventions, 46 (87%) were classed as psychosocial, and seven (13%) as substantive psychological therapy. Interventions were classified as purely psychological if the main component was clearly therapy-related and delivered by a highly trained professional (e.g., a clinical psychologist). Most interventions were offered on an individual basis (66%), some were group based (17%) and others were couple interventions (17%). Most interventions were developed in-house (94%), with three being developed externally (6%). All interventions were ward based (98%), with the exception of one that was delivered by a local charity (2%). The majority of interventions were accessible to all partners (66%), with some being needs-led (33%). Interventions were developed with partners in mind (74%) or were open to partners as well as other family/carers (26%). Most interventions followed a specific structure (70%), but some were delivered more informally (30%). The majority of interventions were facilitated by nurses (49%), consultant psychiatrists (15%), clinical psychologists (9%), and nursery nurses (9%) but often also involved other MBU team members.

Barriers and facilitators

The reported barriers to delivering interventions were grouped into service-related and partner-related barriers. Service-related barriers included lack of psychological knowledge amongst MBU staff relating to interventions for fathers, inflexible shift patterns, poorly trained MBU staff and lack of paid or commissioned childcare provision for other siblings on the MBU. Partner-related barriers included their own willingness/unwillingness to engage, work/childcare commitments, language/cultural barriers and their ability to travel to the unit for sessions.

The facilitators identified were grouped into service-related and staff-related facilitators. The service-related facilitators could be summarised as effort to increase MBU staff resources (e.g., access to training and specialist knowledge) greater flexibility of staff/ward hours, use of religious leaders and interpreters and allowing siblings onto the ward (even if under parental supervision). Staff-related facilitators included the following: taking an informal approach to engagement, staff having an awareness and willingness to offer support and having interventions led by male staff.

Table 2. Details of the support interventions offered across the ten participating MBUs

	N interventions (Offered by *n* MBUs)
Type of intervention	
Psychosocial	46 (10)
Psychological	7 (4)
Delivery	
Individual	35 (10)
Group	9 (7)
Couple	9 (5)
Development	
In-house	50 (10)
External	3 (3)
Setting	
Ward based	52 (10)
External charity	1 (1)
Access	
All partners	35 (1)
Needs led	18 (9)
Specific to partners	
Yes	39 (10)
No	14 (7)
Structure	
Informal	16 (9)
Structured	37 (10)
Facilitated by	
Nurse	26 (9)
Consultant psychiatrist	8 (3)
Clinical psychologist	5 (4)
Nursery nurse	5 (5)
Social worker	3 (3)
Occupational therapist	2 (1)
Ward manager	2 (2)
Infant psychotherapist	1 (1)
Charity worker	1 (1)

Future directions

The MBUs were asked about interventions for partners they would like to be able to deliver in the future. Five MBUs (50%) said they would like to offer support groups, either on the ward, in the community or on a social media platform. Three MBUs (33%) spoke about plans to have ward-based groups specifically designed for fathers and babies, and/or information/education groups for partners. Two MBUs (20%) said they would like to offer individual and/or couple therapy on the ward or in the community. The staff identified as 'best placed' to deliver such interventions were nurses, clinical psychologists and occupational therapists.

Discussion

The current survey was the first of its kind to be conducted, with the aim to determine the nature of support being offered to male partners of patients in MBUs across the UK. The survey collected data on what support was being offered, who was providing it and how it was being delivered. The survey also collected data on staff's perception of the facilitators and barriers to offering support, and any future aspirations they had for support.

