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FROM INFANCY TO MODERN DAY: THE HISTORY OF MOTHER-BABY UNITS (MBUS) IN THE UNITED KINGDOM

Natassia Chin¹, Mao Fong Lim²

- 1. Camden and Islington NHS Foundation Trust
- 2. Cambridgeshire and Peterborough NHS Foundation Trust

St Nicholas Hospita

1963

Newcastle upon



22 MBUs^{31,32}

ngland 22 units (151 beds)

Northern Scotland: No unit³⁴

xembourg,³⁵ Germany³⁶

No MBU in the Republic of Ireland

Wales 1 unit (6 beds)

cotland 2 units (12 beds)

INTRODUCTION

Mother and baby units (MBUs) are inpatient units where women with severe acute postpartum psychiatric problems can be cared for alongside their babies.

This is currently considered to be goldstandard care, recognising the importance of early childhood bonding and family-centred care. The United Kingdom (UK) has spearheaded the development of the MBU, however the history of MBUs in the UK has never been published.

AIM

To explore the history and conception of the MBU in the UK as well as outline scientific, social and political factors contributing to this.

To briefly compare this to the state of MBU provision worldwide.

METHOD

We carried out a narrative review of published scientific, historical primary and secondary sources and grey literature (eg Royal College Reports, Charity/third sector resources) using the search terms "mother baby unit", "MBU", "motherbaby psychiatric", "perinatal mental health", "perinatal psychiatry", "maternal mental health". We also hand-searched reference lists of pertinent papers.

TIMELINE

The Director o Hospital, Thomas joint admission Surrey. A patient preserving asks to be attachment and admitted with her revealing negative toddler son. This aspects of the is noted to be mother-child successful.³ relationship.

1948

Tyne. Small suite of rooms in the women's Channi Kumar, a pioneering figure nodified to become a in the field of in Derbyshire opens psychiatry in the MBU. Rates of UK, helps create discharge against the mother-baby medical advice massively drop, unit at the attributed to the fact Maudsley that mother and infant Hospital in 1981⁸ remain together⁶

A national audit of joint admissions identifies 12 MBUs throughout the UK but that the majority of these are in the south of England ¹⁰

1991

Brockington MBU (Stafford, England)¹² and St John's MBU (Livington, Scotland) are opened 11

2004

1996

occupancy¹⁴ **Bradgate Unit** Leicester closed 2014 due to lack of compliance with standards¹⁵

2009

Cardiff MBU

closed 2013 due

2013-2014

England, enabling an additional 30,000 women/year to be seen by 2020/21 through expansion of community services and MBUs¹⁷.

Five Year Forward

View (5YFV) 2016

to increase access to

specialist perinatal

2016

(Chorley, England)²² Nottingham MBU moves to Hopewood Centre²³

2018

2 new MBUs

(Dartford,

England)²¹

Rosewood MBU

2019

- greater proportion detained under

2021

- psychotic illness more prevalent²⁸

COVID-19

Pandemic

Service evaluation

of the Channi

MBU reports:

Only 1 MBU in North Carolina (baby only present in the

North Wales: Joint unit with England in discussion³

Some provision in France, Belgium, Netherlands,

Northern Ireland: Business case under development³

MBUs WORLDWIDE: A BRIEF GLANCE

WHERE ARE WE NOW?

Australia and NZ: Good provision, but nearly half are private — barrier to

ome provision in India, Sri Lanka^{39, 40}

REFERENCES



https://bit.ly/3wYSr29

Large-scale evacuation of children from London during the Blitz. This separation was later found to have harmful effects on children¹ 1945

1940s

That discovery leads to jointadmission of mothers and young children to paediatric

hospitals becoming standard practice²

Joint admission is made a condition of admission by the Cassel Hospital³

1955

Most women are noted to be admitted with severe neuroses rather than psychotic illness

The first full-time separate MBU is set up in **Banstead Hospital** in Sutton, England, for admission of women with schizophrenia or

psychosis.4

1958

1956

South Thames region has 12 hospitals (1-3 beds each) enabling joint admissions⁷

1981

1979

A survey⁹ of 201 England and Wales health authorities finds 38 districts report having dedicated facilities for mentally ill mothers and their babies. Thirty districts indicated that they planned to set up their own dedicated MBU 140 authorities considered

Scotland's first MBU and community perinatal MH team are established in Glasgow¹¹

this a resource priority

Elkin et. al release a seminal paper 13 defining MBUs as: - at least 4 beds and entirely separate

2006

from other wards - fully staffed 24/7 by MDT to care for both mother and child Using this definition, in a survey of **England they** identified 13 such

Welsh Government invested £1.5m into perinatal mental health care, divided between seven boards. Prior to this investment only two boards had perinatal

2015

mental health services and only one (Cardiff and Vale) met the perinatal quality network (PQN) standards¹⁶

Commitment made to open 4 new MBUs¹⁸ Maternal Mental Health: Womens' Voices survey by

RCOG published19 Maternal Mental Health Alliance (MMHA) maps MBUs and perinatal MH services - 17 MBUs (15 in England, 125 beds, 2 in Scotland 12 beds)²⁰

5YFV Next Steps 2017:

2017

Kingfisher MBU **Uned Gobaith** (Norwich, England) MBU (Swansea, Wales) opens²⁹ Jasmine Lodge (Exeter,

2020

Action on England) opens **Postpartum** The NHS Long Term **Psychosis** plan: aims by 2023/24 campaign for new for at least 66,000 to access specialist care²⁶ Scottish PMH Network recommendations on future specialist services including additional 2-4

MBU beds²⁷

DISCUSSION

The conception of the MBU has been an iterative process and a culmination of scientific evidence, particularly developments in both maternal and child mental health.

As demonstrated between 2016-2017, the development and expansion of MBUs (and specialist PMH services) however relies on the concerted efforts of clinicians providing care, scientific evidence and calls to action, campaign efforts from charities and the third sector, as well as political will to ringfence funding and thus enabling services.

LIMITATIONS

Gaps in literature (especially pertaining to social, cultural and economic driving factors) due to nature of search strategy and difficulty accessing material not easily available online. We have requested access to materials from the RCPsych archives to bridge these gaps.

However, some of these gaps may not be filled with secondary sources. As such, we have been in discussion with the RCPsych archives and the historian in residence, with possible plans to collect oral history from key players in this field.

Additionally, our search strategy does not cover papers in other languages which may result in literature pertaining to MBUs worldwide being missed.

Furthermore, understanding the driving factors behind the development of MBUs will also require a more rigorous and nuanced lens, looking beyond scientific papers and journals but broadening it to a multidisciplinary scope.

CONCLUSION

The story of the MBU is a work in progress, but one that can be emulated when it comes to the strategic planning of expanding cutting-edge, pioneering mental health services.

CONTACT INFORMATION

Corresponding author: Natassiarchin@gmail.com

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