Mothers and babies: Kathryn Grant credits the inpatient Mother and Baby Unit at the Bethlem Royal Hospital in South London, England, for helping her recover from postpartum psychosis. Today, she and her son James are thriving.

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A Humane Approach To Caring For New Mothers In Psychiatric Crisis

In England, Mother and Baby Units allow for joint inpatient admissions—the standard of care for women requiring treatment.

BY APRIL DEMBOSKY

A few days after she gave birth to her son, Kathryn Grant lay in her hospital bed, staring straight ahead. The nurse urged her to breast-feed her baby, but Grant didn’t respond. Her husband arrived, then her sister, peering over the bed, cajoling her to speak, to move. Grant remained frozen.

“I was just scared stiff and couldn’t say anything,” Grant remembers. “I could hear what they were saying, I could see that they were there. But my brain was telling me, you must not answer these people, because if you do, your whole world is going to come crashing down.”

If you speak to this man and it turns out he’s not your husband, she remembers thinking, then the last ten years of your relationship will disappear. If you speak to this woman and she’s not your sister, then your entire life will dissolve into some “Matrix-style” virtual reality. “I was delusional,” she says, “and then I was hallucinating.”

Grant had spent multiple days in grueling labor, then had an invasive cesarean section, during which several sets of hands pushed and tugged her from various directions. Her belly was swollen like a balloon. Grant heard the nurses whispering that she was about to explode. She saw them gowning up to protect themselves from the impending abdominal shrapnel. It was best, she figured, not to say or do anything.

The next thing Grant remembers was waking up in a different room, alone and anxious. It was several more days before a doctor diagnosed her with postpartum psychosis and recommended that she and her son be admitted to a special Mother and Baby Unit for psychiatric care.

They were taken to a red brick building with thirteen small patient rooms lining one hallway and a nursery and playroom stocked with rattles and hanging toys at the back. When Grant arrived, she remembers the night nurse on duty gently taking her son, James. “My brain basically went, ‘Right, he’s safe now. You can do what you like,’” she remembers. “And I was floridly psychotic for several weeks from that point.”

All of this happened in England. And the care Grant received from that point on looked nothing like what most women would ever get in the United States, where there are no Mother and Baby Units. Most American women facing similar crises spend a week, maybe two, on a general psych unit, separated from their babies. Grant and her son stayed on the inpatient Mother and Baby Unit at the Bethlem Royal Hospital in South London for three months. “The average length-of-stay is eight weeks,” says Trudi...
Seneviratne, perinatal psychiatrist and clinical director of the unit. “That sounds like quite a long time, but when people are very, very sick, it takes that long to develop a good treatment plan and to prepare for returning to the community.”

For Grant, the first month was focused on treating her psychotic symptoms. The second month was focused on the massive depression that followed and the “tidal wave of guilt and shame” Grant felt when she regained her grip on reality. The third month was about building her confidence as a mother and getting her ready to return home.

“I felt like I had ruined everything,” she says. “I ruined my husband’s life, I ruined my son’s life before it’s even really begun.”

Grant took antidepressants and did therapy to work through these feelings, but she says the most impactful healing came from the work she did learning to bond with her son. With help from child development psychologists and infant nurses, she learned to read his cues and do the things that seemed natural for other parents but for her were not.

“I would talk to him when I changed his nappy, as opposed to just get really anxious or stressed out,” she says. “I would feed him, but rather than just burp him and put him down, I would burp him and then cuddle him or talk to him, look him in the eye and make funny faces at him.”

Knowing the staff was nearby and always ensuring he was safe, Grant was able to relax and just hang out with her baby. It allowed her to build a relationship with him.

“It’s no good treating just the depression or psychosis,” Seneviratne says. “You have to help that relationship.”

Grant can’t imagine how things might have gone if she’d been placed in a general psychiatric ward, separated from her son. Even in the first few weeks in the hospital, when she was barely capable of holding him, she was glad they were together.

“Despite being so hands off at the start, I was there. And I could watch the nurses do what they were doing,” she says. “I was still encouraged to always know what happened that day or how many ounces in his bottle he was getting.”