The ten participating MBUs delivered care to an inpatient population that was comparable on levels of complexity of presentation to previous surveys of MBUs (19, 20). The mean number of beds was comparable to previous survey data (21); however, average length of admission was shorter (20, 21). The findings suggest that MBUs offered mainly ward-based support to male partners, with the majority offering support that encapsulated a mixture of emotional, informational and practical support to partners, based on the needs of these fathers. Thus, the information offered by the MBUs that participated in the survey suggests that they are meeting the requirements of current guidelines and standards (1, 2, 18). The majority of support was offered on an individual or group basis, was accessible to all partners and was structured. The majority of support interventions were specifically designed for partners, but in some cases the support was open to all family/carers. The MBUs appeared to be guided by the needs of the male partner and his family when deciding on what type of intervention to offer fathers, and it is therefore perhaps unsurprising that the intervention offered differed between units. A previous study suggested that support should be considered on an individual basis in-keeping with the progression of the patient's illness and treatment (16). As previous research highlighted, men may have different needs depending on their prior experience of fatherhood and therefore it may be important for MBUs to continue to assess their needs and offer support accordingly (5). The participating MBUs also shared future aspirations for proving support groups, father-targeted groups and therapeutic interventions to male partners. Prior research has shown that men's' support groups can be a helpful resource which is viewed positively by partners of women with postnatal depression (22). However, further research needs to establish if the MBU setting is the best to offer this type of support. Staff who participated in the survey felt that supporting partners is important to the woman's recovery. However, it is also important to acknowledge that as the partner is not the patient of the MBU, there may be limits to what the service can provide. Furthermore, the provision of target support for male partners would depend on funding and commissioning of services, and the father being considered a 'patient' by the MBU.

In terms of clinical implications, the findings highlighted perceived barriers to providing support to male partners, originating from both the individual partner and wider service level. They also identified aspects of the

individual staff approach and wider service that facilitated and enabled them to support partners. Previous research has found that barriers for men include accessibility issues making it challenging to obtain available support (5), which is influenced by communication with staff, attachment style, personality and anxiety (15). In the current study, information on accessibility of support was not collected; however, factors making support more accessible, namely an informal approach, flexible working hours, and use of interpreters and religious leaders were reported to be facilitators by staff. Another important clinical implication is that the wards were guided by the individual needs of the male partners and this needs-led approach appeared to be the most useful (5)

There are some limitations that need to be acknowledged when considering these findings. Firstly, the response rate of 58% was less than the 89% achieved by a previous survey (20), which may impact the representativeness of the information presented. However, the geographical spread of the MBUs' locations was considered to be a good representation of MBUs nationally. Secondly, the distinction between psychosocial and psychological support and emotional/informational/practical support was made by the researchers at the stage of analysis, not identified by the units. Thirdly, the findings relied on self-report data shared by the MBU staff interviewed, and therefore it is possible that some information was missing or inaccurate. Lastly, information pertaining to engagement and retention of the support interventions was not collected as part of this survey, and it is therefore not possible to comment on the uptake of the support interventions offered.

In conclusion, this study captured the varied nature of support being offered to male partners of women admitted to MBUs in the UK. The findings identified good practice amongst MBUs and highlight opportunities for additional programs that can further improve the quality of support offered to male partners of women admitted to MBUs. The study therefore has clear clinical relevance and the findings can be used to enhance mental health outcomes for the women and their families.

There is currently little research on what type of intervention delivery is preferred by male partners in this setting and under these circumstances. Future research should therefore explore what psychosocial and/or psychological support men would find helpful whilst their partner and baby are admitted to an MBU, and how they wish for this to be delivered, as well as exploring men's perceptions of the barriers and facilitators to accessing this support.

Acknowledgements

We would like to express our sincere gratitude to all the MBU staff members who took the time to complete our survey.

Conflict of interest

The authors would like to declare that they do not have any financial interests or any conflicts of interest.

REFERENCES

1. National Institute for Health and Clinical Excellence (NICE). Antenatal and postnatal mental health: Clinical management and service guidelines. Clinical Guideline 192. London: NICE; 2014.

