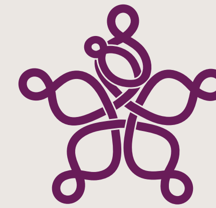

Maternal Mental Health Alliance

Maternal Mental Health Services

Progress Report

October 2024

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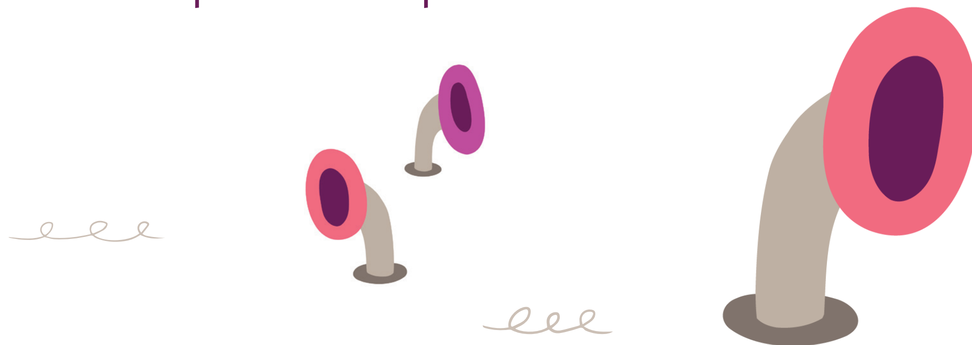
Suggested citation:

The MMHA (2024) Maternal Mental Health Services – Progress Report. maternalmentalhealthalliance.org/MMHS

Summary

The Maternal Mental Health Alliance (MMHA) worked with the British Psychological Society (BPS) faculty of Perinatal Psychology, to create this report which maps the progress of Maternal Mental Health Services (MMHS) across England. The aim is to provide a clear understanding of how these services are being delivered locally, highlight improvements, and identify gaps in care.

By gathering and analysing data of a snapshot in time, looking at service locations, staffing and accessibility the MMHA seeks to advocate for equitable access to treatment, support local commissioning and ensure that these essential services receive the resources needed to expand and improve.



Language

This report often uses the term 'women and mothers' but we recognise that perinatal mental health (PMH) issues affect women, gender diverse individuals and people whose gender identity is different to the sex they were assigned at birth.

It is vital that care systems take an inclusive approach to provide support to all birthing people for their mental health and wellbeing. We will continue to campaign for high-quality, compassionate PMH care for everyone who needs it.

Acknowledgements

Thank you to everyone who took the time out of their busy schedule to answer our questions or help us contact neighbouring services. This research wouldn't have been possible without your vital input. Thanks also to Dr Laura Francis, Dr Camilla Rosan and Dr Rachel Mycroft for their passion, support and expertise.

Disclaimer: In many areas, MMHS follow the boundaries of their local Integrated Care System (ICS). However, some MMHS cover multiple areas or are commissioned by one ICS to provide a service in another area. For this reason, the map shows the location of each team, rather than the boundaries of their catchment area. Details in the maps and levels of provision have been assessed using the best information available at the time of publication. Please contact info@maternalmentalhealthalliance.org if you want further information on the data.

Foreword from Dr Camilla Rosan, Consultant Perinatal Clinical Psychologist and Chair of the British Psychological Society's Faculty of Perinatal Psychology

The recent creation of Maternal Mental Health Services in every area of England is a world leading innovation, which makes me hugely proud to live in this country and be a perinatal psychologist.

These new services have started delivering life-changing care to women, birthing people and their families following the devastating experiences of perinatal loss (including loss of custody), birth trauma and fear of childbirth.

This mapping report highlights huge progress, but it also tells us that there is so much more to do. The findings are stark but they also reflect what perinatal psychologists and psychotherapists are telling us on the ground – there are still huge gaps in what Maternal Mental Health Services (MMHS) are able to offer in the way they are currently resourced.

To manage the high demand for these services alongside the modest resource they have been afforded, we know that services are being forced to get creative, restricting access to who they have capacity to see, which means that who is eligible becomes a very narrow and unrepresentative group. Staff are overworked and understandably burning out. And despite our best efforts– women and birthing people are still left waiting for months and months, still jumping through hoops and leaping over mountains to get to the evidence-based care they need and deserve. All the while their symptoms worsening. This is time they don't have – parents and babies simply can't wait.

The biggest gap of all highlighted by this report is that there are only 11 services in the country offering any kind of psychological support to women and birthing people who have had their baby removed at or soon after birth for safeguarding reasons. These are exactly the people we should be prioritising and supporting. The most recent MBRRACE data tells us that women and birthing people with social care involvement and facing severe and multiple disadvantages are those at an extremely high risk for suicide.

If properly funded, MMHS provide an incredible opportunity to break the intergenerational transmission of trauma and adversity – opening up a potential a new path that prioritises wellbeing.

