CELEBRATING 45 YEARS

mothers for mothers
perinatal mental health support

This Is Our Truth

A Grassroots Call to Reimagine Perinatal Mental Health Care

COMMUNITY FUND

The Queen's Award for Voluntary Service

CALLS TO ACTION

1. Close the Gaps in Care

2. Transform Identification & Access Systems

3. Elevate Workforce Training and Integration

4. Fund What Families Value

5. Support Families Beyond Specialist Service Thresholds

THIS IS OUR TRUTH

Real lives behind the data

791 Women &Birthing People

56 VCSEs

23k Voices Elevated

BARRIERS TO SPEAKING UP

- Worry about being judged
- HCP not interested / too busy
- Worried baby might be taken away
- Felt embarrassed
- Worried it will be written in notes

VCSES NEED

- Stable long-term funding
- Stronger partnerships

TO FACE

- Rising demand
- Increasing complexity
- Increasing costs

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Smile Group

Sydnee Smith

The Association for Postnatal Illness

The National Lottery

The PANDAS Foundation

Tommy's

Dr Trudi Seneviratne OBE FRCPsych

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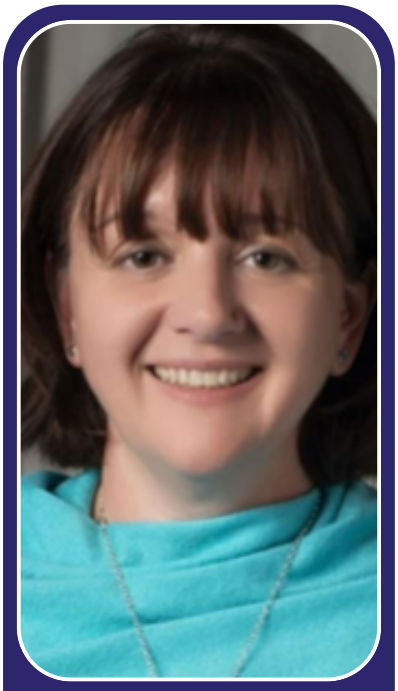
Authors



Maria Viner

CEO of Mothers for Mothers

Maria has been involved with Mothers for Mothers for nearly 20 years, first as a client, then as a volunteer, and later as Chair of Trustees, before becoming Chief Executive Officer in 2018.

An alumna of the King's Fund Top Manager Programme, she draws on her lived experience of perinatal mental health to elevate the voices of families in shaping services. Her Patient and Public Involvement (PPI) work began in 2006, and she is the PPI Lead at the Tommy's National Centre for Maternity Improvement and the associated Partner Trial. As an expert by experience, Maria is a Maternal Mental Health Alliance Lived Experience Champion and serves on the Council of the College of Sexual and Reproductive Health.

Dr Jenny Carter

Midwife & Senior Research Fellow (Department of Women and Children's Health) at King's College London

Jenny Carter has worked in maternity research since 2003 supporting and leading high-quality clinical research in various aspects of women's health, including the evaluation of the implementation of novel interventions.

She is a founder member of the UK Preterm Clinical Network and is currently Senior Research Fellow for Tommy's National Centre for Preterm Birth Research. She co-authored "Preterm birth: a handbook for midwives".

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Dr Laura Richmond

Peer Researcher & Author (All My Worldly Joy)

Laura was admitted to a mother and baby unit after the birth of her son in 2014. She works in a variety of roles promoting maternal mental health, including as an ambassador for MumsAid, a lived experience champion at the Maternal Mental Health Alliance and an evaluation partner at the Hearts and Minds Partnership.

Previously, a senior research and involvement officer at Bliss, the neonatal charity, and a lived experience research consultant at University College London. She also led a research project on maternal mental health and transport on behalf of the Mental Health Foundation.

Laura's memoir of motherhood and mental health, All My Worldly Joy, was published by Wilton Square in January 2026.

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Foreword - Mars Lord

Mars Lord is an award-winning doula, educator, mentor, and founder of Abuela Doulas, one of the UK's first training programmes created for Black and Brown birthworkers. With over 20 years' experience holding space for women and birthing people, Mars is known for culturally safe, trauma-informed practice that centres dignity, honesty, and advocacy without aggression. She is a leading voice in Black maternal health, recognised with the Legacy Achievement Award in Black Maternal Health and shortlisted for a National Diversity Award. Through training, coaching, and community-led work, Mars supports birthworkers to strengthen their skills, build sustainable businesses, and show up with integrity for the families they serve.

This report is not comfortable reading. Nor should it be.

It holds the truths of women and birthing people who trusted us enough to speak plainly about perinatal mental health and the care they did, did not, or could not access. It also holds the truths of community organisations, the voluntary, community and social enterprise sector, that keep showing up to fill the gaps left by a system stretched past breaking point.

I work with people at the moment when "I'm fine" stops working. I see what happens when care is conditional on capacity, postcode, or perception. I see who is believed and who is not. And I know the cost of asking for help in a system that still meets distress with suspicion or delay.

We often hear that women "hide" or "underplay" their symptoms. Let's tell the truth. Many don't. They ask for help and are told they don't meet the threshold. They disclose and are met with silence. They wait months for appointments that never come. They are patched into services that focus on the baby while forgetting the mother/birthing parent. The damage is cumulative and predictable.

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This report also recognises the professionals trying to do good work inside impossible conditions. Many care deeply, but care alone is not a safety net. Families cannot rely on luck or goodwill. They need structure, accountability, and funding that reflects reality. Individual compassion cannot replace collective responsibility.

The VCSE sector is not a side note in this story. It is central. When the system cannot hold families, these organisations do. They create spaces where women and birthing people can be honest, where peer support interrupts isolation, and where practical and emotional help are understood as the same work. They are saving lives, yet too often they survive hand-to-mouth on short-term funding. That must change.

If you are reading this as a policymaker, commissioner or funder, treat it not as observation but as instruction. If screening improves, provision must increase. If we ask people to open up, we must be ready to hold them. Signposting alone is not care. Follow-up is not optional.

We must stop designing systems around the convenience of institutions and start designing them around the lives of families. That means continuity of care, home visits, language support, and culturally safe, trauma-informed practice at every touchpoint. It means understanding that perinatal mental health cannot be separated from housing, money, racism, loss, or relational strain.

It also means naming who keeps falling through the cracks. Minoritised women, neurodivergent parents, families navigating social care, LGBTQIA+ families, fathers and partners left unseen. Then, building pathways that finally fit them.

Mothers for Mothers has created something vital here. A grassroots record of truth and evidence, not statistics stripped of humanity. The numbers are stark, but they represent lives, babies, and generations.

Read this report. Sit with what it shows you. Then act.
Because we do not need more awareness.
We need courage, investment, and change.

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Foreword - Karen Joash

Karen is a UK Consultant Obstetrician and Gynaecologist, senior clinical leader, and national advocate for perinatal mental health, equity, and compassionate maternity care. Her work spans clinical practice, national education, system-level strategy, and community innovation, all focused on improving outcomes for mothers, babies, and families. As Course Director for the RCOG Perinatal Mental Health Course, she leads evidence-based training that strengthens clinical confidence, interdisciplinary working, and the integration of mental health into everyday maternity care. She is also co-founder of the Umbrella Group, a clinician-led alliance amplifying lived experience and accelerating strategic change in perinatal mental health. Karen has shaped regional and national initiatives on perinatal mental health, birth trauma, continuity of care, and health inequalities.

A committed advocate for parity between mental and physical health, she champions personalised, culturally sensitive care and the vital role of VCSE organisations in supporting families who fall below specialist thresholds. Through her leadership, education, and national advocacy, Karen continues to shape the future of perinatal mental health in the UK, driven by the belief that supporting mothers strengthens families and future generations.

There are moments in public health when the data no longer merely informs us – it confronts us. This report is one of those moments.

Mothers for Mothers: The 2026 Report is not simply a review of perinatal mental health provision in the UK. It is a collective testimony. Nearly 800 women and birthing people, alongside 56 voluntary, community and social enterprise (VCSE) organisations supporting more than 23,000 families each year, have spoken with clarity, courage and urgency. Their message is unequivocal: our current system is failing too many families at one of the most vulnerable and formative periods of life.

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As a clinician, leader, and advocate for women's health, I have seen firsthand the consequences of unmet perinatal mental health needs. This report quantifies what families have long known: perinatal mental illness is common, predictable, and treatable – yet support remains inconsistent, reactive and inequitable. One in four women and birthing people experience perinatal mental illness, yet fewer than half receive specialist support. Tens of thousands fall below service thresholds and are left navigating distress alone, often while caring for a newborn. This is not a marginal gap; it is a structural fault line.

What makes this report particularly powerful is its refusal to oversimplify. The findings challenge the persistent narrative that women "hide" or "underplay" symptoms. Instead, they reveal a more uncomfortable truth: many women do disclose – but are not heard, believed, or supported. Fear of judgement, fear of child removal, racial bias, cultural misunderstanding, neurodivergence, and time-pressured clinical encounters all shape whether disclosure is possible, safe, or effective. These are not individual failures. They are system behaviours.

The report also exposes a fundamental imbalance in how we value health. Physical outcomes are monitored meticulously, while mental health is too often relegated to brief checklists or postponed until crisis. Postnatal care – the very period when vulnerability often peaks – is particularly under-resourced. When care becomes reactive rather than preventative, we miss the critical window where early intervention could protect both parent and child.

Crucially, this report reframes perinatal mental health not as an isolated clinical issue, but as a biopsychosocial reality. Mental wellbeing is inseparable from sleep deprivation, feeding challenges, trauma, financial stress, loss, housing insecurity, and social isolation. The call for holistic, personalised care is not aspirational rhetoric; it is evidence-based necessity. When mothers are supported emotionally, practically and relationally, outcomes improve – not only for them, but for infants, partners and future generations.

The VCSE sector emerges in this report as both a lifeline and a warning. Community-based organisations are filling the gaps left by statutory services with compassion, flexibility and trust – often supporting those who do not meet NHS thresholds. Yet they

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do so in an environment of unstable funding, rising demand and limited integration with formal care pathways. A system that relies on goodwill without sustainability is not resilient; it is precarious.

The recommendations set out in this report are therefore not optional enhancements – they are imperatives. Closing gaps in care, transforming identification and access, mandating trauma-informed workforce training, funding what families actually value, and supporting those beyond specialist thresholds are all achievable actions. What is required now is leadership, coordination and the courage to redesign pathways around lived experience rather than organisational convenience.

At its heart, this report is a call to listen – and then to act. Listening is not passive. It requires humility, accountability and a willingness to change entrenched systems. The voices captured here are not asking for perfection; they are asking for safety, continuity, compassion and dignity.

If we are serious about prevention, about equity, and about the long-term health of our society, then perinatal mental health must move from the margins to the centre of care. This report shows us how. The responsibility to respond now lies with all of us – clinicians, commissioners, policymakers, funders and communities alike.

Because when we support mothers,
we do not only change individual lives.
We shape the wellbeing of generations to come.

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Introduction

Maria Viner CEO Mothers for Mothers

This Is Our Truth: A Grassroots Call to Reimagine Perinatal Mental Health Care

In our 45th year, we speak truth to power, to honour the trailblazing women of lived experience who, in 1981, had the vision and courage to create a women-led peer support service. Their legacy lives on in every conversation, every service provided, and every life touched. Their bravery planted the seeds to enable Mothers for Mothers to grow into an organisation that was presented with the Queen's Award for Voluntary Services in our 40th year.

We extend heartfelt thanks to everyone who has shaped our journey: our Trustees, Staff, Volunteers, Funders and Fundraisers, and professional service colleagues who support our work. But most importantly, we thank our clients, the thousands of women, birthing people, and families who have trusted us on their journey and who share their truth bravely every day. They inspire us to do the work, striving for better care, improved service and stronger support. Investing time to build relationships of trust not just with families, but across healthcare systems is key to the success and the foundation for better outcomes for families.

A moment in time that crystallised the power and value of what we do was our "People's Choice" garden at RHS Chelsea Flower Show in 2022. We met many women, of similar ages to our founders, who told their truth to our team. For most, it was the first time they ever voiced the struggles they experienced. Bearing witness to hundreds of stories that week, each one was powerful, each one affirmed the importance of our work, and each one reminded us that care must be available, accessible, and compassionate.

In our 45th year, as we celebrate our past, we also look ahead to the future. As we, along with many other VCSEs, face the perfect storm of rising costs, increased demand for our services and families living with increased complexity, whilst funding opportunities are in decline. That is why we have created this grassroots report, a collective call to action to uplift the voices of women, birthing people, and the VCSE sector. Together, we can drive the change our communities deserve, because this matters not just for today but for future generations.

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Through focus groups and surveys, this report captures the lived experiences of women and birthing people, with 791 voices raised, alongside insights from 56 VCSEs offering perinatal mental health and emotional wellbeing support to over 23,000 families. Maternal mental health matters for both parent and child. When mothers struggle emotionally, it can disrupt bonding and the ability to provide sensitive and responsive care, affecting a child's development and long-term wellbeing. Supporting maternal mental health is also preventative care for the next generation. Early dyadic interventions that work with both mother and baby can repair relational issues and foster healthy attachment. Improvements in a mother's mental health directly benefit her child.

Every year in England, around 600,000 women give birth. 26% will experience perinatal mental illness; that is, around 156,000 women and birthing people annually. Yet of those, only 57,000 receive specialist services [1].

For some, this may be one single appointment. That leaves 99,000 women each year in England struggling without access to the services and care they need and deserve. Put simply: more than half of those affected are left unsupported. When we widen the lens to include Scotland, Wales, and Northern Ireland, the number of women and birthing people left without services rises to around 109,000 every year. That's tens of thousands of mothers and infants across the UK continuing to face common but debilitating issues like anxiety and depression without access to funded support. Their long-term health and wellbeing are left at risk because they do not meet the threshold for specialist support. Perinatal losses are not covered in the birth rate, so if we include those who experience miscarriage, ectopic pregnancy, stillbirth and medical termination, that would include a further 137,000 women and birthing people who have a need for services.

This stark gap can cause these issues to be devastating, yet they are neither irreversible nor inevitable. Early intervention offers a critical opportunity to break cycles of trauma that reverberate across generations and to prevent further escalation. This work, often led by VCSE organisations such as Mothers for Mothers, is urgent, impactful, and must be properly funded. VCSEs play a vital role in addressing gaps where the system falls short, providing essential support that can make the difference between crisis and recovery, and ensuring healthier outcomes for mothers, babies, and families.

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[1] NHS England 2023: Record numbers of women accessing perinatal mental health support: https://www.england.nhs.uk/2024/05/record-numbers-of-women-accessing-perinatal-mental-health-support/

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We want to challenge the existing narrative that 70% of women are "hiding or underplaying" their symptoms when speaking to health care professionals. It is important to consider the reasons why women and birthing people said they felt uncomfortable talking to health care professionals (please refer to Table 11 on page 37) and to ask: what do healthcare professionals need to foster relationships built on trust, where individuals feel safe to fully disclose their experiences?

To modernise perinatal mental health care, we must be bold in reimagining how screening is conducted and how access to support is enabled. This includes embracing digital innovation with the same commitment seen across other areas of healthcare. By adopting approaches like the Tommy's clinical decision support digital tool, we can move beyond basic checklists and introduce personalised and AI-enabled assessments that women and birthing people can complete alongside healthcare professionals or with trusted supporters of their choice. This shift would help reduce inequalities, empower individuals to self-advocate, and promote confident engagement in their own care.

When these 70% are finally heard, how will they be supported?

Despite rising demand for perinatal mental health services, access remains limited and waiting times continue to grow. Enhanced screening will only be effective if it is accompanied by expanded service provision and sustained, appropriate funding for VCSEs, ensuring support that is timely, equitable, responsive to need and effective. Full integration between maternity services and perinatal mental health teams is essential to prevent new parents from falling through the gaps, particularly during the vulnerable postnatal period.