Grant learned that there was never one person who took over James’s care. Nurses worked in rotation, so none of them got too attached. If her son had been sent home to be cared for by Grant’s mother or mother-in-law, then, she feared, he would be their baby. At the Mother and Baby Unit, her bond with her son was the most important thing.

“The baby was my baby still,” Grant says.

Immense Obstacles
Mother and Baby Units are considered the gold standard of inpatient psychiatric care for new mothers in England and several other countries. Doctors there view the separation of babies from their mothers as not just inhumane but also bad medicine that makes the mother’s recovery longer and more difficult. Of 1,081 women admitted to Mother and Baby Units in the UK in 2003, 78 percent were symptom free or significantly improved upon discharge. The vast majority of women surveyed about their experience report high satisfaction overall, with near-unanimous preference for Mother and Baby Units versus general psychiatric wards.

In the UK, there are twenty-two Mother and Baby Units. In France, there are seventeen. There are seven in Australia, two in Belgium, and one in India.

In the US, there are zero.

Maternal mortality in the US is twice that of other high-income countries, with mental health problems among the leading causes of maternal death. Suicide accounts for up to 20 percent of deaths among new moms, and the prevalence of suicidal thoughts and attempts among perinatal women in the US tripled between 2006 and 2017. Psychiatrists and policy makers are embarrassed by these statistics and are calling for a reexamination of how new moms with mental health conditions are treated in the US. They’re looking to other countries for ideas.

“Now is a good time to revisit mother-baby joint admission programs,” says Katherine Wisner, professor of psychiatry and obstetrics and gynecology at Northwestern University, in Evanston, Illinois.

In the 1990s Wisner visited two Mother and Baby Units in the UK, and she and colleagues attempted to open their own unit at a hospital in Pittsburgh, Pennsylvania. Wisner wanted to address the constant clinical dilemmas she confronted from not having a place where she could admit an ill mother with her baby. Many women she treated refused admission to inpatient psychiatric care altogether because they didn’t want to give up breastfeeding. For others, the idea of separation only added to their feelings of guilt and anxiety. For some mothers who were suicidal, the need to care for the baby was “the only motivation to live.”

For the women who did agree to inpatient care on a general psychiatric unit, they complained that the group therapy was not helpful or relevant to their new role as a mother. Women coming home, days or weeks later, to care for a newborn they did not “know” often relapsed as a result, only to be readmitted to the hospital. Several men who were left to care full time for the baby at home lost their jobs.

But the obstacles to opening a Mother and Baby Unit were immense. Wisner explains that there were concerns around infectious disease or risk for injury to the infants, both of which had been documented in England in the 1980s—31 percent of babies at one Mother and Baby Unit contracted upper respiratory infections or gastroenteritis, and 9 percent were involved in assaults, where a disturbed mother shook or slapped the baby or threw the baby onto the bed. Only one baby was injured.

Wisner’s team believed that they could minimize these risks and were able to get preliminary buy-in from the hospital. They even had a floor plan drawn up. But they couldn’t convince the insurance companies to pay for it.

“This was just with the emergence of managed care, and in the negotiations with the insurers, they finally said, ‘We’re not paying anything for the infants,’” Wisner says. “So, the plug was pulled on it because the hospital didn’t want to lose money.”

‘That Time Was Taken From Me’
When Kristina Dulaney first heard about Mother and Baby Units in England and France, she thought, “That’s amazing,” and then, “I’m jealous.”
Five months after giving birth to her second daughter in North Carolina, Dulaney began developing symptoms of postpartum psychosis. At first, she felt like she was on cloud nine. She felt untouchable. And because she felt so good, it was hard to see that something was not right.

Then one morning, she woke up and quit her job. She called people she normally would never call and left them voicemail messages. She texted the women in her prayer group to check on the pastor, and when she started having thoughts that something bad was going to happen to him, she showed up at the church unannounced.

“It was like the sins of the world were on my shoulders and I had to do something about it,” Dulaney recalls. “A lot of people that go through this think they’re Jesus or God.”

