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Birth Activists Briefing: Maternal Mental Health Service Progress Report

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By the AIMS Campaigns Team

The NHS England Long Term Plan published in 2019 called for the establishment of 'maternity outreach clinics', now known as maternal mental health services (MMHS), across the country. This was a welcome initiative, intended to redress the long-standing neglect of perinatal mental health. The aim was for MMHS to support women with moderate to severe mental health conditions directly related to their pregnancy experience, through three "pathways of care" (as quoted in the report):

- Birth trauma
- Tokophobia (severe fear of childbirth)
- Perinatal loss, including miscarriage, stillbirth, neonatal death, medical termination of pregnancy and parent-infant separation at or soon after birth due to safeguarding.

They were also intended to provide training to other healthcare staff and help to facilitate joined up mental health care across the maternity services in their area.

This Maternal Mental Health Services progress report published in October 2024 by the Maternal Mental Health Alliance (MMHA) reveals that, although services have been established in most areas, there is wide variation in the extent and quality of provision. Further, "many of these small services are struggling to cope with levels of demand." It seems that perinatal mental health remains seriously underfunded and under-resourced.

An interim report ESMI-III: The Effectiveness and Implementation of Maternal Mental Health Services was published by the National Institute for Health and Care Research in 2022 but as the MMHA report notes "this does not include detailed information such as locations, staffing levels, pathways available and common challenges faced by teams." It is this gap that the MMHA report sought to address. Their research took the form of an online questionnaire to which replies were received from 41 out of a possible 46 services. Worryingly, one service had already closed due to funding issues.

All the services that replied are offering support to women who have experienced perinatal loss, but only 85% are supporting those who have experienced birth trauma and only 80% those suffering tokophobia. Even more troubling, given the vulnerability of this group, is that only 27% (11/41) are supporting women who have lost custody of their babies due to safeguarding concerns.

The MMHA report also notes that "the wide variation between services: what care is provided; what the criteria are to access care; and how long women must wait, suggests there are not enough resources to meet the true needs of the population." As a result there is a postcode lottery in whether women and birthing people with similar needs qualify for support or receive it in a timely manner. The waiting time for assessment ranged from 'immediately' up to six months, and the wait for one-to-one therapy could be up to a year in some areas. The damage being done to the mental health of mothers and families by these lengthy waits, or by being referred and then told they do not qualify for treatment, is appalling to contemplate.

Although most services have funding assured for their current level of provision this does not allow for expansion, despite there being unmet demand. Many are also struggling to recruit and retain the staff they need.

Another concern highlighted in the MMHA report is the failure by a high proportion of MMHS to collect data on which population groups are accessing their services and, in particular, data on those likely to experience greater discrimination. Without this, attempts to improve equity in access to maternal mental health services are likely to fail.

The MMHA make the following recommendations:

- Commitment to MMHS at national and local level, with ongoing targets and clear expectations of what the MMHS offer should be
- Expand MMHS to meet levels of need, with a clear timeframe
- Make MMHS inclusive for all, ensuring that they are "resourced to reach out, become more culturally inclusive and adapt to the unique needs of their diverse local communities."
- Collect and publish more data to demonstrate progress and gaps
- Quality standards for MMHS to deliver "compassionate and equitable treatment."
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Education and training across the system with sufficient time allocated for MMHS staff to provide this.

These are all worthy aims, but fundamentally what is needed is a commitment to resource MMHS to meet the needs of all who need it, so that "ALL women, babies and families impacted by perinatal mental health problems have equitable access to high quality, compassionate care and support."