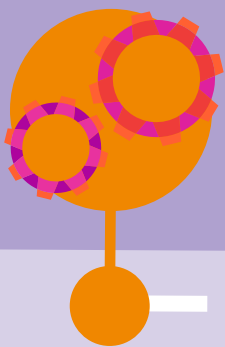


strengthening perinatal mental health

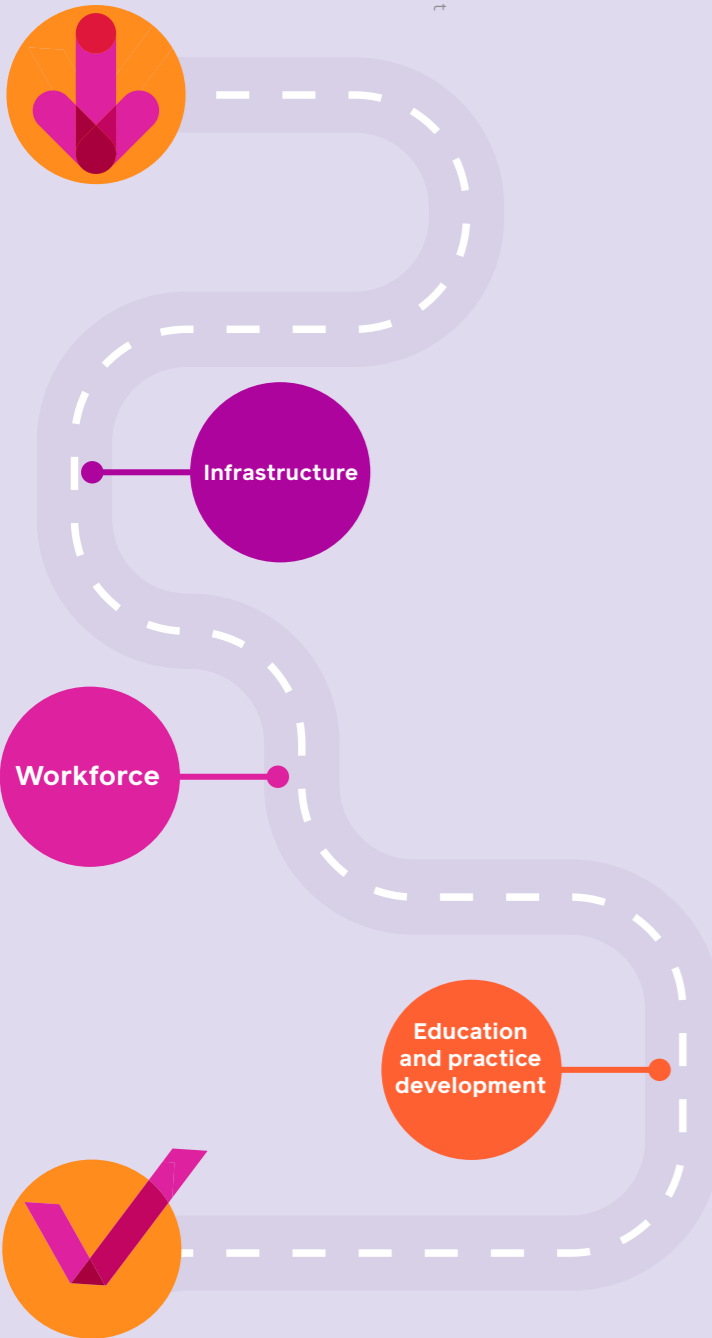
A roadmap to the right
support at the right time



Royal College
of Midwives



Executive summary and recommendations



One in four women experience mental health issues during the perinatal period, with conditions ranging from anxiety to severe psychosis.¹ Midwives are at the heart of supporting women's perinatal mental health, through prevention, screening, detection and provision of direct care,^{2,3} but the provision of good, well-resourced care is inconsistent. Evidence demonstrates that universal care services, including maternity care, have clinical and cost benefits when delivering perinatal mental healthcare.^{3,4}

The Royal College of Midwives calls on policymakers, commissioners, and senior NHS leaders across the UK to support the midwifery community in providing more and better perinatal mental health support and, in this roadmap, sets out how this could and should be done.