As a proud Welsh woman, I carry with me the spirit of Aneurin Bevan's words: "This is my truth, tell me yours." In Wales, storytelling is more than tradition; it is how we build community, foster belonging, and embrace our differences. When looking forward and trying to build for the future, it is good to look back to where we came from, remember the lessons learned and honour the grass roots and original intentions. Having the opportunity to "Tell Your Truth" is crucial; it creates a sense of belonging and community through shared experiences that have the power to drive improvement in services. The truths we have heard illustrate why it is so important that pathways become standardised and why it is also vital that care is personalised.

My truth is different to your truth. "This is my truth, tell me yours".

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Calls to Action

1. Close the Gaps in Care

Address the gaps in care and develop an understanding of the barriers and enablers to seeking perinatal mental health support to ensure families are able to receive timely, compassionate care.

2. Transform Identification and Access Systems

Improve systems to better identify the perinatal mental health needs of women, birthing people and their infants and the process to achieve better access to services for women. Ensure pathways are standardised and support is personalised.

3. Elevate Workforce Training and Integration

Mandate comprehensive, trauma-informed training for all professionals working with families during the perinatal period, embedding mental health awareness into every touchpoint of maternity care, ensuring full integration with maternity services and avoiding the postnatal "cliff edge".

4. Fund What Families Value

Decision makers and funders, locally and nationally, invest in the services trusted and valued by families, providing support in a way that is meaningful to them and ensuring sustainable funding reflects what truly matters to those navigating the perinatal journey.

5. Support Families Beyond Specialist Service Thresholds

A dedicated All-Party Parliamentary Group (APPG) for Perinatal Mental Health is urgently needed to ensure Parliament provides sustained attention and leadership on the needs of the 99,000 women and birthing people in England (109,000 in the UK), who fall below the threshold for specialist services each year. These families are currently left without adequate services and support, despite facing significant emotional and mental health challenges during pregnancy and early parenthood.

Establishing an APPG would create a vital forum for cross-party collaboration, scrutiny, and policy development. It would enable Parliament to hear directly from those with lived experience of being unable to access care and support; and from VCSE organisations, whose frontline work often represents the only support available to those not eligible for specialist care. Crucially, it would also provide a structured space to explore sustainable funding solutions, ensuring these organisations can continue delivering the essential, community-based support that families both need and deserve.

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Lay Summary

This report brings together the voices of nearly 800 women and birthing people and 56 voluntary and community organisations, together **elevating the voices of 23,000 women and birthing people**, to show the reality of perinatal mental health in the UK. It shows, powerfully and plainly, that too many families are **not getting the mental health support they need** during pregnancy and after birth.

While many professionals work extremely hard, the system itself is **overstretched**, **inconsistent and often difficult to access**. As a result, families frequently rely on VCSE charities and community groups; organisations that themselves are under pressure and strain.

Why this report matters

Perinatal mental illness affects around **one in four women and birthing people**, yet **more than half do not receive specialist help**. Many try to seek support but are told they do not meet the threshold for care, or they face long waiting lists. Meanwhile, the emotional impact on partners, parents who have experienced loss, neurodivergent families, and those from underserved communities is often overlooked.

This report makes one thing very clear: **mental health is not a luxury; it is essential to the wellbeing of women and birthing people, babies, and future generations**.

What families told us

1. Services are under-resourced

Families repeatedly described maternity and mental health services as **overstretched and rushed**. Appointments may be too short to discuss mental health, with poor communication, and many feeling dismissed or judged. Information is not always shared between teams, and long waits mean support often arrives too late. Many families who cannot access NHS support try private therapy, but the cost puts this out of reach for many.

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2. Mental health is not seen as a priority

Physical health of the baby is often prioritised, while the parent's wellbeing can be sidelined. Many said they rarely felt asked about their mental health in a meaningful way, especially after the baby was born. They asked for earlier support and services that focus on their emotional wellbeing as much as their physical health.

3. Support is reactive, not proactive

Families described struggling alone until crisis point. They called for:

- more honest and realistic antenatal education
- routine check-ins throughout pregnancy and the first postnatal year
- earlier use of improved screening tools
- better signposting/transfers to support services

4. Relationships with healthcare professionals matter

Positive experiences often came down to **trust, continuity and compassionate communication**. Negative experiences; feeling judged, dismissed, or not listened to, can have long-lasting emotional effects and make people less likely to seek help again.

5. Parents are not "hiding" symptoms. They are not being heard

The common idea that women and birthing people "underplay" their struggles does not reflect reality. Many say they *did* ask for help but were ignored, judged, or told their feelings were "normal". When they did hide their symptoms, it was often because they did not feel safe to speak openly. Fear of judgement, fear of child removal, cultural misunderstanding and racial bias all contribute to feeling they are not heard.

6. Mental health is shaped by wider life pressures

Challenges such as financial stress, relationship difficulties, feeding problems, sleep deprivation, housing insecurity and bereavement all affect mental wellbeing. Parents overwhelmingly asked for **holistic support**, not just clinical treatment.

7. Pathways must be standardised. Support must be personalised.

Some situations, including baby loss, neonatal admissions, neurodivergence, trauma, racial bias or social care involvement, create specific emotional needs that standard services do not meet. Fathers and partners are also underserved.

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What VCSE organisations told us

VCSE organisations provide a **lifeline** for families and are often the **only source of support**. Many offer counselling, peer support, helplines and practical help with very short waiting times.

But these organisations:

- face **unstable, short-term funding**
- struggle to meet rising demand
- need stronger partnerships with the NHS
- need better awareness among health professionals of the support they offer

Many families supported by charities have experienced complex challenges such as housing insecurity, trauma, abuse, poverty or discrimination, circumstances that greatly increase the need for early and compassionate care.

What all this means

This report is a **collective testimony** from lived experience and the grassroots organisations working alongside them. It shows a system under pressure but also highlights the enormous potential for change.

Families are not asking for perfection; they are asking to be:

- heard
- believed
- treated with dignity and compassion
- supported early, consistently and holistically

When we support mothers and birthing people, **we strengthen families and shape healthier futures for generations to come**.

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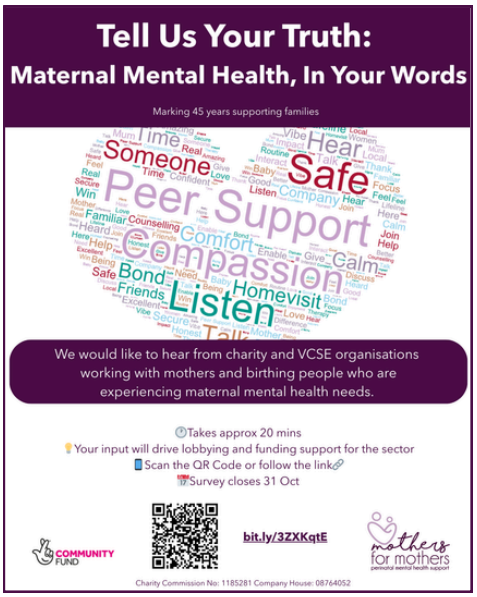
Methodology

Surveys

Two UK-wide surveys were conducted using Qualtrics, a recognised online survey management platform. The first, the Lived Experience Survey, sought to capture the perspectives of women and birthing people regarding their experiences of maternal mental health and emotional wellbeing during the perinatal period. The second, the VCSE Survey, gathered insights from charities and other VCSE organisations to understand the support they provide to women and birthing people in the perinatal period, as well as the challenges and opportunities faced within this sector.

Data collection commenced on 1 July 2025 and concluded on 31 October 2025. Recruitment of respondents was undertaken through targeted advertisements and posts on social media channels, supplemented by email communications. To maximise participation, reminder messages were issued and reposted at regular intervals throughout the survey period.

Promotion of the surveys was supported by several organisations and individuals. Mothers for Mothers, Laura Guckian, and Sydnee Smith actively disseminated the surveys through their networks. Social media assets were translated into Welsh and promoted by Fair Treatment for the Women of Wales. The Hearts and Minds Partnership facilitated the distribution of the VCSE survey among its membership base. Additionally, the Lived Experience survey received wider public visibility through a feature broadcast on BBC Radio Wales.



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Focus Groups

A total of eight focus groups were conducted across Bristol, North Somerset, and South Gloucestershire during the same period in which the surveys were active. These sessions provided participants with the opportunity to reflect on the care they received for their maternal mental health and emotional wellbeing during the perinatal period. Participants offered detailed accounts of their experiences, highlighting aspects of care that were effective, identifying areas of poor practice, and drawing attention to gaps in provision. They also contributed additional insights that they considered important to be represented within the study findings.

We asked a mixture of closed and open questions, none of which were mandatory. Responses were downloaded, and quantitative data were analysed using Microsoft Excel and IBM-SPSS v.31.0.0.0.(117). Responses to open questions data analysis was conducted by a lived experience researcher using thematic analysis, following six stages: familiarisation with the data; generating initial codes; searching for themes; reviewing themes; defining and naming themes, and writing up [2].

In this report, focus group attendees and survey respondents are described collectively as participants. Quotations have been amended for readability in terms of spelling, punctuation and grammar but otherwise left intact. Abbreviations have been expanded for clarity.

The data comprised of the following:

- Qualitative data from lived experience survey responses.
- Qualitative data from VCSE survey responses.
- Focus group data held to collect feedback from those attending Mothers for Mothers' peer support groups.
- Focus group data from groups with Mothers for Mothers' clients held between 24th September and 2nd October 2025 in Hartcliffe, Patchway, St George, Staple Hill, Weston-Super-Mare, Clevedon and Bedminster.
- Focus group data from a group held with Mothers for Mothers volunteers on 24th September 2025.

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[2] Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77-101.1: https://doi.org/10.1191/1478088706qp063oa

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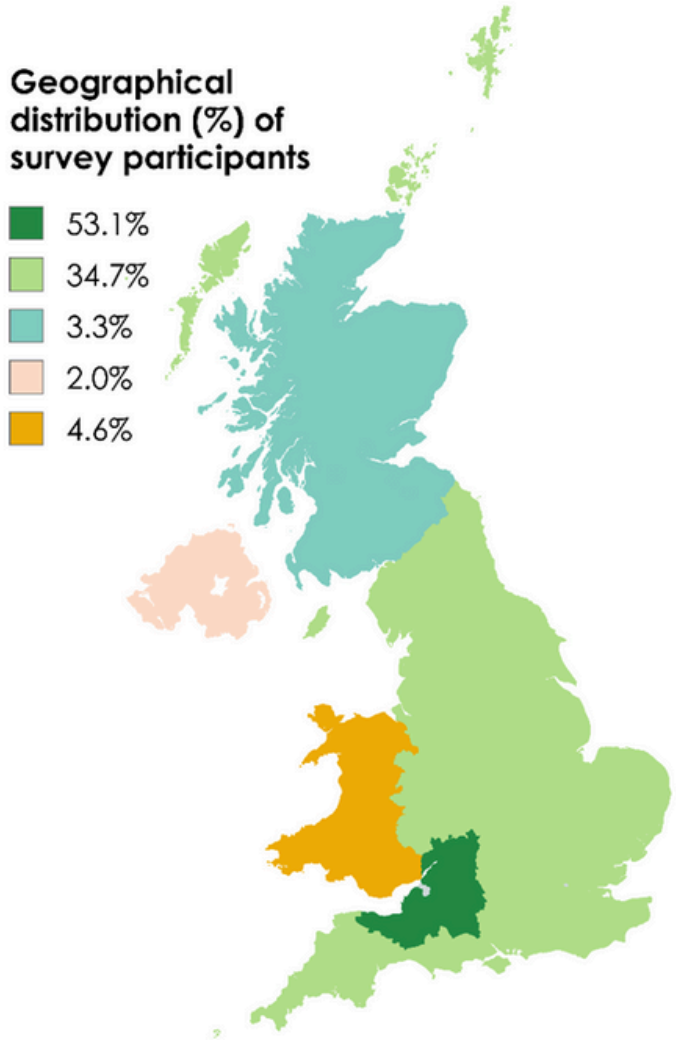
Characteristics of Lived Experience Research Participants

Overall, 699 people responded to the lived experience survey. These characteristics do not include the focus group participants. We asked a number of questions about respondents' demographic and other characteristics, and their experience of pregnancy, birth, mental well-being and access to services. These questions were asked so we would be able to assess the geographic reach of our sample and ensure representation of diverse experiences.

Just over half of respondents lived in the geographical area covered by Mothers for Mothers, with around a third from the rest of England. The remaining respondents were from Northern Ireland (n=9), Scotland (n=15) and Wales (n=21) (Figure 1).

Geographical spread

Figure 1: Responses to the question: "Where do you live?"



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Age Group

Of those who chose to include their age group, the majority were between 25 and 44 years old. Only three were under 25 years old; however, we had responses from 93 who were over 45 years old (Table 1).

Table 1: Number of respondents by Age group

Age Group	n	
20 to 24	3	0.70%
25 to 29	39	8.50%
30 to 34	128	27.80%
35 to 39	120	26.10%
40 to 44	75	16.30%
45 or over	93	20.20%
Would rather not say	2	0.40%
Total	460	100%

Ethnic Group

Nearly 60% (n=416) of all 699 respondents reported that the ethnic group that most closely matched theirs was White (Table 2). Just over half (n=353) said their sub-group category was "British". Others in the "white" ethnic group were Irish (16, 2.3%), and "Any other white background" (45, 6.4%). Two respondents (0.3%) said they would prefer not to say what their ethnic sub-group category was.

Respondents from the "Asian or Asian British" ethnic group were from Indian (5/699, 0.7%), Pakistani (2, 0.3%) and "Any other Asian background" (3, 0.4%).

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In the Black or Black British group, three were Caribbean (0.4%), two were African (0.3%), and two were from "Any other Black Background" (0.3%). One other would rather not say.

In the Mixed Ethnic Group, four were mixed white and Black Caribbean (0.6%), one was white and Black African (0.1%), six were white and Asian (0.9%) and three (0.4%) were from "Any other mixed background".

Respondents in the "Other Ethnic Group" category were Chinese (1, 0.1%) and from "Any other ethnic group" (3, 0.4%).

We acknowledge that people racialised as Black and Brown are underrepresented in our survey, but we were able to obtain valuable information during the focus groups.

Table 2: Number of respondents by Ethnic Group

Ethnic Group	n	
Asian or Asian British	10	1.40%
Black or Black British	8	1.10%
Mixed	14	2%
Other Ethnic Groups	4	0.60%
White	416	59.50%
Would rather not say	8	1.10%
Total	460	65.80%
Missing	239	34.20%
	699	100%

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Indication of social deprivation

We asked respondents to tell us their postcode, if they were comfortable to do this. This was so that we could determine the Index of Multiple Deprivation (IMD) code for the place in which they lived. This is a measure of social deprivation. It is not related to the individual, but the place where they live, which gives researchers some indication of the social diversity of the participants. Our survey findings suggest a good mix of respondents across the spectrum (Table 3).

Table 3: Number of respondents by Index of Multiple Deprivation (IMD) quintile. **More than two-thirds of respondents did not disclose their postcode**.

IMD quintile*	n	% of all respondents	% of those with valid postcode
(most deprived) 1	33	4.70%	15.50%
2	38	5.40%	17.80%
3	47	6.70%	22.10%
4	44	6.30%	20.70%
(least deprived) 5	51	7.30%	23.90%
Total with valid postcode	213	30.50%	100%
Missing	486	69.50%	
Total of all respondents	699	100%	

**Index of Multiple Deprivation (IMD) quintile 1= IMD score falls within 1-20% in the UK population, most deprived; IMD quintile 2 = IMD score within 21-40%; IMD quintile 3 = IMD score within 41-60%; IMD quintile 4 = IMD score within 61-80%; IMD quintile 5 = IMD score within 81-100%, least deprived.*

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Pregnancy status

The majority of respondents, who answered the question on their current pregnancy status, were not currently pregnant (n=428, 92.6%), 30 (6.5%) were pregnant, two were unsure, and another two preferred not to say.

We also asked how recently they had given birth. Over half (n=243, 52.5%) had given birth in the last two years; however, 77 (16.7%) had given birth more than 10 years ago (Table 4). This, along with the fact that 93 respondents (20.2%) were over 45 years old (Table 1, above), highlights the enduring impact of mental health experiences and support needs among respondents engaging with a survey on pregnancy and birth-related mental wellbeing.