I whole heartedly agree with the report's recommendations to expand MMHS to meet the full levels of need of families across the country. In the BPS Faculty of Perinatal Psychology, this mapping report has motivated us to start co-developing an important position statement that clearly describes and quantifies the mental health needs of women and birthing people following perinatal loss, birth trauma and fear of childbirth alongside clearly describing what fully resourced, inclusive, high quality services should look like.

I hope that together this report and the planned position statement will provide policy makers and commissioners with what they need to expand MMHS provision. I am excited to work collaboratively to support this happening, so that every woman and birthing person in every area of England can access fully resourced, inclusive and high-quality care.

Why Maternal Mental Health Services are needed

More than one in five women and birthing people will face a mental health challenge during pregnancy and after birth, known as the perinatal period.

Tragically, suicide is the leading cause of death for women between six weeks and one year after giving birth.

Additionally, some women encounter further obstacles. Women from racialised communities, young mothers, and those experiencing domestic abuse, poverty, or multiple disadvantages continue to suffer from poorer maternity and maternal mental health outcomes.

Among those affected by perinatal mental health issues, many experience complex conditions directly related to their maternity journey, such as birth trauma, baby loss (including loss of custody at birth), or severe fear of childbirth:

- An estimated **25,000 women a year** in the UK **experience Post Traumatic Stress Disorder (PTSD) after giving birth**.
- **Baby loss affects ~1 in 3 pregnancies.*** For many women, losing their baby will be the most traumatic event in their life, with **16%** still exhibiting PTSD symptoms 9 months later.
- **Women from Black and Asian ethnic backgrounds** are at greater risk than their white counterparts of having their pregnancies result in pre-term birth, stillbirth, or neonatal death. The latest data notes that **infant mortality rates** for Black babies are **more than double** those of white babies in England and Wales, leading to increased support needs for these Black mothers.
- The Confidential enquiry into maternal deaths (from MBRRACE) found that **women who have lost custody of their baby due to safeguarding concerns are a high-risk group for suicide**. All ten teenage mothers who died due to suicide during the 2019-21 reporting period had lost custody of their baby.
- Around **1 in 10 women are impacted by tokophobia**, a severe form of anxiety about pregnancy or giving birth. This can lead to women being afraid to go through with having a baby, or impact how they decide to give birth. Fear of childbirth during pregnancy is associated with **anxiety, depression, and stress**.

Despite the devastating human consequences and significant economic costs (estimated at £8.1 billion a year), women's mental health still does not receive anywhere near the same level of attention or investment as their physical health during and after pregnancy.

Even with this clear demonstration of need, many women have struggled to access support. Growing awareness in the wider policy landscape has added to collective understanding and highlighted the suffering that women and families experience when they cannot access the right care at the right time. It is crucial that we identify remaining gaps in care, unmet needs and inequities across the system.

* Not including the ~2,500 newborns who are removed due to care proceedings each year in the UK.

Background to Maternal Mental Health Services

Over the last 12 years, government commitment and focus from NHS England has led to welcome progress in the availability of specialist perinatal mental health (PMH) services and parent-infant relationship support for women experiencing the most severe and complex mental health problems during pregnancy and after birth.

In 2019, NHS England's Long Term Plan then recognised that there remained a gap between specialist PMH services and the care provided by maternity services and talking therapies.[i] A commitment was made to try and address this through the introduction of new Maternal Mental Health Services (MMHS).

What are Maternal Mental Health Services (MMHS)?

MMHS were commissioned to combine maternity, reproductive health and psychological therapy supporting women who have moderate to severe mental health conditions directly related to their pregnancy experience.

There are three pathways of care:

1. birth trauma
2. severe fear of childbirth (tokophobia)
3. perinatal loss (e.g. miscarriage, stillbirth, neonatal death, medical termination of pregnancy) and parent-infant separation at or soon after birth due to safeguarding

In addition to providing these pathways, MMHS are also intended to play a wider role, delivering training to healthcare professionals and helping to join up vital mental health care across and within the whole maternity system.

This new ambition and represents another significant step forward to ensure more new and expectant mothers and their families can access specialist change to mental health care.

i. Non-maternity focussed services aiming to support common/mild to moderate mental health conditions.

Policy context

2020-22

Dec 2020 and March 2022

The Ockenden Enquiries into maternity services noted the need for 'clear pathways for women and their families to access emotional support and specialist psychological support' after adverse experiences during pregnancy and birth.

May 2022

The Birthrights Race Inquiry documents how women and birthing people from many groups of society experience higher levels of discrimination, poorer maternity care and higher levels of baby loss and maternal complications. These are all known triggers for birth trauma.

2023

Oct 2022

The Reading the Signals report into maternity and neonatal services in East Kent noted the impact on the wellbeing and mental health of mothers and families who had received sub-standard and uncompassionate maternity care.

July 2023

The Pregnancy Loss Review (looking at babies lost before 24 weeks of pregnancy) recommended that psychological support for baby loss must be easily accessible for anyone who needs it and must focus on both parents. It also recommended that maternity staff should be trained on the links between baby loss, PTSD and suicide.