1. Infrastructure

NHS organisations must create the conditions for success by establishing a supportive environment. This includes developing strategic midwifery leadership at a senior level (Band 8 or above) to influence integrated care boards. It also requires the creation of an Integrated Care Boards (ICBs) and Integrated Joint Boards (IJBs) with simplified referral pathways, community-based care, and a holistic approach where perinatal mental health is seen as 'everybody's business'.

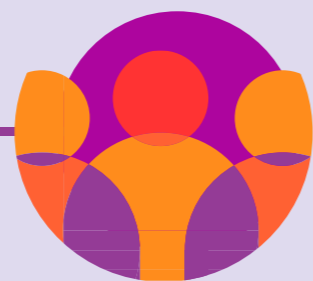
- All Health Boards, Trusts and ICBs/IJBs should have a perinatal mental health strategy and integrated care pathway covering all service levels and encompassing the range of mental health care needs in the local population, including using ethnicity data to ensure culturally appropriate services.
- Universal appointments should be long enough to include sensitive discussion, adopt a trauma-informed approach and assessment of mental health should be the standard. Where required, these should be followed by the development of personalised care and support plans and referral pathways. Accredited interpreting services and local advocates should be provided when required.
- Screening tools and commonly used mental health language should be culturally sensitive and relevant for all populations. These tools and language should be rolled out universally.
- Positive engagement with local and national third-sector support should be encouraged to provide personalised, timely perinatal mental healthcare.
- Midwives should have access to an integrated maternal mental health system and network for referrals. This system should include access to low-intensity psychological therapists to meet the needs of the local population.



2. Workforce

In order to develop a well-supported and knowledgeable workforce, there must be a national workforce plan, in each of the UK's four nations, to align staffing levels with local population needs. Workforce plans should consider factors like geography and deprivation, with specialists having clear role profiles and access to psychological and clinical supervision.

- There must be strategic midwifery leadership, at Band 8 level or above, with oversight of perinatal mental health services to influence across ICBs/IJBs and regional Health Boards for sustainable service improvements.
- NHS leaders should commission the development of a midwifery workforce framework for specialist perinatal mental health midwives.
- A dedicated specialist midwife for perinatal mental health should be a minimum of a Band 7 or equivalent. The specialist midwife should be part of a wider system of support rather than the sole provider of caseload care for women with mental health needs.
- Staffing should be proportionate to the needs of the local population, considering the geographical make up, diversity and levels of deprivation. There should be a local review of demand and capacity, carried out annually, around the specialist perinatal mental health midwife role to ensure staff wellbeing and prevent burnout.
- Workforce planning should account for the time and resource required for effective education, practice development and supervision.



3. Education and practice development

Perinatal mental healthcare must be embedded from the start of a midwife's career. Additionally, all maternity professionals should receive an annual update in perinatal mental health assessment, along with training in a trauma-informed approach. Specialist midwives are also responsible for the ongoing education and practice development of their colleagues.

- The NMC should review its Standards of Proficiency through a mental health lens, along with changes to pre-registration midwifery education, to include perinatal mental health, trauma-informed care, and trauma risk assessment. Education should consider the impact of intersectionality and multiple disadvantages (such as racial discrimination and poverty) on a woman's health and her willingness to disclose mental health symptoms.
- Midwives, maternity support workers (MSWs) and maternity care assistants (MCAs) should receive annual updates in perinatal mental health assessment. They should also undertake ongoing education in trauma-informed care.
- The specialist perinatal mental health midwife's role should be clearly defined to include educating and developing other midwives, MSWs and MCAs and be visible within the local service. All midwives and maternity team members should have access to clinical supervision and ongoing education.



