admitted to MBUs are willing to be readmitted when struggling with mental health, whereas those separated from their baby for non-specialist treatment will not return willingly.

Many hidden costs associated with GPW admission have been included, up to 1 month post discharge – services that are integral to MBUs but whose costs are born elsewhere during GPW admission. Costs may occur later; the quality of these services cannot be compared. The personal stories of mothers admitted to GPWs demonstrate later hidden costs: counselling following the trauma of GPW admission; legal aid to regain custody of children; and financial hardship when fathers, co-parents or other family become the baby's primary caregiver.

Women in this study were more satisfied with MBU versus GPW or home treatment. This is consistent with a 2010 APP survey showing that mothers felt safer, more satisfied, informed, confident in staff, supported with recovery and confident with their baby. In addition, there is evidence of fewer suicides to women admitted to MBUs versus GPWs.[1]

GPWs are inexperienced in providing postnatal care, causing shame and indignity for mothers. They lack facilities and safe spaces for babies and siblings to visit. During a several-month-long admission, the impact on family life can be catastrophic. MBUs provide holistic care, supporting attachment, feeding and parenting skills. Mothers treated alongside other mothers benefit from informal peer support.

The costs and outcomes of perinatal psychiatric care are broader than clinical recovery and include outcomes for the infant, partner, family dynamics, and the long term psychological well-being of the woman and her legal and human rights. The early months of motherhood are precious. Women have a right to adequate maternity care that should be acknowledged and supported by mental health services.

This is a long overdue but challenging attempt to understand the value of MBUs – an area of international importance. Powerful stories, case series and qualitative work show their importance.[2–4] MBUs contribute to system and societal change: building capacity, changing attitudes, and increasing knowledge and skills. The UK leads the world in their development – and should continue to do so with further investment, to ensure all women can access lifesaving services.

Declaration of interest

J.H. is CEO of national charity APP, who campaign for women with severe mental illness to have access to specialist MBUs. A.B. is a health economist and Trustee of APP. G.B. is Chair of APP, and National Speciality Advisor in Perinatal Mental Health for NHS England.

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RE: Effectiveness and cost-effectiveness of psychiatric mother and baby units: quasi-experimental study

The cost-effectiveness of in-patient mother and baby units

I read with interest the report of Professor Howard and colleagues on the effectiveness of in-patient mother and baby units.[1,2] The authors should be congratulated for obtaining the funds for this investigation. In the 1990s, John Cox and I submitted a protocol (unfortunately not funded) comparing the Queen Elizabeth unit in Birmingham with the Hanley day hospital and two general psychiatric services in the West Midlands; we planned to interview the mothers (when ill) to establish diagnosis and severity, in order to match the samples as far as possible.

The investigation published in May this year has shown that mother and baby units, costing £707/day, were no more effective than generic in-patient care, costing £385/day. Efficacy was measured by the readmission rate (22% *v.* 32%) and mother–infant relationship one month after discharge. This result will reassure high-income nations that have not invested in these expensive units and will worry National Health Service planners who may be spending as much as £50 million/annum on the 19 units we have in Britain.

I had the good fortune to work on in-patient mother and baby units in Manchester, Birmingham and Christchurch (New Zealand) and consider that the focus on severe maternal disorders has helped to construct the knowledge base, which is the essence of mother–infant (perinatal) psychiatry. But I can readily accept that many disorders can be treated equally well, and with less disruption, in day hospitals, and even psychoses can be treated at home, with daily visiting.

This was a welcome preliminary investigation. I believe that some maternal disorders cannot safely be managed in any other setting; for example, severe bonding disorders require mother and infant to be treated together but are too dangerous for home or day-patient care. I hope Professor Howard's initiative will stimulate health planners in Australia, Britain, France and other nations investing in these units to conduct a detailed investigation, similar to the one we planned in the West Midlands, and determine which disorders require conjoint mother and infant hospital admission and which can be managed equally well in other settings, without such huge expense.

Declaration of interest

None

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