2024

May 2024

The Birth Trauma Inquiry noted that, left untreated, PTSD symptoms can affect women for many years... the inquiry recommended an expansion of access to psychological therapy for those experiencing trauma following childbirth.

Mapping the progress of MMHS

Understanding how delivery of this NHS England commitment is progressing at the local level has not been simple. The Effectiveness of Services for Mothers with Mental Illness (ESMI III) research programme has undertaken vital evaluation of both the rollout process and some aspects of the delivery of MMHS, with more areas to be covered in coming months. However, this does not include detailed information such as locations, staffing levels, pathways available and common challenges faced by teams.

Furthermore, a lack of information about how many patients from equity groups are accessing these services obscures the picture of where there may be remaining need, particularly for those women who often experience the poorest outcomes.

The MMHA worked with the BPS Faculty of Perinatal Psychology to create this report on the progress of MMHS provision. The aim is not to name and shame specific services, but to build a clearer picture, celebrate the improvements that have been made and understand any gaps or variation in care.

We have spoken to healthcare professionals, women and others in the system who tell us that this information is desperately needed to help campaign for equitable access to treatment, provide information to support local commissioning, and help services share learning and expertise as they develop.

> **"We've been pleased to see a growing awareness in the NHS of the profound psychological impact of traumatic birth. NHS England's introduction of MMHS was a hugely positive and welcome move because it meant that, for the first time, targeted support was available for these women."**
>
> Birth Trauma Association

We hope the maps and the report will be used locally and nationally to ensure these small but vital services are not only maintained, but also given additional resources to expand their life-saving care to more babies and families.

How data for this report was collected

The MMHA and BPS together agreed the data that would be needed, including:

- location of services
- care pathways provided by each MMHS*
- staffing levels, waiting times and equity data collected

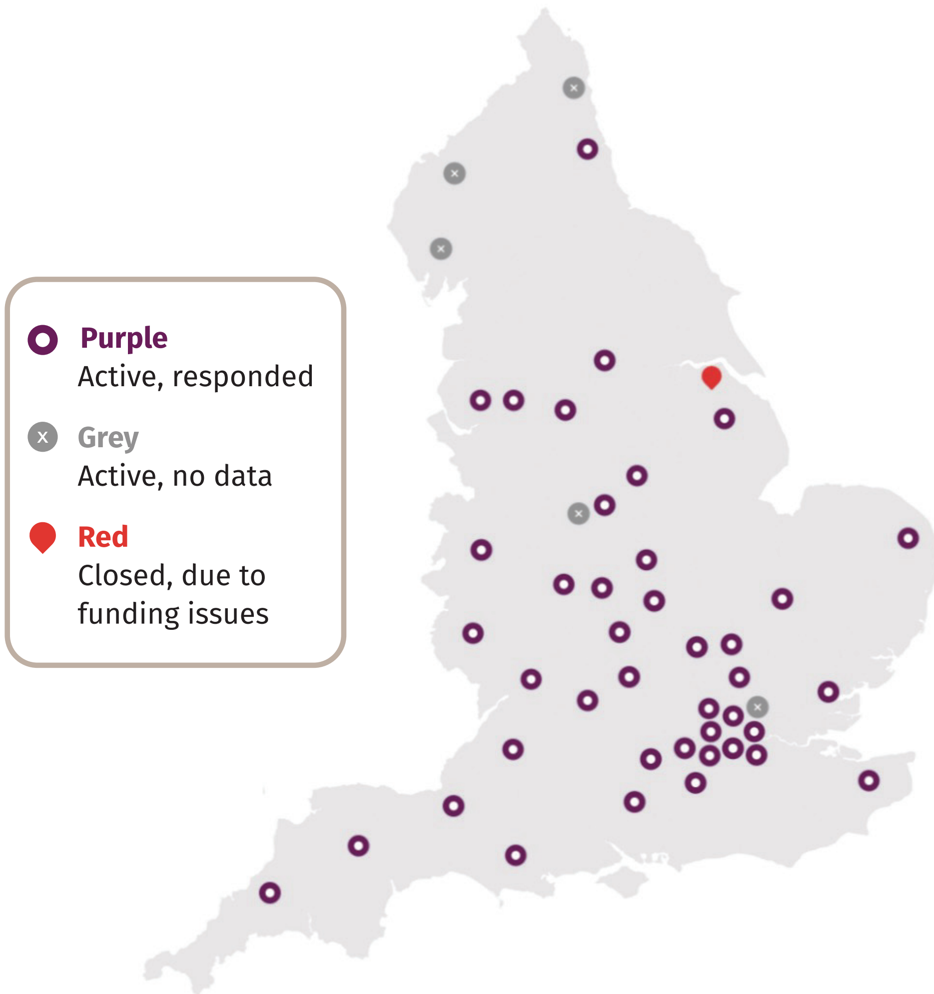
With this, we designed an online questionnaire. After a small pilot, the questionnaire was distributed to services during the first half of 2024.

