COMMENTARY

Gender-Specific Care for Women in Psychiatric Units

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Structural inequalities in health care often result in female patients′ not receiving care tailored to their needs. Women with mental illness in the peripartum period are no exception. Caan and colleagues delve into the benefits of breastfeeding in psychiatric units, highlighting the scarcity of appropriate resources due to the lack of mother-baby units in the United States. They also offer practical solutions and a legal analysis to address this problem. This commentary aims to broaden the scope of the article and emphasize how psychiatric care in the United States needs to address much more than lactation to provide gender-specific care. Elements of care to consider include types of treatment modalities offered, perinatal psychotropic choices, access to co-hospitalization options, lactation resources, and posthospitalization support. Pursuing a holistic and multi-disciplinary approach will allow psychiatric facilities in the United States to provide gender-appropriate care that will not only benefit women with mental health needs in the peripartum period, but also their infants and families as a whole.

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In their article, Caan and colleagues[1] have broached a poignant and thought-provoking topic: breastfeeding in psychiatric units. They highlight the scarcity of resources available in the United States to women with mental illness in the peripartum period, particularly due to the lack of mother–baby units that are available internationally. Additionally, the authors identify some possible legal consequences that hospitals may face as a result of this lack of services. For any forensic psychiatrist working with women, this topic is cause for profound reflection on the current state of psychiatric care.

Caan *et al.*[1] first discuss the unique psychiatric risks women face in the peripartum period. With increased probabilities for deteriorating mental health come higher risks for psychiatric hospitalization. Yet, as the authors demonstrate, many U.S. psychiatric units are not prepared to meet the needs of new mothers, particularly those who are lactating. Understanding the benefits of breastfeeding (and more importantly, that of mother–infant bonding) is essential to comprehend the significance of this topic, particularly for women who are experiencing acute symptoms of mental illness. The effect on families and their communities follows directly from this analysis.

The subsequent focus on current standards for peripartum inpatient psychiatric treatment highlights the differences between services available in the United States and in those countries that have adopted co-admission of mothers and infants in specialized units. The observation that the United States has been resistant to the adoption of these units[2,3] because of "staff anxiety, cost constraints, legal risk, pediatric concerns, and risk of injury to the infant" (Ref. 1, p 201) is a striking commentary on equity and access. By citing recent case law demonstrating a shift to considering breastfeeding as a condition related to pregnancy, Caan and colleagues[1] underscore the possible liability that hospitals may face for sex discrimination under the Affordable Care Act.[4]

Finally, the analysis presents practical solutions to the current unavailability of health care for peripartum women, particularly those requiring inpatient psychiatric hospitalization, who are interested in breastfeeding. Clearly, increasing the number of mother–baby units is preferable to the status quo. Because of the complex nature of the problem and the dearth of resources, Caan *et al.*[1] suggest that those who work in U.S. inpatient psychiatric settings

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should first educate themselves on the topic to improve access to breastfeeding in general psychiatric units. This step not only includes advocating for changes in hospital infrastructure (e.g., lactation rooms, policies, monitoring programs) but also incorporating general education in psychopharmacology to treat lactating women. They also suggest that regular risk assessments can address some of the safety concerns that have been raised in the implementation of these units.

Because of the complex nature of the legal question, the analysis offered by the authors requires a more in-depth review, which might be more suited for attorneys specializing in the intricacies of health care law. An even more pragmatic approach may be to rebut with hard data the traditional arguments hospitals have made against the implementation of gender-specific care: those of safety, costs, and infrastructure.

This kind of empirical and policy work is necessary to address the salient deficits associated with the services and resources available to the peripartum population experiencing mental illness. It is evident from the literature that psychiatric and correctional settings have typically disregarded the specific needs unique to women and instead deliver treatment in a model that is more suitable for men.[5,6] As described by Sidhu and Candilis, "In such cases, the values of the state, often based on the religious or world views of predominantly male representatives, outweigh contemporary principles of clinical practice like individualized treatment, patient-centered care, and trauma-informed practice" (Ref. 7, p 439). Thus, to treat women appropriately, a more purposeful patient-centered approach must consider women's specific needs, including those surrounding the peripartum period. With this scope in mind, several problems and solutions can be associated with women receiving care in mental health units.