Table 4: Respondents most recent pregnancy year

Year	n	
2025	88	19%
2024	99	21.40%
2023	56	12.10%
2022	40	8.70%
2021	37	8%
2020	15	3.20%
2019	12	2.60%
2018	11	2.40%
2017	9	1.90%
2016	9	1.90%
2015	9	1.90%
Before 2015	77	16.70%
Total	462	100%

Shockingly, although perhaps not surprising, given the nature of our survey, 327 respondents (70.2%) said that their experience of birthing their baby, or any of their babies, had been difficult or traumatic.

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Relationship status

We asked respondents what their relationship status was. The majority were married or cohabiting (n=403, 87.8%). Others were single (n=24, 5.2%), separated (n=10, 2.2%), divorced (n=8, 1.7%), widowed (n=2, 0.4%) or would rather not say.

Table 5: Responses to the question: What is your relationship status?

Relationship Status	n	
Married or co-habiting	403	87.80%
Divorced	8	1.70%
Separated	10	2.20%
Single	24	5.20%
Widowed	2	0.40%
I would rather not say	12	2.60%
Total	459	100%

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Faith or Religion

The majority of respondents (n=284, 61.9% of those who answered this question) said they had no faith or religion. Just over a quarter (n=125) identified as Christian, ten were Muslim, and others were Buddhist (n=2), Hindu (n=3), Jewish (n=3) and Sikh (n=1).

Table 6: Responses to the question: "What is your faith or religion?"

Faith or Religion	n	
Buddhist	2	0.40%
Christian	125	26.80%
Hindu	3	0.70%
Jewish	3	0.70%
Muslim	10	2.20%
Sikh	1	0.20%
Other (agnostic/spiritual/pagan)	10	2.60%
I don't have a faith or religion	284	61.90%
I would rather not say	21	4.60%
Total	459	100%

photo credit: Stewart Williams

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Other characteristics

Gender:

The vast majority of the 460 respondents who indicated their gender were female (n=454, 98.7%). One was male, three were non-binary, and two indicated they would rather not say. Two said the gender identity assigned to them at birth was not the same, and three said they would rather not answer that question.

Disability/Neurodivergence:

Of the respondents who answered the question "Do you consider yourself to have a disability?" 16.7% (77/460) said "Yes", while 129 respondents (of 460, 28%) considered themselves to be neurodivergent.

It is estimated that 15–20% of the UK population is neurodivergent, and the survey sample reflects a comparatively higher proportion of respondents identifying in this way. This is consistent with emerging evidence indicating that neurodivergent women and birthing people experience disproportionately elevated rates of perinatal distress, yet remain insufficiently recognised and under-supported [3]. Diagnostic pathways for neurodivergence also demonstrate a marked gender bias, with women more frequently receiving diagnoses later in life. Consequently, many women enter pregnancy without a formal diagnosis, restricting their ability to access appropriate and timely support.

Furthermore, perinatal services are predominantly designed around the needs of neurotypical populations, creating structural barriers that exacerbate risk and limit access to care. Establishing a dedicated neurodivergent perinatal pathway would enable the provision of targeted, specialist support and directly address known inequalities in perinatal mental health. Such an approach would align with national priorities for early intervention and contribute to reducing disparities in maternal mental health outcomes.

[3] Elliott, Buchanan and Bayes, 2024: https://pubmed.ncbi.nlm.nih.gov/39362087/

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Key Findings: Lived Experience

Mental wellbeing

At the start of the survey, we asked respondents to complete the ten questions of the PROMIS-10 validated instrument for capturing health-related physical and mental well-being. This was to gauge the overall well-being of those responding to the survey. 699 respondents completed at least the first 10 questions, so we were able to total the scores and allocate a category based on the PROMIS-10 Global score categories [4] as below:

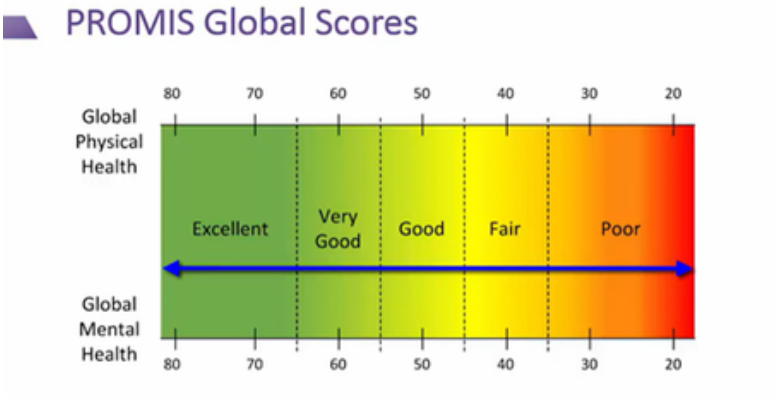
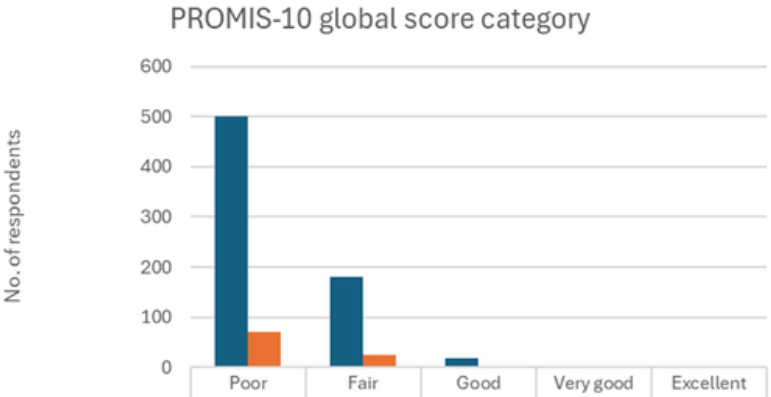


Figure 2: Figure showing suggested interpretation of PROMIS Global Scores (from: https://www.healthmeasures.net/score-and-interpret/interpret-scores/promis/promis-score-cut-points/promis-adult-score-cut-points)

We found that the majority of respondents' (n = 501, 71.7%) PROMIS-10 scores indicated that their overall well-being was poor. In a quarter, their well-being was fair, and only 2.6% had good well-being. There were no respondents whose scores indicated very good or excellent well-being. This is not surprising, given the subject matter of the survey and that it was likely to be of interest to those with a negative experience of perinatal mental wellbeing.



	Poor	Fair	Good	Very good	Excellent
no. of respondents	501	180	18	0	0
Percent	71.7	25.8	2.6	0.0	0.0

Figure 3: Number of respondents in each PROMIS Global score category

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We asked respondents if they had experienced any mental wellbeing problems before they were pregnant. The majority (n=405, 60%) said they had (Figure 4). Again, it is not surprising given that respondents were those who were motivated to complete a survey on mental wellbeing.

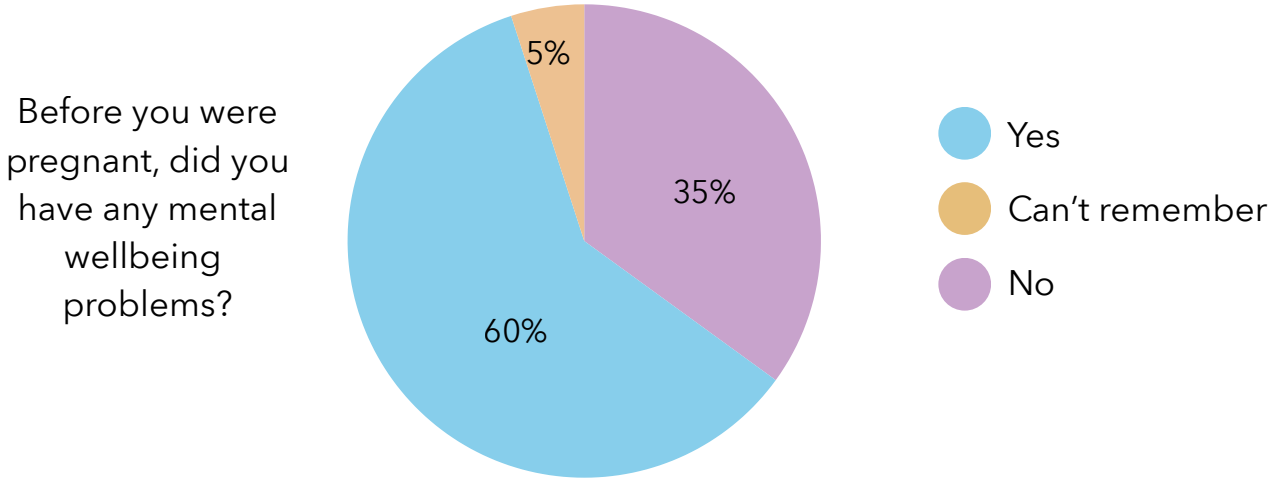

Figure 4: Proportion of respondents who answered the question: "Before you were pregnant, did you have any mental wellbeing problems?"

The vast majority (n=508, 79%) felt their mental wellbeing was worse following pregnancy. Only 45 (7%) thought it was better than before pregnancy, 68 (10%) said it was about the same, and 26 (4%) couldn't remember or preferred not to say.

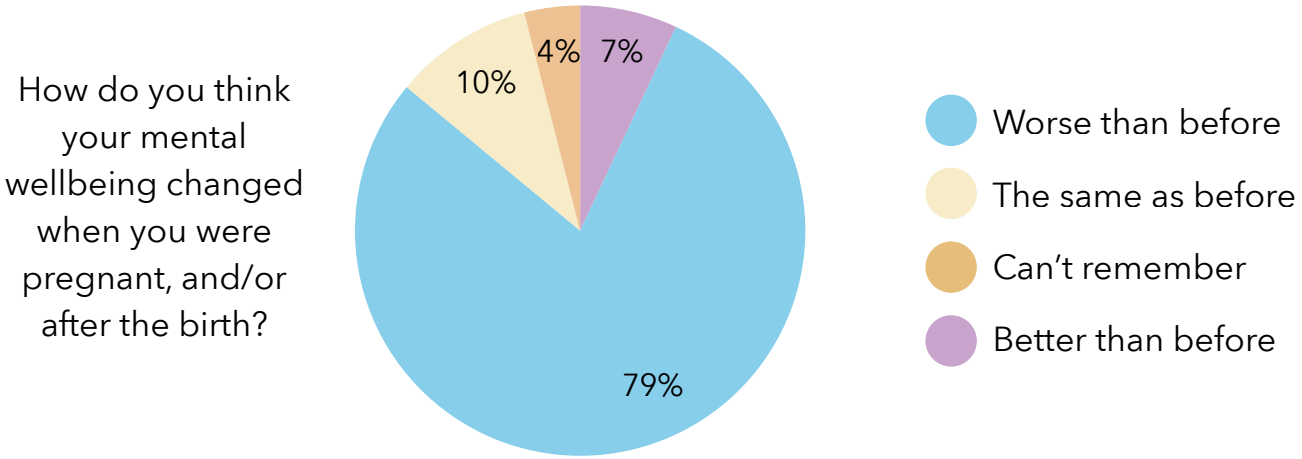

Figure 5: Responses to the question: "How do you think your mental wellbeing changed when you were pregnant, and/or after the birth?"

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We asked whether the respondent had experienced any other problems during their pregnancy, or pregnancies, that may have affected their mental wellbeing. The majority had (n=418, 68%) (Figure 6). Respondents were then asked to expand on their answer, if they felt comfortable, in a free text box. Data collected through these open questions has been analysed, and findings are presented in the Lived Experience Themes.

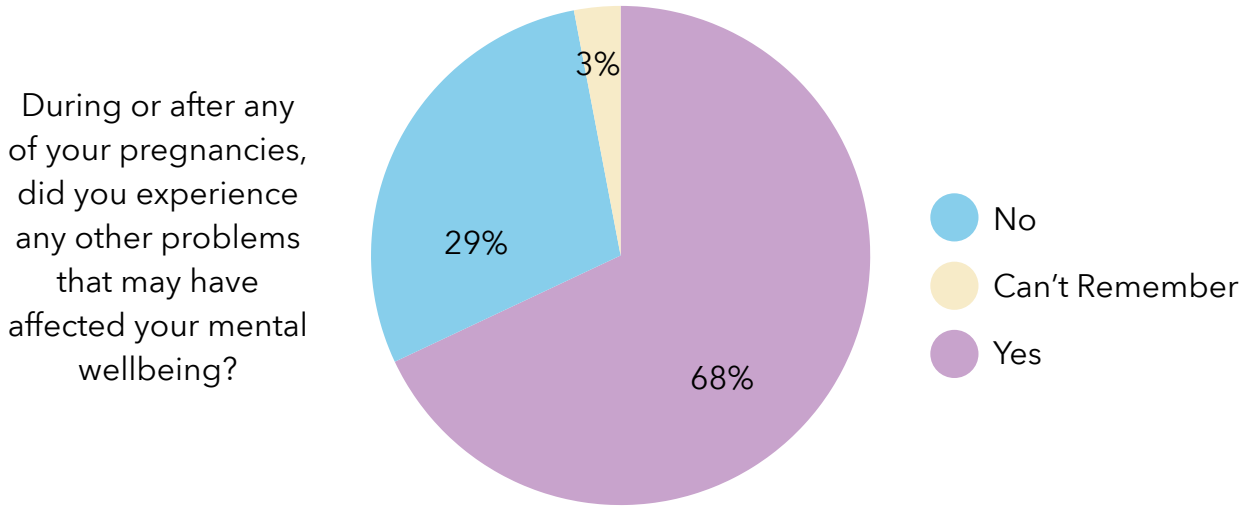

Figure 6: Proportion of respondents who answered the question: "During or after any of your pregnancies, did you experience any other problems that may have affected your mental wellbeing?"

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Experience of maternity services

We asked a series of questions about respondents' experience of maternity care in relation to mental wellbeing, whether they had been asked about it specifically by health professionals, and whether they were comfortable in disclosing their concerns about their mental wellbeing to their health professional.

The first and vital step to supporting emotional wellbeing is the identification of need. We asked: "During your most recent pregnancy care, did any HCPs (e.g. midwife or doctor) ask you about your mental wellbeing?" 596 respondents answered this question. Over a quarter (n=158) said that they didn't remember anyone asking them about their mental well-being. However, 272 (46%) said they had been asked at several appointments, and 106 (18%) remembered being asked at all appointments.

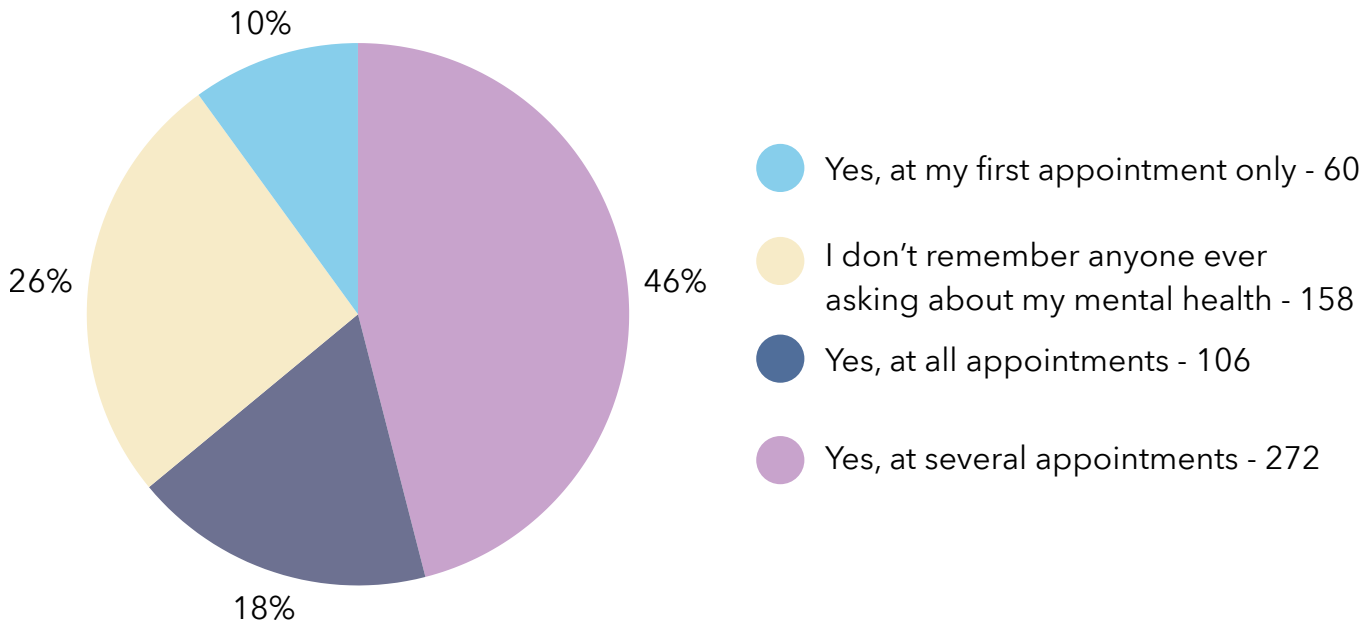

Figure 7: Responses to the question: "Did any HCPs (e.g. midwife or doctor) ask you about your mental wellbeing?"