We received data from **41 out of a possible 46 services**, plus confirmation that **1 service (Humber) had already closed due to funding cuts**. Not all services who sent data answered all the questions.

The data was then examined by the MMHA and some points clarified with respondents.

ii. Loss due to safeguarding concerns has been pulled out as a separate thread in this briefing, as many healthcare professionals talked about this group of women's needs being very different from those who had experienced other types of baby loss. In doing this, our aim is to better understand the support services are currently able to offer to both these groups of women.

Where are Maternal Mental Health Services (MMHS) in England and what support are they offering?



Try our interactive map at
maternalmentalhealthalliance.org/MMHS

100% **All 41** support women who have experienced **perinatal loss**

85% **35/41** support women who have experienced **birth trauma**

80% **33/41** support women with a severe **fear of childbirth (tokophobia)**

27% **11/41** support women who have **lost custody of their baby**

These are encouraging findings but we know what sits behind them is a huge variation in what support Maternal Mental Health Services are providing locally. Confusing referral pathways, inequitable referral criteria, non-evidence-based interventions and very long waiting lists.

Sustaining progress: areas for action

There is currently and rightly a large focus on improving perinatal mental health services at the national level, alongside commitment from local areas to deliver plans, which has enabled huge strides forward with the development of MMHS across England.

This has helped begin to address the undeniable gaps that exist in service provision. Committed teams are providing lifesaving and life-changing support to more women, babies and families. **However, the wide variation between services: what care is provided; what the criteria is to access care; and how long women must wait, suggests there are not enough resources to meet the true needs of the population.** At a time when demands on mental health services are so high, it is vital that this commitment remains, and progress is sustained.

The following areas for action are drawn from themes within the survey data. We hope they will continue to make the urgent case for the crucial role MMHS can play in supporting the needs of women, babies and families.

1. Consistent care across the country

Available pathways

MMHS were intended to be rolled out into every local care system. At the time of writing, we were able to identify 46 MMHS in England, however the data we collected shows clearly that not all services are offering care to ALL the women they were created to support.

Whilst teams need flexibility to design services to meet the needs of the local population, they also need adequate resources to deliver all the four main pathways of care that MMHS were intended to provide.

There is more to do across all the main pathways (baby loss, birth trauma and tokophobia). However, of particular concern is the startling gap in care for women experiencing loss through the involvement of social-care proceedings.

Our survey found that only 11 MMHS were supporting this group of women.

Whilst there are examples of good practice happening, it is not consistent. As MMHA member Birth Companions highlighted:

"We have seen firsthand the incredible work being done in one MMHS in East London with women who all too often fall through gaps in other services. The OCEAN Service is a key partner in our new Izzy Project, which has been designed specifically to support women at risk of separation, or separated, from their baby.

"Yet across the country MMHS provision for women in these circumstances remains patchy. Where services are being offered, they are severely underfunded and stretched far too thinly to meet the level and the intensity of demand." Birth Companions

The fact that only a minority of MMHS are currently providing care for this group leaves women in most areas in England without the vital support they need. MMHA's listening project, highlights the devastating impact that not being able to access the right support can have for this group of women.

Our findings echo those of the ESMI III research study, which recommends 'further guidance, training, and resource to understand this pathway and to ensure that women at risk of loss of custody do not continue to fall through the gaps in mental health service provision'.

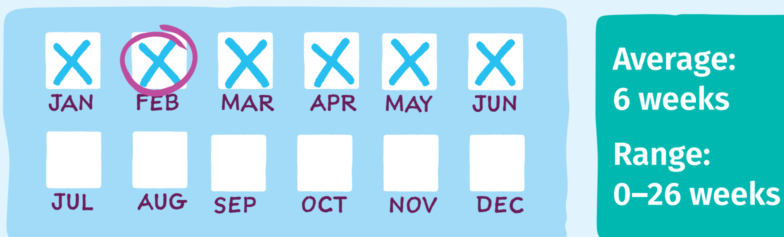
Alongside gaps in the pathways provided by MMHS, our data also highlights other significant differences between services, such as referral criteria and waiting times. These differences mean that women who would receive treatment in one location may not qualify for support in a different area.

Waiting times

NICE guidelines (1.7.3) note that women with mental health problems during the perinatal period should be 'assessed for treatment within 2 weeks of referral and receive psychological interventions within 1 month of assessment'. Yet our data showed a wide variety in how quickly teams are able to assess patients and how long women must wait to access therapy.

"Research from the Baby Loss Awareness Week Alliance into bereaved parents' experiences of psychological support shows that many parents are not adequately informed of mental health services. Referral pathways are inconsistent with assessment and eligibility criteria differing between areas, meaning that **people experiencing the same symptoms can receive different quality support depending on where they live."** Sands

Waiting times to be assessed



The average waiting time for women to receive **assessment following referral** to an MMHS was 6 weeks, although the actual waiting times ranged from 0 (seen immediately) to 6 months.