Perinatal mental health in the UK



One in four women experience mental health issues during pregnancy and up to one year following birth (the perinatal period)¹. Conditions range from anxiety and depression to severe psychosis and suicide. Incidence is higher in some areas, for example 27.5% in North East England⁵ and 31.6% in Wales.⁶



Nearly three-quarters (70%) of women will hide or underplay the severity of their mental health problems, often due to fear of judgement, stigma or the involvement of social services.¹⁵



National confidential enquiry assessors have highlighted that, for some of the women who died in 2020-22, mental health problems prevented their health concerns being heard or acted upon.⁷



Over a third (34%) of late maternal deaths (six weeks to one year following birth) in 2021-23 were due to mental health issues, with deaths due to suicide or other psychiatric causes occurring in equal proportions.⁸



Black women and women living in the most deprived areas were twice as likely to die during the perinatal period than white women and women living in the least deprived areas. Most deaths by suicide during the perinatal period are among white and older women.⁸



Poverty, discrimination, migration, extreme stress, pre-existing disability or mental health illness, exposure to violence, being a young parent and having low social support are recognised factors for worsening mental health in the perinatal period.^{5,9,10}



Women subjected to domestic abuse or multiple disadvantage continue to experience poorer maternal mental health outcomes. Women with antenatal and postnatal depression are three times more likely to report experiencing domestic abuse, including during pregnancy, than women without perinatal depression.¹¹



Approximately 30,000 women in the UK develop post-traumatic stress disorder (PTSD) every year after giving birth.¹²



Women from marginalised groups, particularly those from minoritised ethnic groups, are more likely to experience poor care and both direct and indirect racism during their care.^{13,14,15}



Postnatal depression and anxiety have a profound impact on the parent-infant relationship, which is the foundation of the future emotional, relational and social development of the child.¹⁶



The long-term cost to society of perinatal mental health is £8.1bn for each year of births, according to an independent report⁴ published by the Maternal Mental Health Alliance (MMHA). Nearly three-quarters of this cost related to adverse impacts on the child rather than the mother. This cost is five times that of improving services.

Why midwives?

Midwives provide care from pre-conception through to the early postnatal period. They work across primary and tertiary care as part of the multiprofessional team in a wide variety of settings, including women's homes and their local communities.

Midwives and women spend significant time together during the maternity journey, providing the opportunity to build a unique and trusting relationship proven to have a lasting positive impact on maternal and infant wellbeing, particularly when continuity of midwifery care is provided.^{3,17,18,19}

Accepting that perinatal mental ill-health is a common cause of maternal morbidity and mortality, this relationship must be protected to ensure adequate time for a thorough mental health and wellbeing assessment with equal weighting as a physical and social risk assessments. This should be repeated at each care interaction.

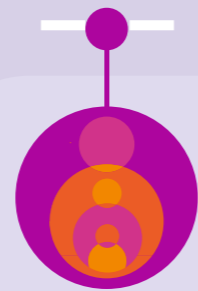
With often only a 15 or 20 minute appointment window, midwives can use this opportunity to build trust and confidence, create an environment where women feel heard, and recognise when health and social inequalities may be affecting care. While midwives cannot resolve wider systemic issues beyond their scope of practice, they play an important role in identifying concerns, offering support, and signposting or referring women who may face judgement, discrimination, or stigma that can act as barriers to accessing services. This includes, but is not exclusive to, women from ethnic minority groups, the LGBTQ+ community and women with disabilities.

Experiences of adverse childhood experiences and adult trauma can be triggered during pregnancy and after birth, impacting perinatal mental health.^{20,21} It is imperative that midwives are given the appropriate training and appointment time to offer screening and referral for previous trauma experiences.²² This is essential if care is to be personalised to the woman's needs. When the mental health needs of a woman are beyond what the midwife can provide within the scope of their role, explicit pathways must exist for additional professional support, while maintaining the continuity of care.

Trauma-informed care in maternity

Trauma informed care recognises how past or current trauma can shape the way people experience health services. It acknowledges that both those receiving care and those providing it may have lived through traumatic events. This model of care is underpinned by values such as creating a sense of safety, offering genuine choice, building collaborative relationships, supporting autonomy, and acting with consistency and honesty. By embedding these principles, services aim to reduce the risk of retraumatisation during care and to foster trust, compassion and dignity in every interaction.

“I felt my mental health improved as the pregnancy went on, with the support of the midwife my worries never manifested.”