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Focus group participants reported that they felt that their mental health was not perceived as a priority. There is an imbalance in the attention paid to physical health compared to mental health. Participants felt that the focus of care was to ensure that the baby was well. They also felt that there was a lack of preventative strategies and early recognition, making the service more reactive and not proactive.

We wanted to capture whether specific questions had been asked about history of mental illness, treatments and family history, so we asked those who had said yes to the previous question for more details (Table 7):

Table 7: Responses to the question: "If a health professional had asked you about your mental wellbeing, what did they ask?"

If yes, did they ask you about…	n=
How you were feeling at the time.	399
Whether you had previously had any mental health problems.	272
Whether you were taking any medication or having any other treatment for mental health problems.	211
Whether your mother or siblings had any mental health problems.	104
Something else (free text included in qualitative analysis)	18

*Respondents could select more than one option

We then posed a series of questions based on the COLLABORATE validated instrument [5]. This is a tool used to assess the extent of shared decision-making during a clinical encounter. The respondent is asked to indicate, on a scale of 0 to 9, how much effort was made to: a) help them understand their health issue; b) listen to things that mattered most to them and c) include what mattered most to them in choosing what to do next.

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The pooled results are shown as mean (averages) in Table 8, and how the scores are distributed across the scale points in Table 9. These findings demonstrate a fairly even spread across scale points, i.e. 10% of respondents in each 0-9 category, the mean (average) overall is shown to be very central. This suggests there is a varied experience amongst respondents, and thus a great variation in care; a likely postcode lottery in quality.

Table 8: Mean scores of the COLLABORATE questions assessing respondents' experience of shared decision making

	n=	Min	Max	Mean	Std. Deviation
When you were talking to the HCP, how much effort was made to help you understand your mental wellbeing issues?	407	0	9	4.43	2.671
When you were talking to the HCP, how much effort was made to listen to the things that matter most to you about your mental wellbeing?	409	0	9	4.45	2.817
When you were talking to the HCP, how much effort was made to include what matters most to you in choosing what to do next?	404	0	9	4.32	2.846

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Table 9: Distribution of COLLABORATE scale points

When you were talking to the HCP, how much effort was made to...						
	...help you understand your mental wellbeing issues?		...listen to the things that matter most to you about your mental wellbeing?		...include what matters most to you in choosing what to do next?	
Scale point	n=	%	n=	%	n=	%
0	24	5.9	38	9.3	39	9.7
1	47	11.5	41	10	52	12.9
2	42	10.3	42	10.3	33	8.2
3	49	12	44	10.8	48	11.9
4	45	11.1	41	10	35	8.7
5	65	16	47	11.5	58	14.4
6	32	7.9	39	9.5	35	8.7
7	39	9.6	47	11.5	36	8.9
8	22	5.4	27	6.6	21	5.2
9	42	10.3	43	10.5	47	11.6
Total	407	100	409	100	404	100

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We asked respondents how comfortable they felt talking about their mental wellbeing with a variety of different health professionals. We asked them to rate how comfortable they felt on a scale of 1-10, where 1 was very uncomfortable and 10 was very comfortable. Again, the results show a fairly equal spread, with ~10% of respondents selecting each scale point, and a mean of around the middle of the range. However, perhaps unsurprisingly, it appears that most respondents felt, on average, slightly more comfortable talking about their mental wellbeing with their midwife, GP, neonatal nurse and health visitor (mean scores 6.05, 5.37, 5.50 and 5.43, respectively), and slightly less comfortable with hospital doctors (mean scores 4.56 and 4.98) (Table 10).

Table 10: Numbers of respondents selecting the health profession with mean of scale points 1-10 in answer to the question: "On a scale of 1-10, how comfortable did you feel talking about your mental wellbeing with the following people?"

	Midwife	Hospital Doctor (Obstetrician)	GP	Neonatal Nurse	Neonatal Doctor	Health Visitor
n=	387	299	345	140	120	370
Missing	312	400	354	559	579	329
Mean	6.05	4.56	5.37	5.5	4.98	5.43
Std. Deviation	2.966	3.03	3.012	3.159	3.197	3.052

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In order to improve services, it is important to understand barriers to discussing mental wellbeing. If they felt uncomfortable, we asked them why by offering a selection of responses and a free text box if they wanted to expand on their answers or it was not available as a selection. The selection option answers are shown in Table 11 and free text has been analysed with the other qualitative data. The most frequently reported barrier was a fear of being judged. Participants also felt less comfortable discussing their concerns when the healthcare professional appeared disinterested or unapproachable. Additionally, some expressed concern about the potential risk of their baby being removed from their care.

Table 11: Numbers of respondents selecting answers to the question: "If you felt uncomfortable talking about your mental wellbeing, please tell us why". Respondents were able to select more than one option.

If you felt uncomfortable talking about your mental wellbeing, please tell us why?	n=
I felt embarrassed	148
They were too busy	144
They didn't seem interested	182
I thought my feelings were normal	115
I was worried about being judged	266
They were not approachable	180
I did not understand what was wrong	153
I was worried this would be written in my medical notes	141
I was worried that my baby might be taken away	169
Something else (free text included in qualitative analysis)	77

This theme is further explored in the focus groups. Focus group participants also highlighted a need for staff training in providing a holistic approach to managing mental wellbeing concerns.

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We asked about which mental wellbeing services respondents had accessed. Results are shown in Table 12. These results show the range of services that have been accessed by our survey respondents, from being advised to contact their GP, to admission to a Mother and Baby Unit, which is a service reserved for the most serious and urgent cases.

Table 12: Numbers of respondents who accepted referral to mental wellbeing services

Type of mental wellbeing service:	Accepted
Referral to a specialist perinatal mental health team (hospital based)	109
Referral to specialist mental health midwife	64
NHS Talking Therapies	136
Referral to specialist perinatal community mental health team	90
Referral to general adult mental health service (community)	44
Referral to general adult mental health service (inpatient)	7
Advised to see GP	135
Mother and Baby Unit	22

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If respondents had been referred, we asked them how long they had had to wait for their first appointment or admission. Of those who had been referred for additional mental wellbeing support, nearly a third (32%) had to wait 1-3 months for their first appointment or admission, 12% had to wait between 3 and 6 months, and 10% had to wait more than six months (Figure 8).

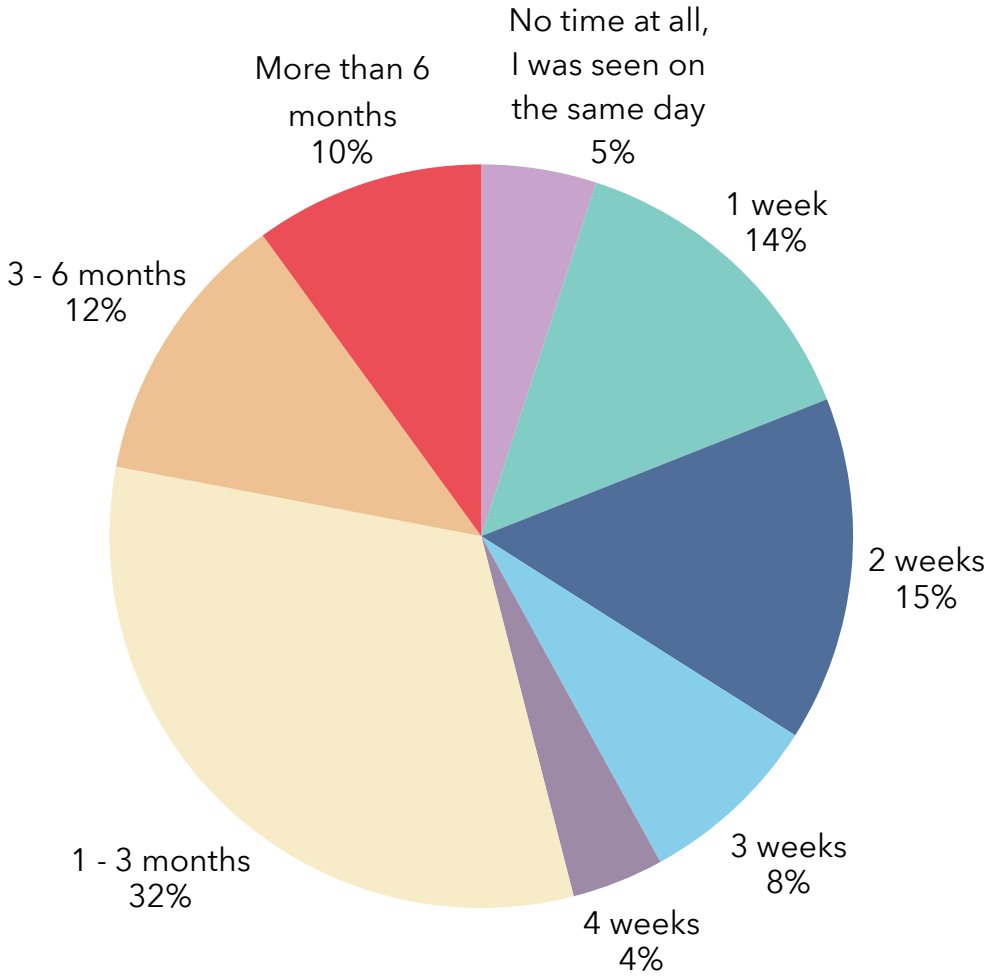

Figure 8: Length of time respondents had to wait for appointment or admission following a referral to mental wellbeing services.

This was raised in the focus groups too, and where the participants recognised that the perinatal services were under-resourced and therefore were only able to see acutely unwell mothers. Even when accepted into the specialist service, there are long waiting lists for receiving specialist mental health support. As a result, many sought support in the private sector and VCSEs.

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Other sources of support for mental wellbeing

We ask respondents whether they had been told about, or found out for themselves about, other sources of support for their mental wellbeing. Our findings show that a larger number of respondents found out for themselves about private counselling/therapies compared to those who had been told about it (219 vs 86). More respondents were told about Family Hubs/Children's Centres (170 vs 82). Support from VCSEs was sought by a significant proportion of respondents.

Table 13: Who were you told about or did you find out about any of the following:

Were you told about, or did you find out about:	I was told about	I found out myself about
Private counselling/therapy	86	219
Family Hub/Children's Centre	170	82
Family Help/Families in Focus	33	16
Early Help (Children and Young People's Services)	33	21
SEND support/FLORA/SENDIASS	10	14
Charity or voluntary sector organisation	128	105
A helpline	133	97
An online chat service/forum/group	58	112
Face to face peer support	97	79
Family and friends	69	232
Faith community	8	37
Other community group	26	56

Tables 12 and 13 demonstrate that there can be numerous organisations and individuals involved in supporting women and pregnant people. It is therefore important that the information is shared by consent with all. The focus group identified this as an area needing attention. When there is a lack of communication, this has a detrimental effect on mental wellbeing.

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Family, especially partners can be part of the support structure surrounding women and pregnant people. It is important to explore the partner's mental health as this may indirectly impact on maternal wellbeing. Of those who answered the question "If you have a partner, did they have mental health or emotional wellbeing issues during your pregnancy or after your baby was born?", a third of respondents reported that their partners had a mental health or emotional wellbeing issue during the respondent's pregnancy or after their baby was born.

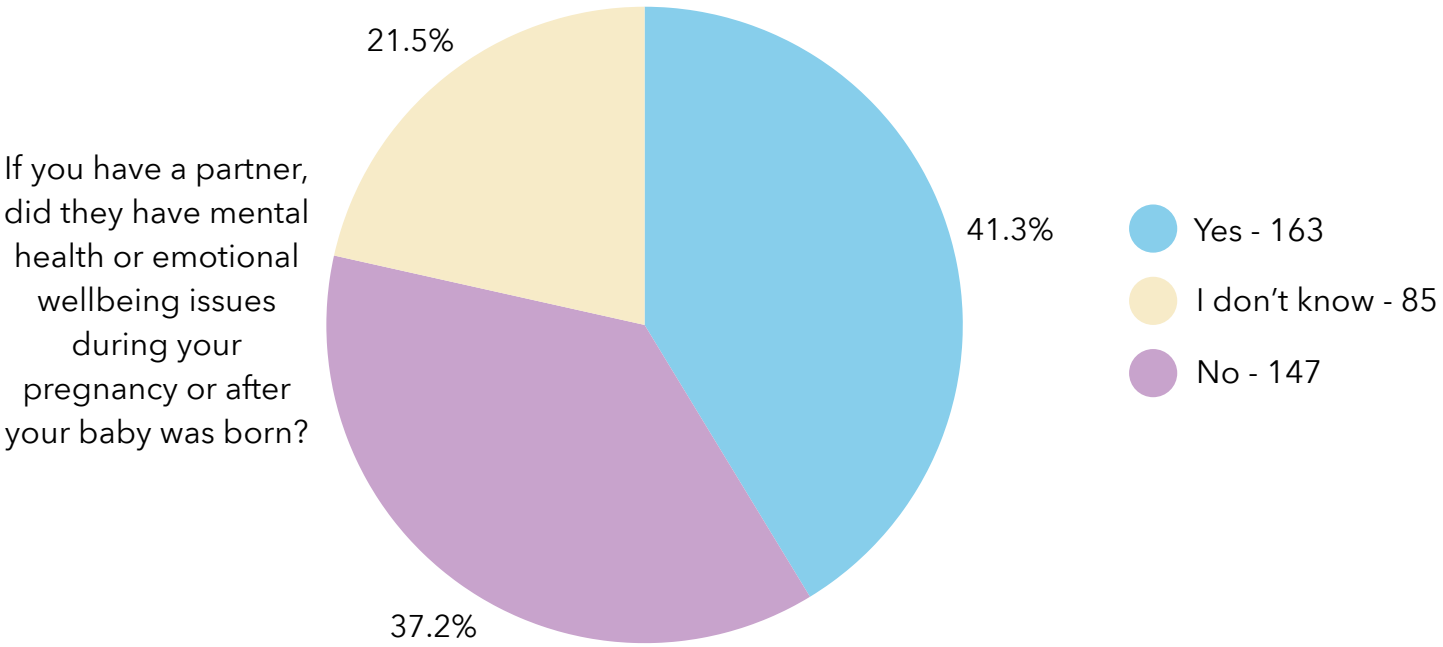

Figure 9: Numbers and proportions of respondents' partners who had a mental health or wellbeing issue during their pregnancy or birth.

We also asked those who had answered "Yes" to the above question whether their partner had received support for this. Worryingly, nearly 4 in 5 partners (77%; 123/160) said they hadn't received support.

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Finally, we asked if respondents felt that they had received support to help them bond with their baby. Sadly, nearly half of respondents (47%, 242) said they did not feel they received this support (Figure 10).