"Many women have told us that **help for their birth trauma isn't available locally, or that they are not eligible for help, either because they are too ill or not ill enough**. In other cases, they have a long wait for treatment. The impact of this can be devastating, leading women to feel even more isolated." Birth Trauma Association

Waiting times for one-to-one therapy

The average waiting time for **one-to-one therapy following assessment** was 16 weeks, although the actual wait times ranged from 0 (seen immediately) to 12 months.

Referral Criteria

Many healthcare professionals told us of discussions about managing waiting lists and of changes in referral criteria in response to challenges and fluctuations with waiting times and staffing levels.

"The service is very small, but we are catering for a large number of women with mental health difficulties following perinatal loss; service is much needed but waiting lists are long due to small resource. "We're not able to assess all referrals and unable to hit targets for assessing patients within 4 weeks. Unable to with limited resource within team. Waiting list continues to grow." Respondent

Without sufficient resources and clear guidance on what good care should look like, local MMHS teams have to make decisions about who they have capacity to provide care for. This risks creating further issues for women and families.

"If people find the courage to seek support and are then told that they're not eligible for NHS support, this further compounds their shame and sense that their experiences are not valid." Make Birth Better

What care women can access varies depending on where they live as MMHS have different eligibility criteria for supporting women

ANYTIME / PRE 30 / 32 WEEKS DURING PREGNANCY?

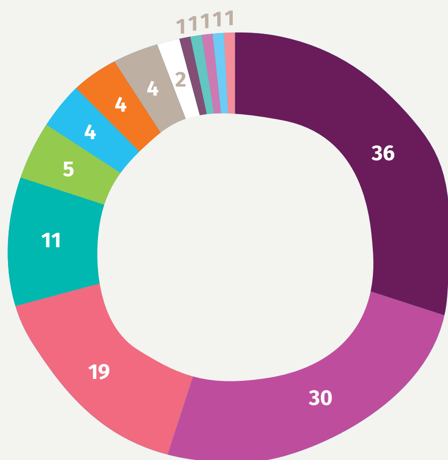
PTSD PRESENTATION?

NO MORE THAN 12 / 24 / 60 MONTHS SINCE LOSS / TRAUMA?

MULTIPLE LOSSES / TRAUMAS?

AT LEAST 4 / 6 / 8 / 12 WEEKS SINCE LOSS / TRAUMA?

Where are women signposted to if they don't meet MMHS criteria? (by percentage)



- NHS talking therapies/IAPT
- Voluntary sector
- Perinatal mental health team
- Community Mental Health team
- Peer support
- Specialist MH midwife
- Bereavement services
- Maternity
- Adjacent MMHS
- Social prescribing
- Drug & alcohol services
- Children's centre
- Health visitor
- GP

The range of other services that MMHS refer women to when they don't meet the criteria for treatment highlights not only the variation in referral criteria across different MMHS, but also the need for a whole system of care supporting the mental health of new and expectant mothers.

MMHS are not able to provide the specialist care they are designed to deliver if they don't have the required resources. In addition, gaps in one part of the system will create even more pressures on other services and could risk women falling into gaps between services.

The two most common alternatives women were signposted to were NHS Talking Therapies (commissioned to support people with more common maternal mental health problems) and the voluntary community sector.

Many voluntary community and social enterprise (VCSE) organisations are supporting women with increasingly complex problems who have been unable to access statutory care. For women who do not expect to have a positive experience of public services, it is often the VCSE who they trust and to whom they turn for support. The voluntary sector has a vital role to play, but they're not always integrated into statutory support and funding is often provided on a short-term, unsustainable basis.

> **"Third sector organisations are doing their absolute best to provide support to everyone affected by birth trauma, perinatal trauma and loss. Between us we offer community-led support which contributes towards helping people feel less alone. But in truth, the demand is greater than our collective capacity and most people need more than we can offer."**
>
> Make Birth Better

For women with more common PMH conditions, there is a real gap in care. **NHS Talking Therapies** are intended to provide support for this group of women, however many women fall through the gaps. A recent paper suggests the integration of these therapies directly into maternity services could deliver more cost-effective, accessible, non-stigmatised care for women with common maternal mental health problems. This would enable MMHS to focus on the specific needs of those women, babies and families they have been established to provide support to.

Support for the wider family

Part of the aim of MMHS has been to offer holistic care assessment including assessment and signposting for partners.

76%

offer some kind of support to dads/partners

While many services are providing some kind of support to dads/partners, most commonly (71%) this was only being signposted to other sources of support. 29% provided a basic assessment of needs and 17% provided the ability to join some sessions with the woman/birthing person.

Given that 1/10 dads will experience mental health problems after having a baby and that dads are more likely to struggle if their partner is experiencing mental ill health at this time, high quality and consistent support for partners is needed in every area.