At home that night, she turned white as a ghost, passed out, and was rushed to the local emergency department, in Greensboro. She was diagnosed with postpartum psychosis and admitted to a general psychiatric unit, sharing the same living space and group therapy circles as men and people with substance use disorders. Dulaney didn’t say much during her stay.

“Why would someone want to share anything about being a mom when there’s an older man in the room?” she remembers. “There was no one else there to relate to. There was no one else there going through what I was going through.”

In the two weeks she was on the inpatient unit, not once did Dulaney see her children. She had only photos of them that she gripped in her hands, carrying them everywhere, showing everyone. “That time was taken from me,” she says. When she was discharged, there was no plan and no preparation for going home. She had barely adjusted to the antipsychotic medication she was put on. “I was still outside reality,” she remembers of that time. Looking back now, she can’t understand how she was expected to look after her children when she could barely take care of herself.

“I couldn’t be with my kids by myself. I couldn’t go to work. I couldn’t drive. I couldn’t cook,” she says. Her husband was told to hide all the knives from the kitchen.

Psychiatrists and policy makers are embarrassed by these statistics and are calling for a reexamination of how new moms with mental health conditions are treated in the US.

“I think I was discharged too early,” Dulaney says, “but I don’t think I would have gotten any better at the place I was at.”

‘Gradual And Deliberate’

In contrast to Dulaney’s haphazard hospital exit, Grant’s discharge process was gradual and deliberate, taking shape over the course of the last six weeks of her three-month stay at the Mother and Baby Unit. Her doctor was explicit that Grant’s first time home would be for a short visit. She and the baby would get a ride there, stay for an hour or so in the afternoon, then come straight back. If that went well, then they could try an overnight. If that went well, then they could try staying a few days. All the while, her bed was waiting for her at the Mother and Baby Unit, she was told.

For Grant, the timing of her first visit home happened to fall on Christmas. At first, she didn’t think she was ready, but when she woke up on Christmas morning, she wanted to be in her house. The staff told her, “You can do this.” Her husband picked her and James up, and they had a lovely day, just the three of them.

“It was funny, we never really got around to Christmas presents because we spent the day opening all the new baby gifts that had just been lying in a pile,” she says.

After that, Grant had to work up to having James sleep overnight in her room at the Mother and Baby Unit. One of the key features of the unit is a staffed nursery where babies can sleep, so moms can get uninterrupted sleep when they’re recovering from acute illness or taking medications that make it difficult for them to wake up in the middle of the night. After Grant and her son slept in the same room uneventfully, she was then encouraged to go home for an overnight.

For women who live in public housing, the nurses or occupational therapy staff may be more involved with transitioning home. A nurse may accompany a woman on her first visit home to see who else is living there and to make sure it’s safe, says Jenny Shaieb, occupational therapist at Bethlem’s Mother and Baby Unit, or someone might visit soon after a woman is admitted if there are concerns about the physical condition of the home that could take time to fix.

“We might go because someone’s saying it’s overcrowded and they want to put in for different housing,” Shaieb says. “Sometimes we get people who are saying the house is hideously damp and not fit for purpose. So we’ll do a report and send that to the housing department.”

Once the mom and her baby are home, the care continues. For nine months after Grant was discharged, until James was a year old, a nurse visited them at home once or twice a week. These “health visitors” are a feature of routine care in England—they visit women who’ve had typical birth experiences as well.

“Normally they’re very overstretched, and they have a lot of women to get around to,” Grant says. “My health visitor, Jane, was different. She had a low caseload. She would come to the house whenever I wanted her, as much as we needed. She was a slightly older lady, really reassuring, had all the answers, all the tricks about baby care. She became this lovely granny-like figure.”

‘A Convenient Laboratory’

The practice of admitting babies into the hospital with their mothers took root in England after the Second World War. Psychiatrists began observing the negative emotional and cognitive impacts of separating children from their mothers in the wake of the Blitz, when children were evacuated from London and other urban regions to escape relentless bombing by the Germans. These lessons were first translated to hospital care in pediatrics. Doctors observed that sick or injured children recovered more quickly and with less emotional damage when their mothers were allowed to stay with them.
Psychiatrist Thomas Main is credited as the first to apply this same thinking when the mother was the one who needed to be hospitalized. He began admitting children with their mothers in 1948, in part because he believed separating mother and child was a danger to the “mother’s confidence and future capacity as a mother,”12 but also because there was no one else to look after the children.