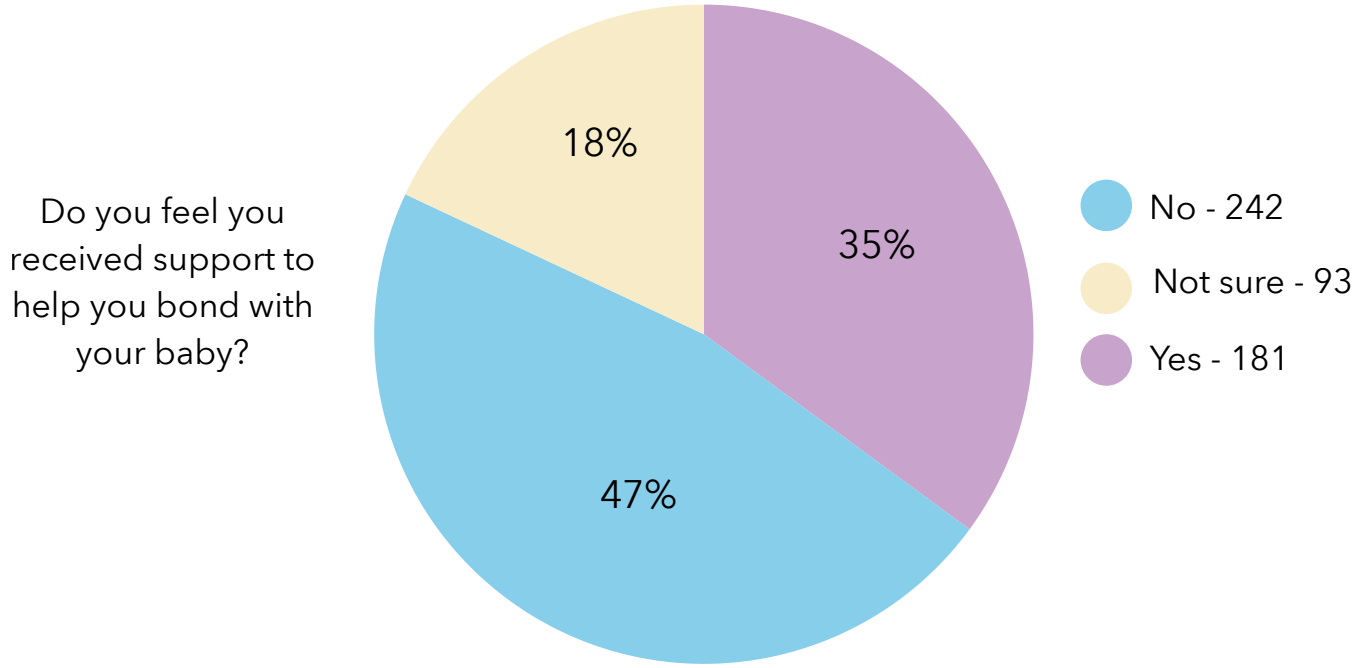

Figure 10: Numbers and proportions of respondents who responded to the question on whether they felt they had received support in bonding with their baby.

The focus group participants stated that there is a gap in postnatal care. They reported that the amount of support was less than adequate during pregnancy, but was even lesser in the postnatal period.

There is currently no specialist perinatal mental health support for women and birthing people who have experienced miscarriage, ectopic pregnancy, stillbirth, neonatal death, medical terminations, or removal of their baby.

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[4] Cella D, Riley W, Stone A, Rothrock N, Reeve B, Yount S, Amtmann D, Bode R, Buysse D, Choi S, Cook K. The Patient-Reported Outcomes Measurement Information System (PROMIS) developed and tested its first wave of adult self-reported health outcome item banks: 2005–2008. Journal of Clinical Epidemiology. 2010 Nov 1;63(11):1179-94. doi:10.1016/j.jclinepi.2010.04.011: https://pubmed.ncbi.nlm.nih.gov/20685078/

[5] Barr, P. J., Thompson, R., Walsh, T., Grande, S. W., Ozanne, E. M., & Elwyn, G. (2013). Developing CollaboRATE: a fast and frugal patient-reported measure of shared decision making in clinical encounters. Patient Education and Counseling, 93(2), 267-273 : https://pubmed.ncbi.nlm.nih.gov/24389354/

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Themes: Lived Experience

Services are under-resourced

Participants believed that maternity and other services delivering perinatal health care were significantly under-resourced. Some expressed **empathy for midwives, health visitors, GPs, and other staff seeking to provide the best possible care** in challenging circumstances.

"Whilst the birth itself was traumatic, it was greatly worsened by a negative experience on the postnatal ward (which was clearly understaffed). There were midwives who were clearly trying their hardest in a broken system, and others who had been broken by working in a broken system."

"There are a lot of health care practitioners who see the problems but there is not the help or resource out there to do anything about it."

"I believe midwives need to be supported to enable these conversations [about mental health] by the systems they work within. They are under-staffed and over-stretched, and the way antenatal and postnatal care is organised makes it very difficult to give women the time they need to talk about their feelings."

Subsequently, participants described **feeling rushed** during health care appointments, which made it more difficult for them to talk about their mental health.

"I always found my midwife appointments really rushed too. I felt like they wanted to quickly do the check then to leave."

"In order for mums to feel like they can talk, they need to feel as though they are not being rushed through an appointment."

"The appointments are so quick, there is no time to delve into something so complicated."

Participants also felt that practitioners working within **maternity and health visiting services did not share information with one another**, possibly because they did not have time. This was the case within individual services and across different services. The result was a **lack of joined-up care**.

"I didn't feel like the care during my labour was very joined up. They were reading my notes and care plan aloud while I was having contractions, bringing up my past trauma."

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"Communication between the hospital midwives and the community staff is lacking and not consistent."

"Poor sharing of information between services and trusts. Living on the border of two counties means disjointed care and health care professionals can't even see your notes."

Waiting lists for specialist perinatal mental health care were cited as a barrier to accessing the right support at the right time.

"I was referred to the perinatal mental health team, but it took about a year to get some support and by then I was returning to work so was unable to attend regular sessions."

"The length of time I waited — nine months — is far too long after such a significant trauma. There is nothing in the community that would understand what we went through… and so really that high level professional support needs to come sooner."

Participants also described being unable to access specialist perinatal mental health care because of high thresholds – **services having the capacity to treat only the most acutely unwell**.

"NHS perinatal teams only accept referrals if you meet a certain threshold. If you don't, you have to rely on community support, which isn't always there."

"The perinatal mental health team have such a high threshold to take on new patients that unless you're suicidal, they won't see you."

"I got referred to everything and met the criteria for nothing, which left me in limbo. 14 months on, I'm still struggling."

As a result, some participants had sought specialist perinatal mental health support via the private practice sector, but **cost was a significant barrier**.

"When my child was one year and seven months old, I reached out to Hertfordshire talking therapies, but they referred me to a service that was 'free' (but strongly encouraged to pay if possible) which is a barrier for me. I didn't receive treatment or support."

"I had to pay privately for a psychotherapist, and this cost me £4000, which put me in debt."

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The **VCSE sector plays a vital role** in supporting families who are unable to access therapeutic treatment and support via statutory services. However, VCSE services also struggle to obtain the necessary funding and resources to meet parents' needs.

"Mothers for Mothers have a lifeline for me. I have felt less isolated and alone. I can be myself. The first time I walked into a group, everyone passed my baby around whilst I cried into my first hot drink in four months. I was not judged. I was fully listened to and felt it wasn't all in my head. My son and I were finally safe."

"A local perinatal mental health charity has been absolutely phenomenal in my journey, and I don't know where I'd be without them"

"There is a lack of community-based groups that parents can access on a drop-in basis to benefit from peer support as well as information and signposting about other options. Although I'm aware that Mothers for Mothers does an excellent job in this area, there is still a lot of unmet need."

Due to the lack of available specialist perinatal mental health support, midwives, health visitors and GPs are tasked with supporting parents experiencing trauma and perinatal mental health difficulties, but they cannot offer enough contact time to provide the more intensive support that these parents need. **Participants called for more contact, and specifically more home visits**, to protect and support perinatal mental health. It can be challenging, and at times impossible, to attend appointments elsewhere with a baby, especially when someone is struggling with their mental health.

"I think having more health visitor visits to my house at the start… would have helped. Instead, I got a different health visitor who heavily encouraged the drop-in hubs that I really struggled to get to with my son, so I felt very isolated and alone when trying to get help with feeding… One health visitor came after I cried on the phone, after several weeks of not making the hubs and feeling like a failure."

"After pregnancy, in both the Netherlands and France, multiple home visits are made to the mother and child to provide support and guidance. Why can't we do so in the UK?"

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In recent years, and particularly since the COVID-19 pandemic, many services have offered **online and telephone support in lieu of face-to-face contact**. This may help resources go further, and some participants found it to be **more accessible**. Some participants had benefitted from online therapeutic support and called for more of the same, while others had not but felt that it would have helped them

"I joined a group online where we journalled together. I found that really supportive, as we were all mums with mental health difficulties."

"I find it hard face-to-face, whereas in an online chat, I would have opened up more."

"[I would have found it easier to access support if there were] more online services. I was isolated because we lived in a remote location, and I couldn't drive after my c-section, so I was totally alone and couldn't go to any local groups for the first eight weeks. Being able to access more things online that included contact with other mums."

However, other parents found health care appointments or therapy offered online or over the telephone **challenging to engage with and less effective**.

"[What made it hard to seek support was] the health visitor being on the phone. You can't really talk freely when you have two under-ones. It would have been better with more home visits as standard."

"After being referred into the perinatal mental health team, I was offered counselling. I was advised it was a long wait for in-person sessions, but I would be seen quicker if I opted for online. As I didn't want to delay, I opted for online. I had my six sessions, and they helped in some way… It was also harder to feel a connection with the therapist due to being online. I'm aware I was lucky to get support so rapidly (within three to four months of the birth), knowing how stretched NHS mental health services are, but I also feel that is still a while to wait even for a lower standard of care."

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Perinatal mental health is not perceived to be a priority

Participants expressed the view that their wellbeing was considered to be of secondary importance, with **health care practitioners focusing primarily on babies**.

"As long as baby is OK nothing else matters – certainly not the birthing woman and certainly not her mental health."

"I was always aware of the queue in the waiting room and the need to check the baby - I felt like I was secondary to the baby."

"Midwifes and health visitors only cared about the baby. I felt like I didn't matter and that my only purpose was to do everything for the baby."

Participants also called for **parity of esteem between physical and mental health**. There was perceived to be an imbalance in perinatal health care, with practitioners prioritising physical health over mental or emotional wellbeing.

"When you first have your baby, health visitors and midwives are around a lot, but they don't ask enough questions around mental health."

"In my booking-in appointment, I told the midwife I had previously had a pulmonary embolism, and this was taken very seriously, and I was referred to an obstetrician for monitoring. When I mentioned I had also had significant mental health issues, including hospital admissions, she tilted her head and 'poor you' and then moved the conversation on. I had to insist on an onward referral as I was concerned about how being pregnant would impact on my mental health. Whenever I saw her again, I did not feel able to talk about my mental health."

"Make it as important as your physical health — this needs to be the first thing they talk about, not the second (or last)."

This is in keeping with the **gap in postnatal care** described by participants who felt that they received significantly more monitoring and support while pregnant than after birth.

"Antenatal care felt better than postnatal care – more people checking in on you and less like you are being left to get on with it."

"Before is great. After, it's like they can't wait to sign you off the books and never see you again."

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The current approach is reactive, not proactive

In accordance with a lack of resources and a lack of emphasis on perinatal mental health in maternal health care, participants experienced harm due to a **lack of preventative measures and early intervention**.

"It seems to be less about prevention and education and more about trying to sort the problems once they have escalated – and that is often too late. The support needs to go in earlier before things get out of control."

"Unless you reach out yourself, no one really checks in on you… I really struggled to reach out and admit I wasn't feeling right, and with no one checking, I can see I could have just stayed unnoticed and struggled until I broke."

"I saw a perinatal psychiatrist before my second birth as I wanted to have an action plan ahead of time. The psychiatrist said this wasn't possible as the service had to respond when and if it did happen. This shows a reactive rather than a proactive approach."

Participants called for a range of measures to improve prevention and early intervention in perinatal mental health. They felt that antenatal classes, health care appointments and society in general should be more realistic about the challenges of the perinatal period. This would prepare families better and make it easier for them to seek additional support if necessary. Participants also called for **better psychoeducation during pregnancy**, so that parents would be aware of perinatal mental health symptoms and what to watch out for, and they would know in advance what support is available.

"I would have loved everyone — professionals, midwives, family, friends — to have been more realistic about how tough the newborn stage can be. I felt like I was the minority for finding bonding tough, for not being in a newborn bubble and feeling like I was failing, and that made it hard to ask for help because I thought I was the only one."

"Explain about perinatal mental health and its impact on the body and brain. Ensure more information is given about groups or home visits for social and mental support."

"They should be upfront about how these illnesses often manifest. Describe intrusive thoughts, medical anxiety and how we have options today. Stop waiting for women to start this conversation."

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They felt that **signposting was an important part** of this process. All parents should be informed about the specific groups, services and support options in their local area.

"I think midwives should signpost mums and dads to the different support agencies BEFORE they give birth."

"Signpost to more services, talk more about getting help, that a lot of mums are struggling and it's normal."

"No signposting happens to [infant] feeding support or to any groups, etc, in the community. Not everyone may access them but finding them is draining and scary and leaves people feeling alone."

'**Checking in**' was also cited repeatedly as essential to preventative care, as well as to facilitating access to further support if and when that was needed.

"Just a call each week to check in from the start would have given me support."

"We need more people checking in throughout the first year – about us, not the baby!"

The use of **questionnaires and screening tools** was also suggested as a useful means of identifying perinatal mental health challenges early and overcoming barriers to seeking support. However, there was a caveat that such tools **must be relevant** and used **within the context of a larger conversation** with a health care professional.

"Give a questionnaire first so they know which approach to take. Not every woman has the same mental health symptoms or needs."

"Have a questionnaire with tick boxes for things which could be useful indicators."

"Make it seem like less of a tick box exercise and make it more conversational, seem like they care."

"I have just sourced therapy, although they've felt I am not distressed enough for specific treatment after filling in questionnaires that had no relation to my situation or experiences."

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Follow-up was identified as another essential element that is currently lacking. Perinatal mental health problems can emerge months or even years after birth, and sometimes trauma will only manifest after a crisis has passed and safety has been re-established.

"I also think my mental health was worst six months after [my daughter] was born, and the support has dried up by that time, so someone checking in and assessing me then would have been amazing."

"… Sometimes trauma takes a little while to process and surface. In the beginning, I didn't realise how bad I was. So, I just said I was okay. They never followed up, even though I'd voiced that I'd had a difficult birth, complications in recovery and was struggling with sleep deprivation."

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Relationships with health care professionals are key

Participants' experiences of labour, birth and postnatal care – both positive and negative – were often **defined by the quality of their interactions with health care professionals**. Good relationships were also essential to seeking help when families were struggling.

"It is 99% down to the quality of the interaction with health care professionals."

"Relationships need to be built between care workers and mothers, so families feel comfortable sharing when they need support."

Continuity of care was essential to building and maintaining these relationships, and this was identified by participants as something that was important to their wellbeing.

"Repeated appointments with the same person would build trust and allow more open dialogue."

"You don't talk and open up to people you have met once. I had never met them before, and they turned up at my house with a textbook when I was at the most vulnerable state."

"Continuity of care and the opportunity to build a relationship with a midwife would greatly help. It would mean not having to repeat your story or feel like you need to explain yourself."

"I received excellent care from the community home birth midwives at my local hospital. They provided great continuity of care in the first two weeks following my birth, which helped me to feel more confident in feeding my baby and therefore bonding with them."

Where health care professionals lacked **empathy and compassion**, participants' mental health was adversely affected. This was often cited as a component of postnatal PTSD, or birth trauma, as well as being a deterrent to seeking help.

"I was not treated with care or compassion. I was made to feel a failure. My mental health difficulties were a direct result of this experience."

"During the c-section of my stillborn son, the obstetrician was telling jokes and there was a complete lack of empathy and compassion."

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There was **praise for individual health care professionals** who had made a lasting impact, as well as anger and distress about negative health care interactions. Participants stressed the influence that both positive and negative interactions had on their mental health.

"My midwife was very supportive and was the first person I opened up to about my struggles. From the start, she was warm and supportive and made me feel like she wanted nothing but the best for me and my baby. I felt that she was understanding. I could be honest with her. She would listen to me and take seriously what I was telling her. I felt I could trust her to do the right thing to keep myself and my baby safe."