34%

Only 1/3 were able to offer couples therapy, despite this being recommended by NHS England for all families accessing MMHS.

"Many bereaved parents struggle to access quality mental health care at a time when they need it most. Despite also being affected by baby loss, partners do not receive adequate support, which puts strain on the entire family unit".

Sands

2. MMHS having sufficient resources

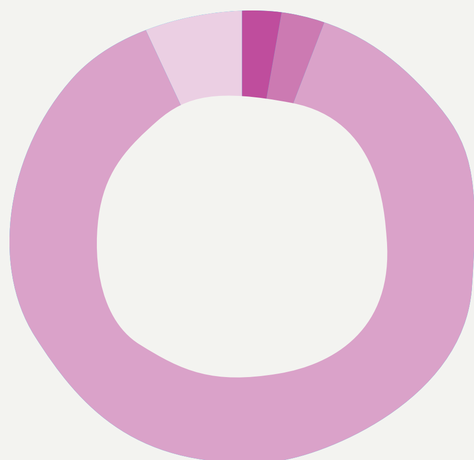
Funding

All areas of England have been allocated money to deliver NHS England's Long Term Plan ambitions, including establishing a MMHS. Most teams report they have funding assured for the current service level but no expansion funding.

This is despite the current funding being not even close to meeting full levels of need. Our survey found that Humber's MMHS service has already had to close due to a lack of local funding.

If the essential role of MMHS is not understood by those with the ability to commission and fund teams, there is a risk that more MMHS will close. We need to continue to highlight what gaps in care mean to the lives of women, babies and families, and ensure MMHS have the resources needed to not only sustain current provision, but to expand to meet the level of need that exists.

MMHS funding situation



- **3%** closed due to funding
- **2%** funding assured for current service level and some expansion
- **88%** funding assured for current level only
- **7%** funding not assured, plans beyond current budget year unknown

Staffing

Well resourced, trained and supported teams are the foundation for compassionate, high-quality PMH care. MMHS are small teams, and many told us of recruitment difficulties and challenges with managing roles where there are job-shares or staff also work in other services.

"We have grown exponentially in terms of referrals since the launch of our service without additional investment in staffing. We are able to prove the value of our service in Trust surveys, qualitative feedback direct from women and clinical outcome measures. However, there are no local plans for more psychology to be able to offer specialist maternity-focussed therapy to more women rather than signpost to generic NHS therapy services because we are discouraged from operating a waiting list." Respondent

Our data also highlighted variety in the make-up of teams. **67%** reported they did not have any dedicated admin support and only **50%** have a peer support worker. A lack of secure resourcing to confidently recruit and retain staff is a common theme between this report and MMHA's survey of specialist perinatal mental health teams. Staffing challenges place more pressure on existing team members and impact the care available.

A submission to the recent Birth Trauma Inquiry highlighted the challenges MMHS are facing. The submission from Oxfordshire spoke of a **lack of funding to recruit permanent staff, resulting in staff burnout. Women were having to wait six months for a psychologist appointment, and nine months for a debrief after experiencing a traumatic birth.**

The submission also reported challenges in integrating MMHS with maternity wards that do not see mental health as a primary concern.

3. Addressing health inequities

The maternity journey shines a focussed light on health inequities. There is clear, compelling evidence of the poorer health outcomes for people who experience discrimination, trauma, poverty and deprivation during pregnancy and after birth.

"Health inequities affect the same group of people over the years.... ethnic minorities, the poor, those with previous mental health history, those affected by trauma or addictions, those with different sexual orientation/choices." Maela, Lived experience champion

Decisive action is needed to change this. MMHS need to be resourced to put additional focus on meeting the needs of women from oppressed and marginalised communities, including ensuring the voices of women and birthing people help to shape the design of services.

In addition, it is important that we improve the collection of information about which population groups are accessing MMHS and where there are gaps. This is particularly true for those groups already identified as likely to experience greater discrimination.

NHS England has acknowledged that 'inclusion health groups are not consistently recorded in electronic health datasets... which means...services do not meet their needs.'

Our survey found this was an issue within MMHS where over a third of MMHS did not track whether their patients were part of NHS inclusion groups.

"Black mothers face unique challenges when it comes to maternal mental health. Evidence shows us that Black women experience higher rates of pregnancy complications than white women and Black women face unique challenges when it comes to maternal mental health, for instance they may face additional fears about giving birth due to higher maternal mortality rates in their community. Black mothers are disproportionately affected by loss of custody at birth, often due to systemic biases in healthcare and social services. It's crucial that Maternal Mental Health Services recognise and address these specific challenges to provide effective, culturally competent care." Sandra Igwe, The Motherhood Group

To improve equity in maternal mental health, better information about which population groups are accessing these vital services is needed. Our survey found variety in what data MMHS collected'.