2. Scottish Intercollegiate Guidelines Network (SIGN). Management of perinatal mood disorders: A national clinical guideline. SIGN Publication no. 127. Edinburgh: Health Improvement Scotland; 2012.
3. Gillham, R. & Wittkowski, A, Outcomes for women admitted to a Mother and Baby Unit: A systematic review. International Journal of Women's Health, 2015. (7): p. 459-476.
4. Poinso, F., Gay, M. P., Glangeaud-Freudenthal, N. M. C., & Rufo, M, Care in a mother-baby psychiatric unit: Analysis of separation at discharge. Archives of Women's Mental Health, 2002. (5): p. 49-58.
5. Reid, H., Wieck, A., Matrunola, A., & Wittkowski, A. The experiences of fathers when their partners are admitted with their infants to a psychiatric mother and baby unit. Clinical Psychology and sychotherapy, 2017.(24): p. 919-931.
6. Ballard, C. G., Davis, R., Cullen, P. C., Mohan R. N., & Dean C, Prevalence of postnatal psychiatric morbidity in mothers and fathers. British Journal of Psychiatry, 1994. (164): p. 782-788
7. Dudley, M., Roy, K., Kelk, N., & Bernard, D, Psychological correlates of depression in fathers and mothers in the first postnatal year. Journal of Reproductive and Infant Psychology, 2001. 19(3): p. 187-202.
8. Paulson, J. F., & Bazemore, S. D, Prenatal and postpartum depression in fathers and its association with maternal depression. Journal of the American Medical Association, 2010. (303): p. 1961–1969.
9. Webster, A. The forgotten father: the effect on men when partners have PND. Community Practitioner 2002; 75: 390–393.
10. Matthey, S., Barnett, B., Ungerer, J., & Waters, B, Paternal and maternal depressed mood during the transition to parenthood. Journal of Affective Disorders, 2000. (60): p. 75–85.
11. Meighan, M., Davis, M. W., Thomas, S. P., & Droppleman, P. G, Living with postpartum depression: The father's experience. American Journal of Maternal Child Nursing, 1999. (24): p. 202–208.
12. Di Folco, S., & Zavattini, G. C,. Father–child attachment relationship: A review of the literature [La relazione d'attaccamento padre-bambino: Una rassegna della letteratura]. Giornale Italiano di Psicologia, 2014 (1): p. 159–190.
13. Mezulis, A. H., Hyde, J. S., & Clark, R, Father involvement moderates the effect of maternal depression during a child's infancy on child behavior problems in kindergarten. Journal of Family Psychology, 2004. (18): p. 575–588.
14. Goodman, J. H, Influences of maternal postpartum depression on fathers and on father–infant interaction. Infant Mental Health Journal, 2008. (29): p. 624–643.
15. Marrs, J., Cossar, J., & Wroblewska, A, Keeping the family together and bonding: A father's role in a perinatal mental health unit. Journal of Reproductive and Infant Psychology, 2014. 32(4): p. 340–354.
16. Boddy, R., Gordon, C., MacCallum, F., & McGuinness, M, Men's experiences od having a partner who requires Mother and Baby Unit admission for first episode postpartum psychosis. Journal of Advanced Nursing, 2017. 73 (2); p. 309-409.
17. Kowlessar, O., Fox, J. R., & Wittkowski, A, First-time fathers' experiences of parenting during the first year. Journal of Reproductive and Infant Psychology, 2015. 33(1): p. 4-14.
18. NHS England. Perinatal Involvement and Support for Partner/Significant Other. Mental Health Program of Care Scheme MH7; 2016.

Citation: Turner B, Garrett C and Wittkowski A. Male partners of women admitted to MBUs in the UK: A survey of available psychosocial and psychological interventions. Women's Health Research [2017; 1(1): 25-36].

19. Wittkowski, A., Harvey, J., & Weick, A, A survey of instruments used for the psychological assessment of patients admitted to mother and baby inpatient facilities. Archives of Women's Mental Health, 2007. (10): p. 237-240.
20. Wittkowski, A. & Santos, N, Psychological and psychosocial interventions promoting the mother-infant interaction on Mother and Baby Units in the United Kingdom. JSM Anxiety and Depression, 2017. 1(2): 1022-1026 (published 10 April 2017 as early online).
21. Elkin, A., Gilburt, H., Slade, M., Lloyd-Evans, B., Gregoire, A., Johnson, S., & Howard, L, A national survey of psychiatric mother and baby units in England. Psychiatric Services, 2009. 60(5): p. 629-633.
22. Davey, S. J., Dziurawiec, S., & O'Brien-Malone, A. Men's voices: postnatal depression from the perspective of male partners. Qualitative Health Research, 2006. 16(2): p. 206-220.

Citation: Turner B, Garrett C and Wittkowski A. Male partners of women admitted to MBUs in the UK: A survey of available psychosocial and psychological interventions. Women's Health Research [2017; 1(1): 25-36].