"There was one midwife who took the time to speak to me on the ward, and she set up debriefs... I was wanting to leave the hospital as quickly as I could, although I could not really walk. I was so terrified and wanting to get out of there as quickly as possible. But she ensured, before I went, I had appropriate debriefs. That reduced flashbacks and I was able to finally sleep and eat after she did this. I think this is something that helped save my life mentally."

"The health visitor was awful: all tick boxes, very judgey. I was just left with a very unwell baby and anxious thoughts."

Sadly, **feeling judged was a common motif** of many participants' interactions with health care professionals. This was a strong deterrent from seeking help for a perinatal mental health issue.

"I was a teen mum and felt judged. My midwife spoke to me like I didn't have a clue what I was doing and gave me the impression that she disapproved. It made me not want to tell her about anything in case she thought I was incompetent."

"Because I felt judged before, I am even more scared of reaching out now."

Trust in health care services and professionals was identified as an **essential facilitator** to engagement and therefore to perinatal wellbeing. When trust had been eroded, it need to be actively re-established.

"Having a traumatic birth reduced my trust in health professionals, so I didn't see the point in engaging with NHS services."

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"I was failed by so many services that it took me a really long time to go to the GP to explain how I was feeling and start medication. I explained to the doctor that if I appeared guarded, it was because I had trust issues because I'd been failed by so many people, and every time I opened up and was hopeful for help, I was shot down and no support was given. I was greeted with the response of "What's that supposed to mean?" and "It will get better. You just need to be positive." These dismissive interactions made me feel worse about seeking help."

Participants felt more able to engage with discussions about mental wellbeing, when health care professionals were **warm and approachable rather than authoritative**. Human connection was sometimes established through openness about shared lived experiences.

"Midwives who shared personal experiences really helped me feel more relaxed. Open honesty and care are as important as being 'professional'."

"The midwife that really helped me talked about her own issues, and it helped to know I wasn't alone and helped me open up."

"Stop making it so formal and scary."

Listening skills were identified as essential. Listening in itself could be a therapeutic intervention, but was sadly often lacking in health care, with many participants feeling unheard.

"Have time to listen. I previously worked in mental health and in palliative care… and having time and inclination to actively listen is the biggest difference between NHS acute ward and specialist care settings such as hospice."

"For someone to listen and offer help. To just sit and say, 'You've had a really rough time. Tell me about it.'…I never got to share my birth story and no one else seems to care, even though it was one of the hardest, scariest and biggest moments in my life."

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Similarly, good **communication from health care professionals was a priority** for participants. Poor communication was frequently a factor in traumatic birth stories.

"Communication was very poor. Several times I became aware that what I'd agreed to had risks I wasn't aware of, or an intervention I agreed to went very differently to how it was described."

"My baby was resuscitated at birth and taken straight to NICU. This wasn't explained well to us, which left me with intrusive thoughts and dreams about the experience."

Subsequently, participants felt that health care professionals needed **better training in interpersonal skills** such as listening and communication. Specific training and support are also needed to enable health care professionals to effectively talk to parents about mental health.

"Have better training on recognising symptoms and leading personalised care sensitive conversations."

"Ensure they are properly trained to have those conversations, so women feel heard and not judged or silly or like we're time wasting."

"I feel more staff need trauma informed training and to be aware of how comments which are not trauma-informed (although potentially well meaning) have a long lasted negative effect."

photo credit: Stewart Williams

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Narratives around "hiding" or "underplaying" symptoms obscure a complex picture

In many cases, participant responses challenged the existing narrative that 70% of women are 'hiding or underplaying' their symptoms when speaking to health care professionals. Many participants described **honestly and clearly asking for help, only to be dismissed**.

"I was consistently ignored when asking for help or told that I just needed to have confidence in myself. I actually was very confident in myself, but I also knew I needed help."

"I became depressed and anxious, having previously been in good mental health. I sought help from both GP and midwife and felt very much dismissed, which further exacerbated my feelings of anxiety and isolation."

"When I eventually did go to the GP for help, they said I wear make-up and I made it to the appointment so I'm fine, and because of that I felt stupid and never asked for help again."

Racial bias and a lack of cultural awareness among health care professionals made it more difficult for some parents racialised as Black or Brown to share that they were struggling with their mental health. When they did ask for help, it was more difficult for them to be heard.

"Feelings of being judged as a south Asian mother. Some unhelpful comments by my midwife made uncomfortable to share how I feel."

"I'm not British, and there is also an added stress of having a different culture and therefore different approach to raising kids. Not hugely, but enough that some of the advice feels unfamiliar or unhelpful, and that difference makes it uncomfortable to talk."

"Being Black and health professionals not seeing me as someone who needed help or support because I was 'strong and resilient'."

Participant responses presented **a tension between normalising** of difficult feelings and experiences as a helpful reframing and **a way to combat stigma**, versus normalising as a **means to dismiss** perinatal mental health symptoms when someone is asking for help. Participants called for the former, but equally, responses indicated that sometimes health care professionals intend to do the former and inadvertently do the latter.

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"Show that mental health issues are normal and it's not you being abnormal."

"[It would have made my experience better if there was] more support around mental health - especially just talking and letting me know it's normal and I'm not alone."

"Stop brushing things off as 'normal'. I was constantly told it was normal to feel scared or to be experiencing different things without any support, compassion or help or advice, which made me feel dismissed and silly for worrying."

"I think sometimes they say things like, 'I've seen a lot worse this week' coming from a good place – but instead of comforting, it invalidates and shuts us down. We want to hear that we've done a hard thing and been through a hard thing. Just that acknowledgement will release some tension, de-stigmatise what we're feeling, and help us make an informed decision about whether to seek help or not."

Where participants had not been able to disclose that they were struggling with their mental health, they identified several barriers which had prevented them from doing so. Many were **not informed enough to recognise** that they were experiencing symptoms of a mental health problem.

"I also didn't really understand what was happening to me and I thought this is what motherhood must be like."

"I thought what I was experiencing at the time was normal. I had no one to tell me otherwise."

Mental health stigma was a powerful deterrent to seeking help. Participants expressed **fear of being judged** for struggling with their mental health, and **feelings of shame and failure** around that.

"I was scared of being judged as I had just given birth to the most beautiful son, so why should I feel depressed?"

"I felt a lot of shame around feeling depressed and struggling after having my baby."

"There needs to be a way to reach mums that will not make them feel ashamed or feel like they will be judged for struggling. There is still so much stigma."

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"Despite the work being done, there is still a stigma."

Many participants **feared that admitting they were struggling would lead to social services' involvement** and their child(ren) being removed from their care.

"I was too scared to reach out as I thought they would take my baby away."

"Staff need to expressly acknowledge that fear of judgement of being a 'bad' mum or that your baby may be taken away from you is a reason why women struggle to confide."

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Perinatal mental health care needs to be holistic

When asked about any 'mental wellbeing problems' both before and during the perinatal period, respondents were as likely to cite relationship issues and/or domestic abuse, difficulties with work, money or housing, or bereavement as any symptoms or diagnoses of mental illness. This illustrates that mental wellbeing is not experienced as separate from social, emotional, or physical wellbeing, and there are numerous factors which directly influence perinatal mental health.

Feeding difficulties were cited as directly affecting mental wellbeing. Some participants described experiences of being unable to access feeding support that they and their babies desperately needed, while others felt pressured into breastfeeding at all costs. Participants felt that accessible, high-quality information and support around feeding would have improved their mental health.

"Struggling with breastfeeding had a big impact on my mental health… I don't think anyone, once the midwives had finished visiting at ten days old, gave me any help."

"Breastfeeding knowledge and support in hospital and community is really lacking, and this can have a significant impact on mental health and bonding with baby, etc. There should be dedicated, knowledgeable support in hospital, which is given routinely whether there are issues or not, and there should be better follow-up support after."

"The push for breastfeeding made me feel like a failure when it didn't work out, so I would have liked to know about alternatives before giving birth and for it to be explained more clearly that sometimes breastfeeding just doesn't work."

"I also think my midwife, visiting me at home on day three or four after birth, pushed me into breastfeeding, not taking into consideration my very unstable demeanour."

Participants also believed that **sleep deprivation was a major contributor** to perinatal mental health issues, and they felt that their mental health would have improved if someone had intervened to enable them to get more sleep.

"I had no sleep, not even ten minutes, for two days in labour, then two nights in hospital. It would help to have someone take baby for a while so I could rest when beyond exhaustion in hospital."

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"Even though we had told the ward about prior postnatal depression and negative experiences in hospital, and that sleep deprivation was a trigger for me, I still had to fit in with the ward timings of having to wake up at 5 am to take baby down to NICU for intravenous antibiotics."

"If I'd had more sleep, I think my mental state would have been a lot better."

Practical help with tasks such as shopping, cooking, cleaning, and caring for older children was another intervention that participants felt made, or would have made, a significant difference to their mental health and their bond with their baby.

"Family and friends helped me with practical activities and encouraged me to spend time with my baby instead. It meant I didn't worry about the jobs to do and had prolonged periods of time with my baby and people I trusted to talk about it."

"It would have helped to have practical support so that I have time to rest and just be with my baby."

"I don't think NHS Talking Therapies are suitable for perinatal mums who are burned out rather than depressed. Perhaps practical support where you can go somewhere and just have a cup of tea when somebody else is looking after your baby. Or someone who could come to your house to look after the kids so that you can have a shower."

Financial difficulties were another major contributor to perinatal mental health issues, and participants felt that help with this would improve both perinatal mental health and maternal bonding.

"Even simple things like decent maternity leave would go a long way in giving time for mother and baby to bond and flourish without the burden of financial difficulty and pressure."

"Financial support is a big one: something to help families if a mum needs to go to the mum and baby unit. Or to support dads being able to stay home longer on paternity leave to support a struggling mum."

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Participants also **called for help with navigating health care services**. Ironically, mental health symptoms can be a barrier in themselves when someone is trying to find and access support, especially when they are trying to care for a baby at the same time. Participants described feeling overwhelmed, lacking the time and capacity, and not knowing where to start.

"Being depressed makes it hard to do anything, let alone find the energy and motivation to seek help. Plus, with a newborn as a first-time mom and you're exhausted and overwhelmed..."

"People being signposted to the correct support at the right time and not falling through the gaps. Helping people to get to where they need to be and appreciating that they may not feel able to seek support easily themselves if they lack motivation. Help with referrals and chase them up and advocate for them on their behalf."

"More compassionate, less judgemental health professionals… with a better variety of services and a good knowledge of other things in the area that I could have accessed to help me rather than me having to find things for myself when I was really poorly."

Finally, **peer support was felt to be desperately needed**. Many participants described being socially isolated. Even among those who had a support network, there was a need to speak with others who were living through similar experiences.

"Motherhood is supposed to be natural but, in a world where we have less community, it is extremely lonely."

"Being immigrant from Finland, most of my support network is back there. I felt that I wasn't supported and there weren't groups or support networks for people like me. I felt left out, scared and lonely."

"Women are isolated, so a peer support group from the beginning so important, so that pregnant women would have the opportunity to go for park walks or visits, have a cup of tea, etc, and chat with fellow pregnant women, with no government official involved, no one taking notes, just human beings being human beings."

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"Talking to people who understand would have helped. No one tells you how hard it is and how lonely you'll feel."

"Some of my pregnancies ended in loss. Some of my pregnancies resulted in my baby in intensive care and in hospital for a week. One of my babies went on to have physical issues identified at the six-week check at the GP surgery. In all the circumstances, I felt alone as no one I knew had been though any of these situations."

As such, good perinatal mental health care is about more than treating symptoms of a mental illness. It needs to transcend a medical approach to address a range of issues that the mother, baby, and whole family might be experiencing.

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Care and support must be personalised to individual circumstances

As illustrated above, perinatal mental health challenges are multifaceted, and every set of circumstances is unique. Therefore, **effective care is tailored to the individual**.

"The charity that worked with me with my first baby and the community interest company with my second: both offered such a personalised and tailored approach, it made me feel welcome and safe and able to share."

"Treat women as the individuals that they are."

There are **some circumstances in which the usual approaches to perinatal mental health may not be appropriate**. Participants to whom such circumstances applied highlighted how their care needed to be adapted and personalised. For example, participants whose **babies had been admitted to a neonatal unit** described their specific mental health needs in the wake of what was sometimes a deeply traumatic experience.

"Support for NICU parents, even just some validation of my experience or what to expect. We were completely in the dark about everything, and no one stopped to help us or advise us or check we were okay."

"There was a real lack of support for me and my mental health while I was in NICU with my child. I was eventually referred to psychological services, but this seemed to be more about improving communication between me and the consultants looking after my baby."

"While staying in the NICU, ward their mental health team came and had a chat with me which allowed me to just open up and express how I was feeling with no judgement, but they understood what I was feeling."

Participants **called for a more proactive approach to mental health during and after a neonatal admission**. The same was true of participants who had experienced **miscarriage or baby loss**. These participants often felt that no one quite knew what to do with them, since they were experiencing perinatal mental health difficulties without a baby present. The results were often inappropriate and insensitive, such as placing a recently bereaved mother where she would be surrounded by other people's babies. **Participants who became pregnant after a loss were particularly** vulnerable to perinatal mental health difficulties during that subsequent pregnancy, but many did not receive additional monitoring and support.

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"Signpost and offer support for baby loss in the first place. There was zero bereavement support available when we lost our baby (2022), which meant that I suffered severe postnatal issues following the birth of our daughter a year later. Encourage midwives to ask about previous losses and do more regular check-ins following the next pregnancy."

"I was admitted into the labour ward for my inpatient care as the psychiatric ward wouldn't have been the right place following my baby's death, but the mother and baby home wasn't right either. This was difficult as it was where I lost my daughter, but it was the only place where the right care could be given."

"Being put into a room full of newborn babies on the labour ward after my baby died. We should all be split up. It's not fair."

Participants who were neurodivergent, with **conditions such as autism and ADHD**, described how this had played into their perinatal mental health difficulties. They felt that conventional treatment approaches that did not factor this in were not effective, and yet there was no support available that would meet their needs. In some cases, this was further complicated by their not knowing that they were neurodivergent at the time: late diagnosis is more common in women and girls, **due to a lack of recognition that challenges present differently than in men and boys**.

"I have ADHD and autism, which I didn't realise until after I had my daughter. So, I thought I was depressed and anxious, but it was unmet needs for these disorders."

"More personalised approach. For example, I have ADHD, this definitely played into it."

"There has also been zero support available for new parents with autism or ADHD."

Finally, participants highlighted the **lack of support available for fathers and partners**. For some families, it was the father as well as or instead of the mother who was struggling. Respondents in this situation found it particularly difficult to access appropriate support.

"No support for men at all from pregnancy to raising children. Very isolating. Told this is all very normal but no practical support provided."

"My husband displayed symptoms of PTSD and trauma himself but did not seek help and put on a brave face to support me."

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Key Findings: VCSE

(Voluntary, Community, and Social Enterprise)

Findings

Fifty-six respondents completed at least one survey question. A final question gave respondents the opportunity to enter the name of their organisation if they wished to be entered into a thank-you draw. Because providing the organisation name was optional and only 16 respondents chose to do so, we cannot confirm whether multiple responses came from the same organisation. Consequently, these findings should be interpreted with appropriate consideration.

Organisation characteristics

We asked: "What area does your organisation cover?" Nearly 20% (n=11) covered Bristol, North Somerset or South Gloucestershire, the area covered by Mothers for Mothers. Although there was representation from other parts of the UK, and even two whose area covers outside the UK, 55.4% covered England, outside the area covered by Mothers for Mothers (Table 14). In order to understand the size of the organisation, we also asked their annual turnover and the number of employees. The annual turnover ranged from under £50,000 (n=15, 30%) to over £1 million (n=1, 2%) and employee numbers ranged from 1 to 29. Volunteers form a significant proportion of the workforce in this sector. Five respondents did not have any volunteers in their workforce. The remaining responders had varying numbers, with two responders having over 200 volunteers working with them.