Specialist midwives

Specialist perinatal mental health midwives are crucial to the provision of universal, effective mental health care. They are at the heart of forming and leading local care pathways and providing training, advice and support for maternity staff and teams. The leadership embodied within the role provides for quality improvement relating to how services are delivered and reduce the gaps through which vulnerable women can fall.

Specialist perinatal mental health midwives support learning from local incidents, national reports, and coroners' reports, which is fundamental to effecting change. A timely and managed response, and the application of learning, both systemically and on an individual basis, not only benefits the staff at the forefront of care but also ensures women and babies receive the best and safest care possible.

Perinatal mental health specialist midwives, alongside the practice development team, are positioned to lead a robust programme of training and updating for all maternity staff. Their visibility and leadership are essential for raising awareness of perinatal mental health across the whole multidisciplinary team. However, if the role is not full-time or the scope is too large, this impact is limited. There also needs to be a strategic leadership midwife (at Band 8 or above) whose job plan includes wider strategic influence to lead and develop improvements in and a commitment to funding perinatal mental health services.

RCM members describe a range of specialist role responsibilities and a wide variation in the hours employed, from half a day a week to full time hours and across different sites. This not only makes their workloads complex and difficult to manage, but it also restricts the capacity of the wider team to refer women for specialist care and support.

A 2023 survey of RCM members survey found only 68% of respondents received annual training on perinatal mental health, with 12% only doing so in response to national reports. Further RCM research has identified key challenges faced by those offering perinatal mental health support: a lack of clarity about the specialist midwife role; inadequate capacity across the whole service to meet the clinical demands of perinatal mental health; and a real sense that midwives want to do their best but are exhausted and time limited.

Specialist midwives reported these challenges:

- Being used to cover staff shortages.
- No dedicated space to work, speak or see women.
- No administrative support and rarely have MSW/MCA support.
- Single person team, with little capacity to cover sickness, annual or maternity leave.
- Growing demand for mental health care and support from the local population have not been met.
- Lack of strategic, influential midwifery leadership to represent perinatal mental health services within the organisation and externally across the ICB, IJB or regional health board.
- Inequitable access to clinical supervision and clinical psychologist support impacting midwife wellbeing and retention.
- Complex referral pathways and siloed mental health teams.
- Limited time for educating midwives to support a universal care approach to preventing mental ill health.

For Trusts and Boards employing one person in a mental health support role, there is little resilience to cover short notice clinics or annual leave periods, contributing to low morale and burnout. Subsequently, specialist midwives felt their role goes

unrecognised, that they have little time and space to focus on helping women and supporting midwives through training.

For specialist midwives to thrive there needs to be commitment at senior midwifery leadership level to see parity between mental and physical health. With this support perinatal mental health care can be seen as part of universal care and prioritised as essential for the provision of safe care.

“Our role continues to be underfunded and unrecognised. While the demand only gets stronger we are constantly working at a pace that is unsustainable, with no restorative supervision in this emotionally demanding role. It saddens me that despite MBRRACE we continue to be overlooked, at the detriment of the women and people we care for... And ultimately ourselves.”

Perinatal mental health specialist



10 Strengthening perinatal mental health

11 Strengthening perinatal mental health



Investing to save

The Maternal Mental Health Alliance (MMHA), of which the RCM is a founder member, estimates that the long-term cost of perinatal mental health to society is £8.1 billion every year. This cost is five times that of improving services. Investing in services not only has a profoundly positive impact on women and families, it also makes financial sense.

Where services have recognised the need for responsive perinatal services, the investment in staff and the system has been tangible. Midwives working within a system-wide mental health service have access to clinical supervision as a core part of their role and are not used during escalation within maternity units. They also report overall a more positive experience.

While maternal mental health systems/networks have been established across the four UK nations, their stages of maturity are hugely variable.⁷ This was mirrored in the RCM member survey that described local services without a dedicated lead obstetrician

and restrictive barriers to referrals limiting where women could receive care. Midwives can influence as leaders within a system, and in ensuring seamless pathways and also for ensuring seamless pathways for women to access.