“Just as it seemed important to keep a man patient in touch with his job, and to treat him for the difficulties he might meet there, so it seemed important that a mother should be kept in touch with her job, and the children who were part of it,” Main wrote.12

The practice grew in the next few decades, with Mother and Baby Units popping up across England in the 1960s and 1970s, driven primarily by a sense of humanity.

“I was never a particularly sentimental doctor, but I remember thinking that that was a desperate cruelty, to separate, at that stage, a mother and her infant,” says Margaret Oates, retired perinatal psychiatrist at Nottingham University Medical School, who opened a Mother and Baby Unit in Nottingham in the 1970s.

But the movement wasn’t completely altruistic.

“A lot of people, a lot of famous researchers, were intrigued by the postpartum period as a kind of research paradigm,” Oates says, and Mother and Baby Units were a convenient laboratory for observing mentally ill mothers and their babies. “They were fascinated by its research possibilities.”

As a result, the survival of the Mother and Baby Units during this time often relied on the passion and commitment of the academic who started it. If that person moved on or retired, the unit might close down. “What none of those people was very interested in at that time was providing a service that was equitable and accessible to everybody in the United Kingdom,” Oates says.

That changed in 2016, when the National Health Service recognized Mother and Baby Units as a critical piece of perinatal care and determined that the national government should fund them directly, sparing them from the “vagaries” and “variability” of competing for local funding. The government dedicated nearly £75 million to developing more Mother and Baby Units during the following five years, so that more women could access them closer to home.13 Four new units have since opened in the UK, Oates says.

There is evidence of a few US doctors experimenting with joint admissions in the 1960s, but after the 1970s any mentions in research literature dried up. By the 1980s doctors like Wisner were struggling to get recognition that postpartum depression even existed. When she was a resident in the mid-1980s, she remembers telling her attending physician that one of her pregnant patients appeared depressed. “She can’t be depressed,” he told her, “because pregnant women are fulfilled.”

A decade later came her attempt to open a Mother and Baby Unit in Pittsburgh that was halted by insurance companies’ lack of interest. About a decade and a half after that, though, in 2011, Wisner attended the grand opening of the Perinatal Psychiatry Inpatient Unit at the University of North Carolina at Chapel Hill.

The new unit, although the first of its kind in the US, was decidedly not a Mother and Baby Unit. Babies were allowed and encouraged to visit their mothers on the ward as much as possible, which was itself revolutionary in inpatient psychiatric care, but they were not admitted to the hospital, and they were not allowed to stay overnight.

This limitation attracted some early critics from unlikely corners. “There was weird resistance from people who were major proponents in the field, saying you can’t open it if you can’t do it exactly like the European mother baby unit.” I just thought that was absurd,” says Samantha Meltzer-Brody, chair of the psychiatry department at the university, who helped launch the inpatient unit.

“If we’re waiting around for the United States to have a mother baby unit that is like what they have in the UK, that will never happen in my lifetime,” she continues. “I mean, never say never, but it’s certainly not looking promising. So we’re going to have to figure out what works for us, given the US health care system.”

The University of North Carolina team modeled their unit after Mother and Baby Units in the UK and France primarily by emulating the programming and services tailored to perinatal women. They have mother-infant attachment therapy, focused on reading and responding to the baby’s cues; family therapy, focused on helping partners understand how to support a mom with mental health struggles; and occupational therapy, focused on managing time and stress as a new mom, setting routines and rituals that allow time for the mom to take a shower and get some exercise while caring for the child. There’s also biofeedback therapy, nutritional therapy, spiritual support, and lactation consulting.14

The team kept start-up costs to a minimum by renovating existing hospital space—shifting beds from the geriatric psych unit to the new perinatal unit—instead of building new structures.

The perinatal unit has beds for five patients, each with its own glider, bassinet, and hospital-grade breast pump. Most women spend much of their day in the family room, which has a couch, tables for activities, and a television.