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Table 14: Locations covered by organisations responding to our survey.

	no. of organisation representatives completing survey	
Bristol, North Somerset or South Gloucestershire	11	19.6%
England (outside Bristol, North Somerset or South Gloucestershire)	31	55.4%
Scotland	1	1.8%
Nationwide	8	14.3%
International	2	3.6%
I would rather not say	3	5.4%
Total	56	100.0%

Table 15: Responses to the question: "Please tell us your annual turnover".

	no. of organisation representatives completing the question	
Under £50,000	15	30%
£50,000 to £100,000	9	18%
£100,000 to £250,000	3	6%
£250,000 to £500,000	5	10%
£500,000 to £1,000,000	7	14%
Over £1,000,000	1	2%
I don't know	10	20%
Total	50	100%

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We asked respondents to tell us who funds their organisation. Thirty-three people selected at least one option provided. The majority of respondents (n=24, 72.7%) indicated that their organisation received funding from “Grants and Trusts”, while 60.6% (n=20) selected “Community Fundraising/donations”. “Corporate fundraising/donations” was a funding source for twelve (36.4%), while the NHS or Integrated Care Boards (ICB)s and Local Authorities provided funding for a third of respondents’ organisations. Other funding sources were, “Paid for services” (n=6, 18.2%), “Subcontracting from other voluntary organisations” (n=1, 3.0%) and unspecified “Others” (n=1, 3.0%) (Table 16).

Table 16: Responses to the question: "Please tell us who funds your organisation". Respondents could select more than one answer.

	no. of organisation representatives completing the question	
NHS/ICB	11	33.3%
Local Authority	11	33.3%
Grants and Trusts	24	72.7%
Community Fundraising / donations	20	60.6%
Corporate fundraising /donations	12	36.4%
Paid for services	6	18.2%
Subcontracting from other vol. organisations	1	3.0%
Others (unspecified)	1	3.0%
Number who selected at least one option	33	

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The services provided by organisations varied, as can be seen in Table 17. Twenty-nine respondents selected at least one option in answer to the question “Please tell us about the type(s) of support you provide”.

Table 17: Responses to the question: “Please tell us about the type(s) of service you provide."

	no. of organisation representatives completing the question	
Peer support groups	17	58.6%
Peer support 1:1, mentoring or befriending	16	55.2%
Antenatal support	16	55.2%
Helpline or telephone support	16	55.2%
Online support	18	62.1%
Therapy or counselling	11	37.9%
Signposting	25	86.2%
Infant Mental Health / parent-infant work	12	41.4%
Other (2=advocacy, 1=SEND, 1=unspecified)	4	13.8%
Number who selected at least one option	29	

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We asked if their organisation had a waiting list, and if so, how long the waiting time usually was. It is reassuring to see that, of the 27 respondents who answered this question, 16 (59%) had no waiting lists (Figure 11). Just over a quarter (n=7) had an average waiting time of usually less than six weeks, while another four (15%) said their waiting time was usually 6-12 weeks.

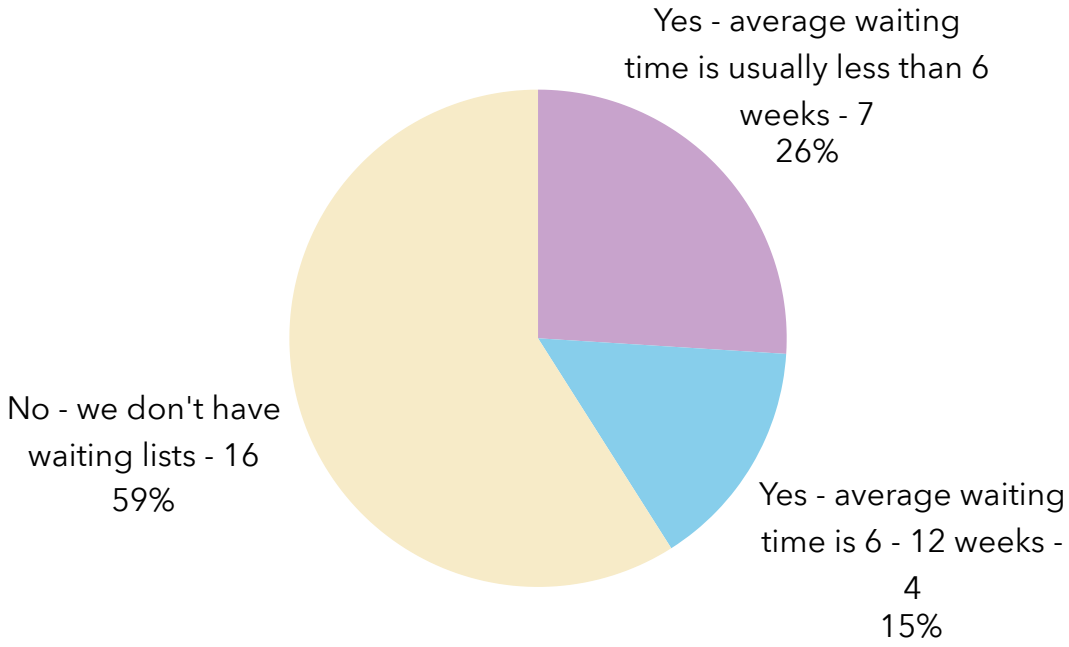

Figure 11: Responses to the question: "Do you have waiting lists for your services?"

This shows that the waiting times in the VSCE sector are much shorter than those in the NHS agencies, making the contribution of VSCE invaluable for people who are on the NHS waiting lists and are unable to afford private care

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Table 18: Q: If you work with a specific groups or communities of parents, please could you tell us who your services are for. Please tick all that apply:

	no. of organisation representatives completing the question	
Fathers and partners	14	51.9%
Families affected by disabilities or special needs	6	22.2%
Pregnant and expectant families	21	77.8%
Families from a specific ethnic or racialised community	12	44.4%
Younger parents	10	37.0%
Neurodivergent parents	10	37.0%
Families affected by pregnancy or baby loss	10	37.0%
Others (incl. those with other social issues, friends and professionals)	5	18.5%
Number who selected at least one option	27	

The respondents provided support for a range of perinatal mental wellbeing issues ranging from mild to moderate anxiety and depression (84.6% and 80.8% respectively) to postpartum psychosis support provided by over a third of respondents (Table 19). This support is invaluable when the NHS services are stretched beyond capacity as discussed in the focus groups.

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Table 19: Perinatal mental issues for which respondents' organisations provided support. Q: Please tell us about the perinatal mental issues for which you provide support. This can be where you are the only source of support, or where you are providing support alongside other statutory services. Please select all that apply:

	no. of organisation representatives completing the question	
Post Partum Psychosis	10	39%
Chronic or long-lasting mental illness	13	50%
Post Traumatic Stress Disorder and Complex Trauma	14	54%
Birth Trauma	18	69%
Maternal OCD	15	58%
Tokophobia	6	23%
Mild To Moderate Anxiety	22	85%
Mild to Moderate Depression	21	81%
Severe anxiety or depression	14	54%
Adjustment Disorders	7	27%
The Blues and The Pinks	9	35%
Loneliness and Isolation	22	85%
Other (incl.problems related to child removal and other social issues)	2	8%
Number who selected at least one option	26	

The lived experience survey respondents reported that in over two-thirds of cases, additional conditions had a detrimental effect on their mental wellbeing. We asked VCSE survey respondents about the other challenges and complexities faced by the women and birthing people who access their services.

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A very high proportion of respondents said that their clients experienced a variety of other challenges, including difficulty in accessing services (n = 24, 92.3%), economic deprivation, debt or benefit problems (n = 23, 88.5%) and violence, emotional or sexual abuse (n = 22, 84.6%).

Table 20: Q: Please tell us about the other challenges and complexities that women accessing your services face. Please select all that apply:

	no. of organisation representatives completing the question	
Violence/Emotional/ Sexual Abuse	22	84.6%
Economic deprivation/Debt/Benefit problems	23	88.5%
Uncertain/Unsafe housing	17	65.4%
Exploitation	11	42.3%
Uncertain Status/Leave to Remain	14	53.8%
Physical Health Needs	17	65.4%
Physical disabilities	11	42.3%
Fear/Lack of Safety within Community	14	53.8%
Difficulty Accessing Services	24	92.3%
Drug and Alcohol use	14	53.8%
Child removal	15	57.7%
Bereavement	18	69.2%
Discrimination	15	57.7%
Other (incl. criminal justice involvement)	3	11.5%
Number who selected at least one option	26	

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We asked respondents to estimate the percentage of women who are accessing specialist perinatal mental health services alongside accessing their services. Responses shown in Table 21 show that a large proportion of women seen in VCSE did not access specialist perinatal mental health services.

Table 21: Estimated percentages of women accessing specialist perinatal mental health services in addition to respondents' organisation support.

	no. of organisation representatives completing the question	
under 10%	3	13%
10-19%	3	13%
20-29%	5	21.70%
30-39%	3	13%
40-49%	2	8.70%
50-59%	1	4.30%
60-69%	0	0%
70-79%	1	4.30%
80-89%	1	4.30%
90-100%	1	4.30%
Unsure	3	13%
Total	23	100%

We then asked them to estimate the percentage of women for whom they were the only source of perinatal mental health or emotional wellbeing support. Worryingly, nearly three quarters (n=17, 73.8%) estimated that they were the only source of perinatal mental health support for over half of their service users.

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Table 22: Estimated percentages of women where organisation was the only source of perinatal mental health support.

	no. of organisation representatives completing the question	
30-39%	1	4.30%
40-49%	3	13%
50-59%	3	13%
60-69%	4	17.40%
70-79%	3	13%
80-89%	2	8.70%
90-100%	5	21.70%
Unsure	2	8.70%
Total	23	100%

As detailed above, the VCSE sector provides support to a large proportion of women and birthing people. It is important that they are adequately resourced to provide these services. We asked if it has been necessary for the respondents to close their services to new referrals over the last 12 months. A third of the organisations had faced closures to new referrals.

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Table 23: Responses to the question: Over the last 12 months, has it been necessary for you to close your services to new referrals, at any point or for any period of time?

	no. of organisation representatives completing the question	
Yes	8	33.30%
No	16	66.70%
Total	24	100%

We asked respondents to tell us how many members of staff and volunteers their organisation had.

Table 24: Number of staff employed by organisation.

	no. of organisation representatives completing the question	
No staff	1	3.30%
1 to 2	4	13.30%
3 to 5	6	20%
6 to 9	10	33.30%
10 to 19	5	16.70%
20 to 29	4	13.30%
Total	30	100%

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Table 25: Number of volunteers engaged by organisation.

	no. of organisation representatives completing the question	
None	5	16.70%
1 to 9	6	20%
10 to 19	5	16.70%
20 to 29	4	13.30%
30 to 39	2	6.70%
40 to 99	2	6.70%
100 to 199	4	13.30%
200+	2	6.70%
Total	30	100%

And finally, we asked respondents to estimate how many families they support each year. **The total number of families supported by the 27 respondents who answered this question was 22,899**. The ranges are presented in Table 26.

Table 26: Estimated number of families supported by the organisation every year.

	no. of organisation representatives completing the question	
None	1	3.70%
Up to 50	3	11.10%
50-99	1	3.70%
100-199	4	14.80%
200-499	8	29.60%
500-999	5	18.50%
1000-1999	3	11.10%
2000+	2	7.40%
Total	27	100%

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Themes: VCSE
(Voluntary, Community, and Social Enterprise)

Services are under-resourced

Respondents to the VCSE survey described the **same difficulties with limited capacity in statutory care** as respondents to the lived experience survey and focus group attendees. This manifests in **long waiting lists, high clinical thresholds**, and a **lack of early intervention and follow-up**.

"Maternal mental health services (which deal with birth trauma and perinatal loss) in England are very over-stretched, so there are long waiting lists. We also hear of women being turned down by maternal mental health services or NHS Talking Therapies either for being too mentally unwell or not unwell enough."

"You have to be really ill in order to qualify for NHS treatment."

"Many women are discharged from maternity services with no mental health follow-up, even when they've flagged difficulties. There's a lack of structured postnatal mental health check-ins, which means many deteriorate without support."

Additionally, respondents outlined the **funding issues for VCSE services** supporting perinatal families. They understood the **time-sensitive nature of perinatal care**, and they employ a variety of strategies to limit the waiting times for their own services.

"We recognise that timing is key in the perinatal period, so we make our offer flexible, adding and taking away counselling sessions depending on demand. This keeps our waiting list at around three to four weeks, frequently less."

"In order to manage our waiting lists for art psychotherapy, counselling and home visiting, we triage weekly and periodically shut the waiting lists."

"Peaks and troughs throughout the year but one of our key aims is to offer very short wait times for families."

They described an increasingly challenging landscape, with **ever-increasing demand but no additional resources**. The closure of children's centres was cited as one reason for more families needing support from VCSE services. As urgent, frontline work is prioritised, it becomes more and more difficult for services to cover core costs and to operate strategically.

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"Increasing demand and women living with increasing complexities or challenges has been on an upward trajectory for the last five years without the equivalent increase in funding. This makes it difficult to keep services open and to function in a strategic way: planning for the future, maintaining and developing a skilled staff and volunteer team, and it stifles the ability to innovate with new interventions."

"Higher demand and lack of funds currently. We have had to reduce the service for twelve months, and by closing one venue, it has meant we can increase the other services. This is connected to children's centre closures."

"The need for culturally competent perinatal mental health support within our community has grown significantly. We are consistently working at full capacity and often have a waiting list, which is distressing given the urgency of many cases."

VCSE services are particularly **hindered by short-term funding contracts**, creating instability and inconsistency for families accessing services, which are always under threat of closure. Organisations are required to use their limited resources on seeking new sources of funding and writing applications rather than supporting families directly.

"Despite the clear impact and success of our work, long-term funding remains uncertain. Our model relies heavily on charitable donations, which creates financial instability and limits our ability to expand or plan ahead."

"We are really struggling with twelve-month funded contracts! We need three years minimum for everyone to lean in… and staff and volunteers to not have to start looking for jobs every year at Christmas because we don't have confirmation of funding."

"We really need a reliable funding stream so that we can make sure services, such as a phone line, are guaranteed funding, and we also find that recruiting and managing volunteers is costly and time-consuming. So, a reliable source of funding is the biggest thing."

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There are groups for whom appropriate perinatal mental health care is not available

Just as respondents to the lived experience survey and focus group attendees emphasised the **absence of personalised care for families in certain circumstances**, VCSE survey respondents also named under-served groups for whom the usual approaches to perinatal mental health may not be appropriate or accessible. The groups or circumstances identified overlapped with, but were not identical to, those named by lived experience participants.

Families who were experiencing **involvement with social services and those who had had a child removed** from their care were named as one of the most under-served populations.

"There is no perinatal mental health support for women who experience child removal at birth. These women are not treated as mothers, which increases the risk of removal becoming permanent."

"Significant gaps linked to support during involvement with children's social care, including after removal."

VCSE survey respondents also identified a **lack of support for families experiencing miscarriage and baby loss**.

"We have also heard of women whose baby was stillborn being denied help because there was no bereavement service."

"No formal psychological support is offered to pregnancy or baby loss parents through NHS. This needs to change."

Fathers and partners are affected by a lack of support provision, with a knock-on effect for mothers and babies when they were struggling. Additionally, the limits on paternity leave and compassionate leave dictated by employers can alienate fathers from the family unit and prevent them from accessing support.

"Fathers and wider family members are deeply affected by perinatal struggles, yet there are no dedicated support channels for them. This can increase household stress and worsen maternal mental health."

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"[One gap in the support available is] fathers not being able to take time off for appointments (including befriending calls or visits) and the limitations of two weeks paternity leave."

VCSE respondents emphasised the **lack of culturally appropriate support** for families from certain ethnic or religious backgrounds, and the **lack of support for families for whom English is not their first language**.

"Many families in our community struggle to access other services due to a lack of cultural and religious sensitivity. Mainstream perinatal mental health services often don't reflect the values, lifestyle, or specific needs of culturally observant families. This can lead to a sense of mistrust or fear of being misunderstood or judged. Women may be reluctant to engage with professionals who don't understand the importance of modesty, family roles, or the community's unique pressures around motherhood. Without providers who 'speak their language' — literally and culturally — families are less likely to seek help or fully engage with support... This mismatch leaves many vulnerable women without access to appropriate care during one of the most critical times in their lives."