Both models of care have significant merit and positive impact on local service provision. However, employers of midwives need to be cognisant of the potential for attrition of midwives from one service to another that affords better work conditions.

Investing in staff – including through appropriate workforce planning and training – is also imperative. Specialist perinatal mental health midwives have told the RCM of the significant challenges they face, both in terms of workload and their working environments. This also needs to be recognised and addressed by employers.

Specialist midwives must have a framework of supervision and support wrapped around them to reduce the compassion fatigue, burnout and vicarious trauma.

“The specialist midwife gave me my life back.”

“The perinatal mental health team were fantastic. Every single staff member treated me with high levels of care, understanding and empathy. This team have got me to a place in my recovery that I never thought I would see.”²⁴



Follow this link for further resources



References

1. Maternal Mental Health Alliance. Maternal mental health statistics. 2023. <https://maternalmentalhealthalliance.org/campaign/> [Accessed 21 July 2025].
2. Royal College of Midwives (RCM). NHS 10-year health plan consultation response. 2024. <https://rcm.org.uk/wp-content/uploads/2024/12/Royal-College-of-Midwives-NHS-10-year-plan-consultation-submission.pdf> [Accessed 16 July 2025].
3. World Health Organization (WHO). Transitioning to midwifery models of care: global position paper. 2024. <https://www.who.int/publications/i/item/9789240098268> [Accessed 21 July 2025].
4. Centre for Mental Health, London School of Economics, Maternity Mental Health Alliance. A sound investment. Increasing access to treatment for women with common mental health problems.. 2022. https://maternalmentalhealthalliance.org/media/filer_public/e2/79/e27962f1-cd9c-42e9-a0e2-827a2c71f8c4/a-sound-investment-report-centre-for-mental-health-2022-mmha.pdf [Accessed 8 September 2025].
5. Office for Health Improvement & Disparities. Estimated prevalence of perinatal mental health conditions in England, 2016 and 2019. 2025. <https://www.gov.uk/government/publications/perinatal-mental-health-condition-prevalence/estimated-prevalence-of-perinatal-mental-health-conditions-in-england-2016-to-2019> [Accessed 22 July 2025].
6. GIG Cymru / NHS Wales. The women's health plan for Wales. <https://performanceandimprovement.nhs.wales/functions/networks-and-planning/womens-health/the-womens-health-plan-for-wales/> [Accessed 16 July 2025].
7. Felker A, Patel R, Kotnis R, Kenyon S, Knight M, editors, on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care Compiled Report - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2020-22. 2024. <https://www.npeu.ox.ac.uk/mbrrace-uk/reports/maternal-reports/maternal-report-2020-2022> [Accessed 21 July 2025].
8. MBRRACE-UK. Data brief: Maternal mortality UK 2021-23. 2025. <https://www.npeu.ox.ac.uk/mbrrace-uk/data-brief/maternal-mortality-2021-2023> [Accessed September 2025].
9. World Health Organization (WHO). Perinatal Mental Health. [no date]. <https://www.who.int/teams/mental-health-and-substance-use/promotion-prevention/maternal-mental-health> [Accessed 21 July 2025].
10. World Health Organization (WHO). WHO recommendations on antenatal care for a positive pregnancy experience. 2016. <https://www.who.int/publications/i/item/9789241549912> [Accessed 21 July 2025].
11. Maternal Mental Health Alliance. Briefing: Perinatal Mental Health and Domestic Abuse. 2023. MMHA BRIEFING - Perinatal mental health and domestic abuse - Jan 23. [Accessed 5 September 2025].
12. Yildiz P, Ayers S, Phillips L. The prevalence of posttraumatic stress disorder in pregnancy and after birth: A systematic review and meta-analysis. *Journal of Affective Disorders* 2017; 15(208):634-45.
13. Thomas K. Listen to Mums: Ending the Postcode Lottery on Perinatal Care. A report by the all-party parliamentary group (APPG) on birth trauma. <https://www.theo-clarke.org.uk/birth-trauma-report> [Accessed 21 July 2025].