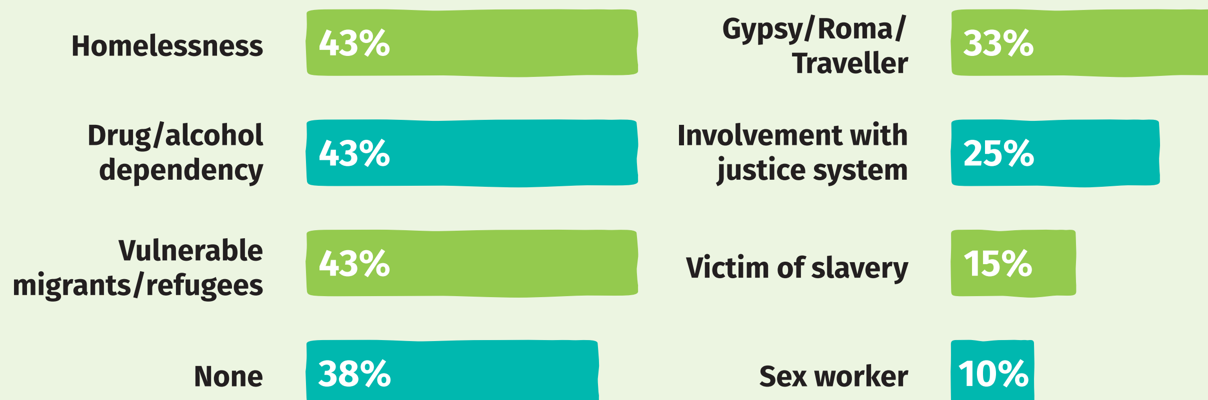
33%

of services weren't collecting information on the sexual orientation of their patients

59%

weren't collecting information on gender reassignment among their patients.

Services collecting data on patients who fall into NHS inclusion groups



4. Supporting the wider system

MMHS have an important role working with colleagues across maternity services and beyond to create psychologically informed systems, which work to prevent trauma in service users and staff wherever possible, as well as to treat it. They can also provide specialist training and increase understanding of maternal mental health and how a trauma informed approach supports women suffering from mental illness due to trauma or loss and can also prevent retraumatisation.

Experiences of trauma have a pervasive effect on a person's mental health, and this is exacerbated in the perinatal period. However, a lack of understanding of the crucial links between trauma and poor maternal mental health results in missed opportunities. MMHS delivering a trauma informed approach to care, is very welcome, but it is essential that they are given the resources and time to work with colleagues across the system, to educate, train and support a wider change across all areas of maternity care.

MMHS can support with ensuring that maternity pathways and protocols are psychologically informed (for example, guidance on how to respond to a request for a Caesarean section due to fear of childbirth). They can provide reflective and supportive spaces for maternity staff to manage the emotional impact of the work, reducing the likelihood of burnout and PTSD in the workforce.

Many MMHS are able to provide a level of training with maternity teams and other healthcare professionals and some teams shared examples of good practice.

Does your service provide training for other professionals?	
Yes – For maternity professionals	32
Yes – For other professionals	21
No	7

"The service provides group reflective psychological supervision sessions for identified groups of specialist midwives (PNMH Specialist Midwives, Birth Reflections Midwives and Bereavement Midwives) and there is dedicated time for this work."

Respondent

However, teams shared that one of the main barriers to providing training to other professionals was a lack of time. Only **34%** of teams have dedicated time for this work. Other barriers include pressures stemming from levels of demand for MMHS, as well as staffing issues.

"We are trying to provide training for midwives, but they have to attend in their own time, due to staffing issues on the maternity units. The hospitals cannot backfill their staff to attend training due to lack of funding."

Respondent

A lack of dedicated time for training is a challenge across the system. Our findings mirror wider research which has highlighted this issue. In 2023 for example, the Department of Health and Social Care's 'Pregnancy Loss Review' recommended 'mandatory training and education in the importance of sensitive communication to ensure that [staff] are fully equipped to care for patients compassionately.'

They stated, 'funding must be allocated to allow NHSE to increase the current investment in NHS staff training to ensure that time is protected for all staff to undertake mandatory annual training in bereavement care.'

Recommendations for change

MMHS have started delivering life-changing care to women, babies and families. To continue this success, sustain the progress being made and end the current postcode lottery, further action is required at both the national and local level.

Recommendation 1

Commitment to MMHS at national and local level

Ongoing targets for MMHS are needed as the current commitments have not yet delivered the mental health care women and birthing people and their families need.

Given it is not 'job done', continued focus from the government and NHS England is required, as well as clear expectations for all local areas of what the MMHS offer should be.

Recommendation 2

Expand MMHS to meet levels of need

Further resources are required so all MMHS can deliver care across all the required pathways, including equipping every MMHS to provide a pathway for women whose babies have been removed due to safeguarding concerns.

The current variability in care across different parts of the country, means existing levels of funding are not enough. A clear timeframe showing how teams will be supported to deliver care across all pathways is urgently needed.