In the first year the unit was opened, women experienced clinically and statistically significant declines in depression and anxiety scores, and more than 90 percent of women said that they were always or mostly satisfied with the services.15

But even this approximation of a Mother and Baby Unit has been difficult to replicate. Only a handful of other hospitals have opened their own perinatal or women-only psych units in the US.

“It never spread because, frankly, it’s not a priority,” Meltzer-Brody says.

Insurance reimbursement is still a battle. Even taking the cost of baby admission off the table, doctors at the University of North Carolina often feel like they’re racing the clock to get women better. As soon as a patient comes off suicide watch, doctors say, insurers start calling, asking when she can go home.16

In 2016 the National Health Service recognized Mother and Baby Units as a critical piece of perinatal care.
The average stay is seven days.

In general, Meltzer-Brody and Wisner say that there’s a lack of urgency to confront the problems of motherhood in the US, not just in the health care system, but culturally. Even in the US feminist movement in the 1960s and 1970s, “the motherhood issue was really just stuffed in the closet,” Meltzer-Brody recalls. “It was like, ‘Put on your power suit and don’t ever talk about the fact that you have children at all.’”

The US ranks at the bottom of the list of developed nations in child care subsidies and maternity leave benefits; it is the only country that does not guarantee any paid parental leave.7 Doctors see this as a contributing factor to postpartum depression and a complicating factor in delivering care, because there’s just not enough time to treat new moms.

“I have some women who give birth and go back to work in a week because there’s no other way to get money to pay for diapers,” Wisner says. “There’s a lot of work to be done in America.”

‘A Sticking Point’
One of the major impediments to the Mother and Baby Unit movement is the lack of research on their cost-effectiveness. This was the sticking point for insurers back when Wisner tried opening one in the US. In the UK it’s been difficult to raise the amount of money needed to do a systematic study of this kind, but researchers are working on one right now, testing their hypothesis that the units are cost-effective compared with general wards and intensive home treatment. They believe that women admitted to Mother and Baby Units will have lower rates of readmission and fewer unmet health and social needs and that their babies will be more cooperative and less passive.18

Americans should not be satisfied with the status quo of warehousing new moms on the same psychiatric wards as men, with no targeted perinatal services, forbidding them from seeing their babies.

“A lot of people are very gung-ho about these units, it’s almost compulsory,” says Ian Brockington, retired chair of the psychiatry department at the University of Birmingham, in England, who ran the affiliated Mother and Baby Unit for ten years. “Personally, I think it’s a little overstressed.”

The units themselves are expensive to run, mainly because of the staffing. The one Brockington ran had nine beds and required thirty nurses to ensure the safety of the babies.

Day programs or partial hospitalization programs, where women spend most of the day with their baby in treatment, but not overnight, are seen as a less expensive alternative. Capital costs of a day program are half those of an inpatient program, Brockington says, and there’s less disruption to family life if a mother is able to go home to her partner and other children at night.

Wisner has also come to see the value in day programs in the US. Except for the women with the most severe psychiatric ailments, a day program might work just as well, if not better, she says, primarily because women can be with their babies and because insurers are more willing to pay for intensive outpatient treatment, although such programs’ availability is still limited compared with the need.

Still, there are times when women need inpatient care, says London’s Seneviratne, especially if they are severely suicidal or psychotic.

“A day program isn’t going to help them, because what will they do when they go home?” she says. “You can’t leave the partner in charge of a floridly psychotic woman. That’s just not fair.”

Wisner and Meltzer-Brody agree that those women deserve better than what is typically on offer in the US. They are not prepared to abandon the fight for improved inpatient care, even if a network of Mother and Baby Units is unlikely.

Neither is Kristina Dulaney. When she developed postpartum psychosis, she lived within driving distance of the University of North Carolina’s perinatal psychiatric unit, but it was full at the time. She says there need to be more, better options for perinatal women. Americans should not be satisfied with the status quo of warehousing new moms on the same wards as men, with no targeted perinatal services, forbidding them from seeing their babies.

“It’s atrocious,” she says. “For one of the so-called richest nations in the world, and that’s the best we can do?”

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