14. Birthrights. Systemic racism, not broken bodies: An inquiry into racial injustice and human rights in UK maternity care. Executive summary. 2022. https://birthrights.org.uk/wp-content/uploads/2022/05/Birthrights-inquiry-systemic-racism_exec-summary_May-22-web.pdf [Accessed 21 July 2025].
15. Walcott S, Nightingale G. How racism affects health. <https://www.health.org.uk/reports-and-analysis/reports/how-racism-affects-health> [Accessed 22 July 2025].
16. World Health Organization (WHO). WHO recommendations on maternal and newborn care for a positive postnatal experience. 2022. <https://www.who.int/publications/i/item/9789240045989> [Accessed 21 July 2025].
17. World Health Organization (WHO). WHO recommendations on maternal health: guidelines approved by the WHO Guidelines Committee. 2nd edition. <https://www.who.int/publications/i/item/9789240080591> [Accessed 21 July 2025].
18. Renfrew M. Enabling safe quality midwifery services and care in Northern Ireland. 2024. https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-midwifery-renfrew-report-oct-2024_0.pdf [Accessed 16 July 2025].
19. Cibralic S, Pickup W, Diaz AM, Kohlhoff J, Karlov L, Stylianakis A, Schmied V, Barnett B, Eapen V. The impact of midwifery continuity of care on maternal mental health: A narrative systematic review. *Midwifery* 2023;116:103546. <https://doi.org/10.1016/j.midw.2022.103546> [Accessed 22 July 2025].
20. Reuveni I, Lauria M, Monk C, Werner E. The impact of childhood trauma on psychological interventions for depression during pregnancy and postpartum: a systematic review. *Archives of Women's Mental Health* 2021;24(3):367-80.
21. De Backer K, Felker AM, Rose E, Bull C, Labisi O, Kitchen K, Mason C, Montgomery E, Sandall J, Easter A, Knight M, Vousden N. Characteristics, outcomes, and maternity care experiences of women with children's social care involvement who subsequently died: national cohort study and enquiry. *BMJ Medicine* 2025;4(1):e001464 <https://doi.org/10.1136/bmjmed-2025-001464> [Accessed 8 September 2025].
22. Callanan F, Bradshaw C, Tuohy T, Noonan M, Murphy S, Grealish A. An integrative review of how midwives are screening and assessing for trauma in women within perinatal services. *PLoS One* 2025; 20(7):e0327253. <https://doi.org/10.1371/journal.pone.0327253> [Accessed 8 September 2025].
23. Perinatal Mental Health Network Scotland. Evaluation: specialist perinatal mental health midwife role. 2025. <https://www.nn.nhs.scot/pmhn/wp-content/uploads/sites/11/2025/06/2025-05-28-Evaluation-of-Specialist-PMH-Role-V2.0.pdf> [Accessed 15 July 2025].
24. Department of Health Northern Ireland. Mental health strategy 2021-2031. 2024/25 Annual delivery plan. 2024. <https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-mental-health-strategy-delivery-plan-2024-25.PDF> [Accessed 22 July 2025].

Other resources

1. International Confederation of Midwives. Beyond the surface: re-framing perinatal depression. 2024. <https://internationalmidwives.org/beyond-the-surface-re-framing-perinatal-depression/> [Accessed 22 July 2025].
2. Maternal Mental Health Alliance. Executive summary. Specialist perinatal mental health care in the UK 2023. May 2023. https://maternalmentalhealthalliance.org/media/filer_public/cc/9c/cc9cb61d-c9f6-4dd8-97c5-b5c74070b892/summary-mmha-specialist-perinatal-mental-health-services-uk-maps-2023.pdf [Accessed 21 July 2025].
3. Maternal Mental Health Alliance. Maternal mental health services progress report. 2024. <https://maternalmentalhealthalliance.org/news/england-maternal-mental-health-service-progress-report/> [Accessed 15 July 2025].

Ensuring all those who use and work within maternity services feel that they belong and are represented is the right thing to do. The RCM will always use women (and mothers) in our work, to reflect that the majority of maternity service users are and identify as women. We will use gender neutral language in addition in some of our communications to recognise other gender identities.



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Strengthening perinatal mental health

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