Recommendation 3

Make MMHS inclusive for all

If we want to see changes in the current trends of negative outcomes for certain groups of women and birthing people, it's crucial that MMHS are resourced to reach out, become more culturally inclusive and adapt to the unique needs of their diverse local communities. The voices of those with lived experience must be included in service design.

Recommendation 4

Collect and publish more data to demonstrate progress and gaps

Improving the quality of the data being collected to identify inequalities in prevalence, experience and outcomes in maternal mental health could help ensure services meet the needs of ALL women and birthing people and their families.

The link between better data quality and improvements in care needs to be made clear to staff who face many pressures on their time.

Recommendation 5

Quality standards for MMHS

Our data shows variation between MMHS in referral criteria, assessment methods and psychological therapies offered. Quality standards exist for specialist perinatal mental health services where they have helped determine basic levels of care and raise standards.

Having such guidance for MMHS would ensure there are baselines so that all women, babies and families accessing these services receive compassionate and equitable treatment regardless of where they live.

Recommendation 6

Education and training across the system

For healthcare professionals to effectively support women in the perinatal period they need to be able to access education, including training on maternal mental health and trauma. MMHS can play an important role in delivering this training, if they are given allocated time to provide this.

In addition, all services working with women and birthing people during pregnancy and after birth must have knowledge of their local MMHS, so that women who need this specialist support can be appropriately referred and women, babies and families can access care as quickly as possible.

What care is available in the devolved nations?

This report focuses on England as it is only here that MMHS have been formally established. In the other nations of the UK, there are varying pathways for women experiencing birth trauma, loss, removal or tokophobia meaning some women can access support, but it is not consistent or complete care.

Further work would be required to better understand to what extent the provision of care in the devolved nations is meeting the needs of all women and birthing people and their families. However, given the variation in services across England, the creation of standards articulating best practice could be useful to help ensure that women receive high quality maternal mental health care wherever they live.

In Northern Ireland...

The clinical pathway specifically mentions PTSD as a potential postnatal illness but does not detail any particular treatment route for mothers experiencing birth trauma, baby loss or tokophobia. It notes that all mild to moderate mental health conditions should be supported through services such as GPs, midwives and health visitors as well as primary care talking therapies. Those experiencing moderate to severe mental health conditions in the perinatal period should be referred either to specialist perinatal mental health or community mental health teams.

In Scotland...

The clinical pathway for women experiencing 'emotional difficulties related to complications during pregnancy, birth and neonatal inpatient care' offers treatment from specific Maternity and Neonatal Psychological Intervention (MPNI) services. A 2022 update noted that these teams were operational in 10 of Scotland's 14 Health Boards, (1 of which had been expanded, 7 were new and 2 were in development). A 2024 update on these services is expected soon.

In Wales...

Primary care mental health services and specialist perinatal mental health teams in Wales have a talking therapies pathway, which includes support for those experiencing PTSD in the perinatal period or severe fear of giving birth. Some women who have experienced baby loss are supported by bereavement midwives or the third sector. Work has begun in Cardiff to establish a fledgling service offering evidence-based psychological therapies for women (and their partners) with moderate to severe trauma resulting from baby loss, but there are currently no specific services for these women in other parts of the nation. There is currently no psychology pathway for women in Wales experiencing trauma due to loss of custody.

Moving forward

Currently where a woman lives affects the care that she can access. It is crucial that all Maternal Mental Health Services have the resources they need to meet the levels of need that we know women and birthing people and their families have.

The Maternal Mental Health Alliance will continue to work in collaboration with the BPS and our other members, lived experience champions and national and local partners to encourage progress. We won't stop until ALL women, babies and families impacted by perinatal mental health problems have equitable access to high quality, compassionate care and support.

"What this report says, way beyond its words and numbers, is that we need to listen and act fast, [with] ... genuine humanity, compassion and empathy.... My heart goes out to those families who have lost loved ones to the conditions we talk about in this report. We can all do better and we know how."

Maela, Lived experience champion

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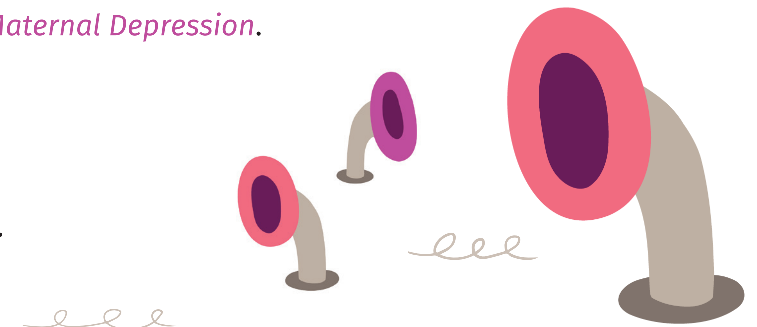

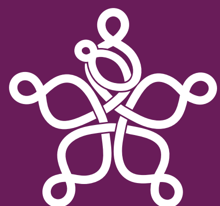

Maternal Mental Health Alliance

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