The Context of Women's Institutional Care

A recent review of the literature by Archer *et al.*[6] highlights some basic differences in women's inpatient treatment needs: female patients reported having several inpatient treatment preferences such as being offered a broad range of treatment options, single-gender environments, good interpersonal relationships with staff, and treatment focused on distress, family, and relationships. Although women in acute care psychiatric units have been found to be aggressive at comparable rates to men, women may require a higher level of observation for self-harm.[6] For these reasons, female-only units are considered to require more resources, possibly explaining why they are also associated with higher levels of staff burnout.[6,8] Because of these identified differences, Archer and colleagues suggest that staff should be trained and monitored to provide gender-sensitive treatment.[6]

In addition, when considering the female forensic population, as explained by Friedman *et al.*,[5] women of reproductive age face similar challenges "in a correctional environment designed for men" (Ref. 5, p 365). Just as in long-term psychiatric hospitals, women in corrections face barriers to prenatal care, access to abortion, childbirth support, breastfeeding, and childcare. As a response to these needs, correctional settings have implemented programs allowing women to have access to specialized care, including mother–baby units. In fact, several U.S. programs allow infants to stay with their mothers in prison until 12 or 18 months of age.[5,9] Although the literature is sparse, evidence has shown that women who participate in correctional mother–baby programs show lower rates of recidivism and higher likelihood of living with their children after incarceration.[5,10,11] In addition, the annual cost of prison nurseries ($24,000) is comparable with the cost of supporting a child in foster care ($21,902).[5,11] Although these results are limited to correctional populations, similar outcomes can be extrapolated to forensic psychiatric populations.

Furthermore, when assessing specific treatment needs for peripartum women experiencing acute mental disorders, diagnostic considerations play an important role. A deeper look into the care provided internationally in mother–baby units shows that treatment needs can vary significantly by diagnosis. Although depression and some postpartum psychoses can be adequately managed in mother–baby units, they may not be suitable for women with more severe psychotic illnesses.[12] In an Australian study, for example, 80 percent of mothers were admitted to other facilities (inpatient psychiatric units or emergency departments) without their children because of the acuity of their mental illness.[12] But they were ultimately referred to co-admission units. Most of these women required involuntary admission. In addition, when looking at lactation status in this at-risk population, despite access to breastfeeding, 56 percent of women were breastfeeding on admission, while only 36 percent were breastfeeding at discharge. Because of the lack of

caregiver support at discharge, there was still a concern for child protection in 20 percent of cases. Although the sample size was small (n = 25), these data highlight specific factors that warrant further analysis. When severe mental illness is present, it is necessary to consider whether the priority is to treat symptoms or preserve the mother–infant dyad, or whether these goals must be seen as mutually exclusive.

Little emphasis has been placed on support of women after their children are born, when they are not able to provide appropriate care and mother-child separation occurs. Despite attempts to allow mothers to interact with their children in some psychiatric units, separation is often still the end result. A study examining 16 mother–baby units in France and Belgium[13] found that mother–infant separation was still a significant problem, even after treatment in specialized units. Of the 320 mother–baby dyads included in the study, 87, or 27.2 percent, were separated at the time of discharge. Potential predictive factors linked to early separations included sociodemographic factors such as lack of social support, mother's history of institutionalization during childhood, psychiatric decompensation during pregnancy, and neonatal hospitalization. In addition, the literature shows that women who have more stable support at home are more likely to be admitted to mother–baby units, leaving those without resources more vulnerable to separation.[13] A similar study in France[14] analyzed mother–infant separation at discharge from mother–baby units. Women with diagnoses of chronic psychosis were more likely to be separated from their children. Furthermore, of the women in whom schizophrenia was diagnosed, all who did not have support from their partners were separated from their children. Women with personality disorders also had a higher risk of separation, although family and social dynamics played a key role in the separation decision.[14] These data suggest a basic and unfortunate reality: although mental illness can present challenges in maternal-infant bonding and eventual separation, lack of social resources and support may play an even more significant role. In sum, when taking all these data into account, it is evident that gender-appropriate care must be comprehensive to address the needs of women, mother–infant dyads, and families as a whole.

Recommendations

Multiple factors must be considered to pursue a comprehensive patient-centered approach. Addressing the concerns of safety, costs, and infrastructure might overcome traditional resistance to the implementation of gender-specific services. As Caan *et al.*[1] suggest, international mother–baby units offer plausible models that can be emulated in the United States. Similarly, outpatient mother–baby clinics or day hospitals, some of which are already available in the United States,[15] might be a reasonable modality that allows greater access to treatment. These outpatient options might also decrease some of the safety and infrastructure concerns that have historically been a barrier to the creation of mother–baby units.

In correctional settings, the cost of mother–baby units is comparable with that of a child in foster care.[5,11] Further research into the cost-effectiveness of mother–baby psychiatric units might help resolve financial concerns. Similarly, additional research could explore both the social and financial costs of mother–infant separation. By providing more social resources to families, the unfortunate sequelae of separation can be minimized.

In conclusion, available evidence underscores the crucial need for gender-specific care, particularly affecting women requiring psychiatric care in the peripartum period. Their needs include the types of treatment modalities offered, perinatal psychiatric medication choices, access to co-hospitalization with infants, breastfeeding support, and post-hospitalization services. Only by looking at the systemic challenges that women in the peripartum period face will the American health care system be able to provide truly patient-centered care that will benefit a generation of mothers and their infants.

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