of end-of life decisions, yet it is not obvious that this would suffice, and significant concerns remain where legislation for assisted dying has been passed. For example, in jurisdictions such as Belgium and The Netherlands, where assisted dying is already available and seemingly extensive safeguards are in place, there are ongoing complaints voiced by relatives of patients and advocacy groups that are submitted to governing bodies with the responsibility of legal and professional oversight. These complaints question the validity of the decisions made by physicians and procedures used to consult family and friends.

We disagree also with the point made that 'perhaps it is unnecessary to single out assisted dying as a novel problem for the specialty', given that putatively psychiatry already has a role in the management of such requests made by patients suffering from terminal illnesses. There is no global or even national agreement as to what psychiatric care should be made available to those receiving end-of-life care. Consenting to assisted dying solely on the basis of suffering from a physical illness ignores the important psychological impact of a terminal physical ailment such as cancer. Having in addition a mental illness not only adds to the suffering but invariably complicates the evaluation of quality of life, as it may impair the individual's reasoning. Further, the comorbid mental illness may not be optimally treated, especially if the suffering is considered to be inevitable. Thus, the development of a mental illness or its existence concurrently generates a whole new and separate set of implications where psychiatrists must be centre stage. New proposed legislation also suggests that capacity should be assessed more comprehensively, in particular if there are complications; in these instances, psychiatrists might be engaged precisely for such purposes, rather than for the overall assessment of optimal care for mental illness and the ability to weigh up decisions in the absence of suffering.

We are also somewhat puzzled by the challenge to our claim that 'patients may be coerced'. We state quite clearly that this is a possibility that is evidenced in the original drafts of the proposed legislation. Coercion may come from all quarters, including in particular family and those that may have a conflict of interest. Procedures set up to monitor assisted dying in The Netherlands and Belgium, for example, which focus largely on the role of physicians, have regularly found procedural irregularities, with doctors often not following the stipulated steps. The insinuation in some of these instances is that physicians have a conflict of interest and are perhaps overly keen to facilitate the assisted dying pathway. We haven't commented on this specifically but have simply raised the concern that families and friends may also succumb to questionable practices. Again, this seems possible and needs safeguards, especially in those that are vulnerable such as the disabled, elderly, poor, and chronically and/or mentally ill.[2] These concerns are borne out by research. For example, studies in 2010 in Oregon and Washington (states within the USA that permit physician-assisted dying) have shown that nearly a quarter of those ingesting lethal drugs did so because they no longer wanted to be a burden on their family.[3] Furthermore, insurance companies were reported to favour funding for assisted dying rather than more intensive treatment.[4]

Therefore, it is perhaps better to examine practices in jurisdictions where legislation and procedures are already in place and construct a pathway that allows for close monitoring and measurement of any provisions made for assisted death. However, trials of 'denying' end-of-life care are highly implausible both where the legislation for assisted death is already in place and, similarly, where the legislation does not permit end-of-life care – as is the situation in the UK at present. Suggesting that it is unjust to not pass legislation, by invoking the false premise that if assisted death is not permitted then care is being denied, does not advance a moral or logical argument.

In the UK, and where legislation is not in force, we assert that the necessary preconditions for legislation are not yet in place. Better-funded end-of-life care generally and standards of care that apply to people with severe mental illness may achieve much, if not all, of what legislation might achieve. In addition, we need further research and trials with appropriate monitoring of processes and procedures – all under the umbrella of close careful legal scrutiny. Thus, our emphasis is on a much more considered approach that allows for further investigation while maintaining choice and dignity for those involved.

Declaration of interest

G.S.M. is a deputy editor of *BJPsych*. K.B. is the editor-in-chief of *BJPsych*.

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

MBUs in the UK: value and cost

As academics, clinicians and leaders of UK charity Action on Postpartum Psychosis (APP), we campaign for mother and baby units (MBUs) for women with postpartum psychosis. We hear daily of their importance and the devastating consequences of units not existing.

The methodological limitations of this study are laid out by the authors and must be borne in mind when interpreting the findings. Owing to the small sample, the control group consisted of women who received treatment from general psychiatric units (GPW) and women receiving home treatment, which typically provides care for women with less severe illness. Therefore, as the authors explain, the inclusion of home treatment is likely to mask differences between MBU and GPW care. This is confirmed by the study's findings showing differences between the home treatment group and in-patients: women with severe and relapsing illness are underrepresented. When these groups are examined separately, readmissions are in the expected direction (22% MBUs, 32% GPW, 21% home treatment).

Twelve-month relapse rates are a problematic outcome measure for several reasons. In patients with postpartum psychosis and pregnancy-triggered bipolar, relapses are common and represent the expected illness course rather than indicating care quality. MBUs have a lower threshold for readmission than GPWs. Women

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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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