"There needs to be better psychological support for families when English isn't their first language. I find sometimes it's easy for people to not be supported, as its harder for professionals to make time for translators if interpreting needs to be done with someone who understands perinatal mental health."

"We would also like to reach more families from racially marginalised backgrounds than we do at present."

"We are struggling to meet the diverse equity, diversity and inclusion needs of families from across the city."

Various other groups were mentioned, including (but not limited to):

- Homeless parents, van dwellers, and the travelling community,
- Young parents,
- Parents affected by hyperemesis gravidarum (extreme pregnancy sickness),
- Parents living in Scotland, Wales and Northern Ireland, where provision is sparser.

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Families need to be actively supported to engage with services

Again, VCSE survey findings echoed responses from lived experience participants in stressing **the importance of holistic support**. This was considered vital to facilitate access to healthcare and support services.

"We are currently supporting a woman in a homeless hostel who has no other support."

Respondents understood the **challenges of navigating healthcare services while mentally unwell and caring for a baby**. Supporting and helping parents with this process featured as a part of daily work for many VCSE organisations.

"There should be better options for continued care rather than just being signposted and the emphasis on the new parent, who is sleep deprived and worrying about their baby or if they're doing a good job, to follow up and re-refer if they don't get a response from the much-needed support."

"The nature of perinatal mood disorders — exhaustion, hopelessness, low motivation — can make it incredibly hard for women to take the first step, even when they know help is available."

"We often need to advocate for our clients within NHS systems — navigating Multi-Agency Safeguarding Hub referrals, safeguarding concerns, or seeking urgent assessments — because families are unclear on how to access help or face long delays."

Families also **struggle with transport** in terms of reaching both VCSE and statutory services. Barriers include cost, limited car parking, and poor provision of buses and trains. [6].

"[Families might find it difficult to access our services due to an] inability to travel to one of our groups, as we cover a very wide geographical location."

"Groups are too far away to get to."

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[6] Transport and Maternal Mental Health, Summary Report Published by the Mental Health Foundation: https://www.mentalhealth.org.uk/sites/default/files/2023-11/Transport%20and%20maternal%20mental%20health%20report%20-%20Mental%20Health%20Foundation.pdf

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There is still a stigma attached to perinatal mental health difficulties

VCSE respondents also described **stigma as a deterrent and a barrier to support** for families affected by perinatal mental health difficulties.

"They think they're going crazy, and that they're the only one suffering and feeling guilty and shameful about this, and they don't realise that it's okay to not be okay."

"Many women in our community are hesitant to reach out due to fear of judgment or shame. They worry about how seeking help might affect their reputation, relationships, or standing in the community."

As described by lived experience participants, this is linked to a pervasive fear of being referred to **children's social care and having their child removed**.

"Some women fear that disclosing their mental health challenges will lead to safeguarding referrals or social services involvement, which can delay or prevent them from accessing help."

"[Families are] worried about their child being taken away or someone finding out they are accessing the service."

Stigma was considered to be **particularly prevalent in certain ethnic or faith communities**.

"In some communities, stigma around mental health causes many women to suffer in silence. They often present late or after reaching crisis point. There is a lack of culturally sensitive early intervention pathways that encourage and support women to seek help earlier."

"Cultural stigmas or personal beliefs in some communities might prevent them from seeking support."

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There is a lack of awareness about the support available

VCSE respondents lamented a **lack of awareness about existing support** for families, resulting in many who need that support not receiving it.

"So many of our [telephone helpline] callers have struggled for many months before Googling and finding our service. It's so sad, as once they have some awareness and knowledge that it isn't due to their failings in any way, things can improve quite quickly."

"We advertise in a health visiting magazine and midwife magazine — yet so many families are struggling for months, unaware that there is support out here."

"Despite our efforts, some women and families simply don't know that our organisation exists or that their symptoms warrant support."

"Although we have posters in some hospitals and GP surgeries, our services are not widely known about by the general public."

Health professionals were considered to play an important role in signposting families, but unfortunately, the lack of awareness often applied to them too. It was suggested that healthcare services can be **reluctant to engage** with the VCSE sector or to work collaboratively.

"Several mums said they hadn't been referred by health professionals. GPs especially didn't seem to know about us."

"[There is a] lack of awareness of what support is available, and GPs, midwives and health visitors lack the knowledge or are simply so busy. They fail to pass on relevant support services to any families who would really benefit."

"[We need] better communication and transparency with maternity services to understand how our services could benefit and work alongside each other."

"Many statutory services are not equipped to meet the cultural and religious needs of our client base, which leads to under-referral or inappropriate signposting. Stronger collaboration with local NHS and statutory bodies, with clear and respectful referral routes into our organisation, would ensure more women receive timely, effective, and culturally competent care."

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Respondents felt that **better antenatal education about perinatal mental health and support options would help** families to know what is available and to access support if needed. This was something that lived experience participants called for as well.

"[One gap in the support available is] antenatal education looking at the mental health impact of becoming a parent."

"[There is a] lack of being prepared for birth and just after."

"[Families] don't know where to turn and aren't sure if their symptoms are 'bad enough.' [They are] worried they are wasting people's time. [They] aren't aware of many different symptoms."

Finally, respondents were clear that **awareness is not enough** to ensure that families can access support from VCSE and statutory services. For many families, it is also necessary to **build trust and provide reassurance** so that they feel safe to engage.

"Poor experiences with statutory services lead to mistrust in seeking support from any services."

"[Families might find it difficult to access our services because of] feelings of lack of safety and trust with services."

"Because they don't meet the needs of the women we support, there is fear around accessing other services, especially statutory services where culture and differences are approached as a safeguarding concern rather than as a positive thing."

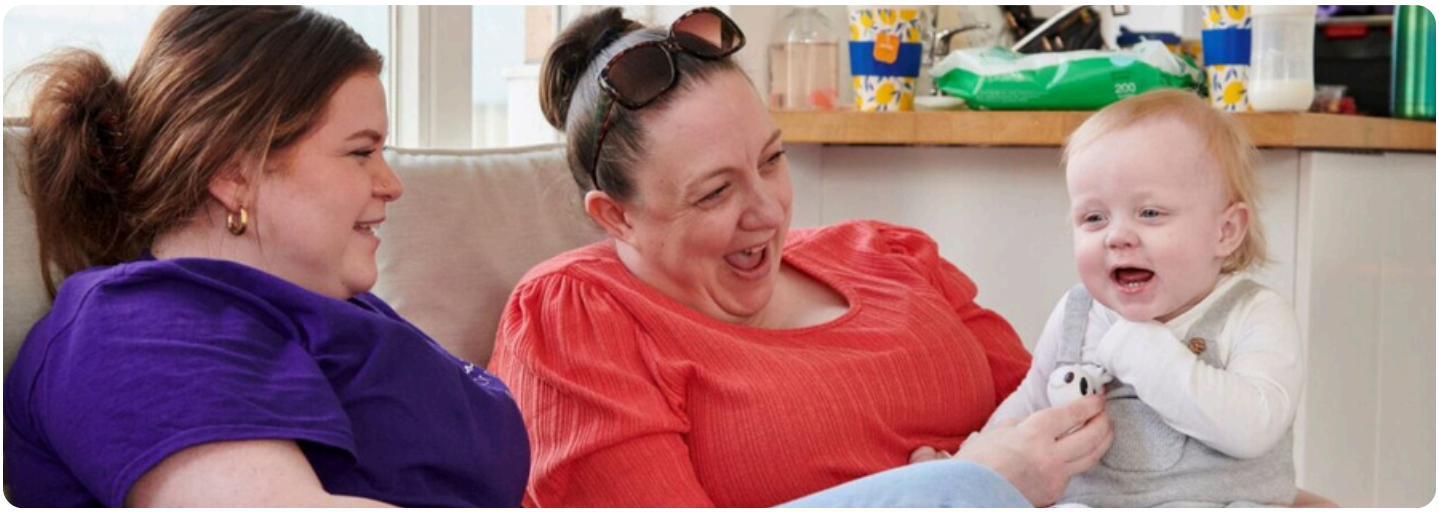

photo credit: Stewart Williams

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Closing Comments

Dr Trudi Seneviratne OBE FRCPsych
Consultant Adult & Perinatal Psychiatrist

Dr Trudi Seneviratne was Registrar of the Royal College of Psychiatrists between 2020 - 2025. In this role she had overall responsibility for policy, public education, revalidation and membership engagement.
She qualified as a medical practitioner in 1992, having trained both at St. Bartholomew's Medical School and later, as a research registrar at the Institute of Psychiatry, Psychology & Neuroscience (IoPPN).

Trudi has been a consultant adult and perinatal psychiatrist at South London & Maudsley NHS Foundation Trust since 2002. She is also the Clinical Director for the Psychological Medicine Clinical Academic Group and Lewisham Directorate at the Trust, supporting the clinical, academic and educational aspects of a range of services: general adult, liaison, crisis, rehabilitation services and specialist services: Neuropsychiatry, Eating disorders, Perinatal.

She has collaborated on a range of activities including service development, the use of mother and infant interaction videos, quality improvement and outcomes research. She is a current member and previous vice-chair of the National Clinical Reference Group, NHS England; Chair of The Perinatal Faculty, Royal College Psychiatrists (2016-2020). In 2019, she was awarded an Order of the British Empire for services to Perinatal Psychiatry and the President's medal of the Royal College of Psychiatrists. In 2023, Trudi was appointed to an expert Advisory Group that supports The Princess of Wales' work with the Royal Foundation Centre of Early Childhood.

Perinatal mental health matters. We know that looking after the mental health of women and birthing people through pregnancy, childbirth and the postnatal period is critical, not only for their own well-being but also to that of the developing baby, child, partner and their family. We have come a long way in advancing our understanding of perinatal mental health over the last few decades, in terms of possible causation, detection and potential treatments. And we also know that left untreated, perinatal mental health difficulties can have a devastating impact on all concerned both in the short and longer term.

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As a society, we want to nurture childbearing and continue preventing these issues from occurring in the first place. This is challenging given the complex environments in which children are born. Factors such as existing or new mental health and psychological issues, physical health complications, pregnancy loss or separation, the support from family and professionals, as well as challenges such as poverty, isolation, discrimination and geopolitical issues, may all significantly impact on an individual's mental well-being at this time. Rates of suffering are extremely high. One in four women in the UK suffer from some sort of perinatal mental health difficulty, with rates even higher in areas of deprivation. This must change as we move forwards.

In the UK, we have witnessed an extraordinary development of perinatal mental health care pathways across statutory and VCSE communities and increasing numbers of women and birthing people are able to access these. However, we also know that there are many thousands who continue to struggle during the perinatal period and that this continues to have devastating impacts for them, their children and their families. We also know that if help is not sought, available or received, that the impacts may last a lifetime.

I am delighted you have read this important report 'This is Our Truth. A Grassroots Call to Reimagine Perinatal Mental Health Care', which has been written by Mothers for Mothers, a grassroots charity that started in 1981, with the vision to create a women-led peer support service for those struggling with their mental health during pregnancy and beyond.

Through the use of focus groups and surveys, this report captures the voices of women and birthing people, alongside remarkable insights from 56 VCSEs offering perinatal mental health and emotional well-being support to over 23,000 families. The results are timely, highlight the stark gaps that still remain, and illuminate just how much more we need to do as a society to ensure that every voice is heard and that we continue to cherish pregnancy, childbirth and ultimately our children.

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Closing Comments

Laura Guckian

Laura Guckian, Mothers for Mothers Ambassador, is a Motherhood Coach with lived transformation experience. From suffering severe maternal mental health challenges, including a psychiatric hospital stay, to becoming one of the UK and Ireland's leading voices in maternal mental health, Laura now supports mothers through her coaching practice, advocacy and storytelling. She is a recognised award winning advocate for Maternal Mental Health and winner of Best British Parenting Podcast for her podcast Momfessions.

The findings in this report reflect what mothers say to me everyday. This is not a story of women failing to speak up, it is a story of systems failing to listen, respond, and provide meaningful support when they do.

Too often, the focus is on the cost of providing maternal mental health support. The more urgent question is this: what is the cost of not providing it? When a mother struggles with her mental health during pregnancy or the early years, the impact does not stop with her. It ripples outward, affecting her children, her partner, family stability, participation in work, communities, public services and the wider economy. These consequences are predictable, cumulative and largely preventable.

This report also makes clear that maternal mental health cannot be supported through medical systems alone. While clinical care is essential, it is not sufficient. Community-based, peer-led and voluntary sector support is not supplementary; for many families, it is the only accessible and trusted form of care. Any serious commitment to improving outcomes must recognise, integrate and sustainably fund this wider ecosystem of support.

Supporting mothers early, consistently and holistically is not just compassionate; it is one of the most effective investments a society can make.

When we fail mothers, the cost is borne by us all.

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Mothers for Mothers Milestones

1981 Bristol MaternityHospital allowed the use of their office for 1 evening per week to use their phone line

1992 Registered as a charity

Groups at Gloucester House, Southmead & Bristol Maternity Hospital

10th anniversary Study Day - 100 people & 10-year report

1994 Part-time Office Administrator employed and first IBM computer and photocopier

1999 Move to the Centre Gate - shared offices with Womankind

2005 Barton Hill Peer Support Group begins

2011 No longer funded for work in BANES

2012 Maria Viner appointed as Chair

2013 Company Limited by Guarantee

Face to Face support in South Gloucestershire

2014 Family Fun Day Fundraiser

2020 Antenatal Support Group begins & North Somerset Face to Face Support

Round table meeting with the Duchess of Cambridge

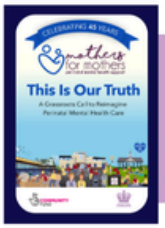
First CEO, NHS contract, and the launch of the REACH service

2021 40th Anniversary & received the Queens Award

Dads and partners online support started

2022 Won the People's Choice Award at the RHS Chelsea Garden Show

mothers for mothers
perinatal mental health support



2026 Report launched in the House of Commons for our 45th Anniversary

First Big Give Matched Fund campaign

Woman & Girls Match Fund
BigGive

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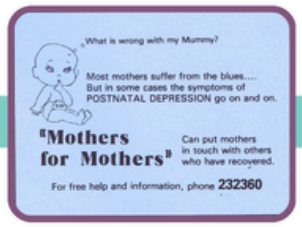
1987 First co-ordinator Annette Lang

Our first office in Barton Hill with a grant from Bristol City Council's Womens Committee

1990 First counselling service



50 Helpline calls per day & Home Visits, including visits to MBU at Barrow Gurney Hospital **1991**

Moved offices to Gloucester Road and bought our first Amstrad computer

Involved in training Avon Health Visitors (Post-Natal Illness)

2000 First website

mothers for mothers
postnatal depression support group

2001 Moved offices to Colston Street

Rachel Langford appointed as a Trustee **2003**

Justine - Finance Manager employed

Bedminster Peer Support Group begins **2002**

2015 Lawrence Weston Peer Support Group begins

2016 35th anniversary celebration at Bristol Zoo

Presented at the Royal College of Obstetricians and Gynaecologists

Maternal Mental Health Alliance Award Winner of the Perinatal Peer Support Award **2018**

Moved to Hartcliffe & start of Art Psychotherapy Service **2017**

2023 Patchway Peer Support Group begins

2024 Moved to The Gatehouse Centre

Tell Us Your Truth Nationwide Survey **2025**

Received the 2024 Bristol Social Impact Award

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CELEBRATING 45 YEARS

reach@ mothers for mothers

perinatal mental health support

ART PSYCHOTHERAPY

COUNSELLING

PEER SUPPORT GROUP

SEND SUPPORT

ANTENATAL

HOME VISITS

HELPLINE
01179 359 366
MON-FRI
10am-9pm

Are you or someone in your family experiencing anxiety, depression, distress or isolation during pregnancy and/or after the birth of your baby? Are you supporting someone who is experiencing this? CONTACT US

support@mothersformothers.co.uk

www.mothersformothers.co.uk

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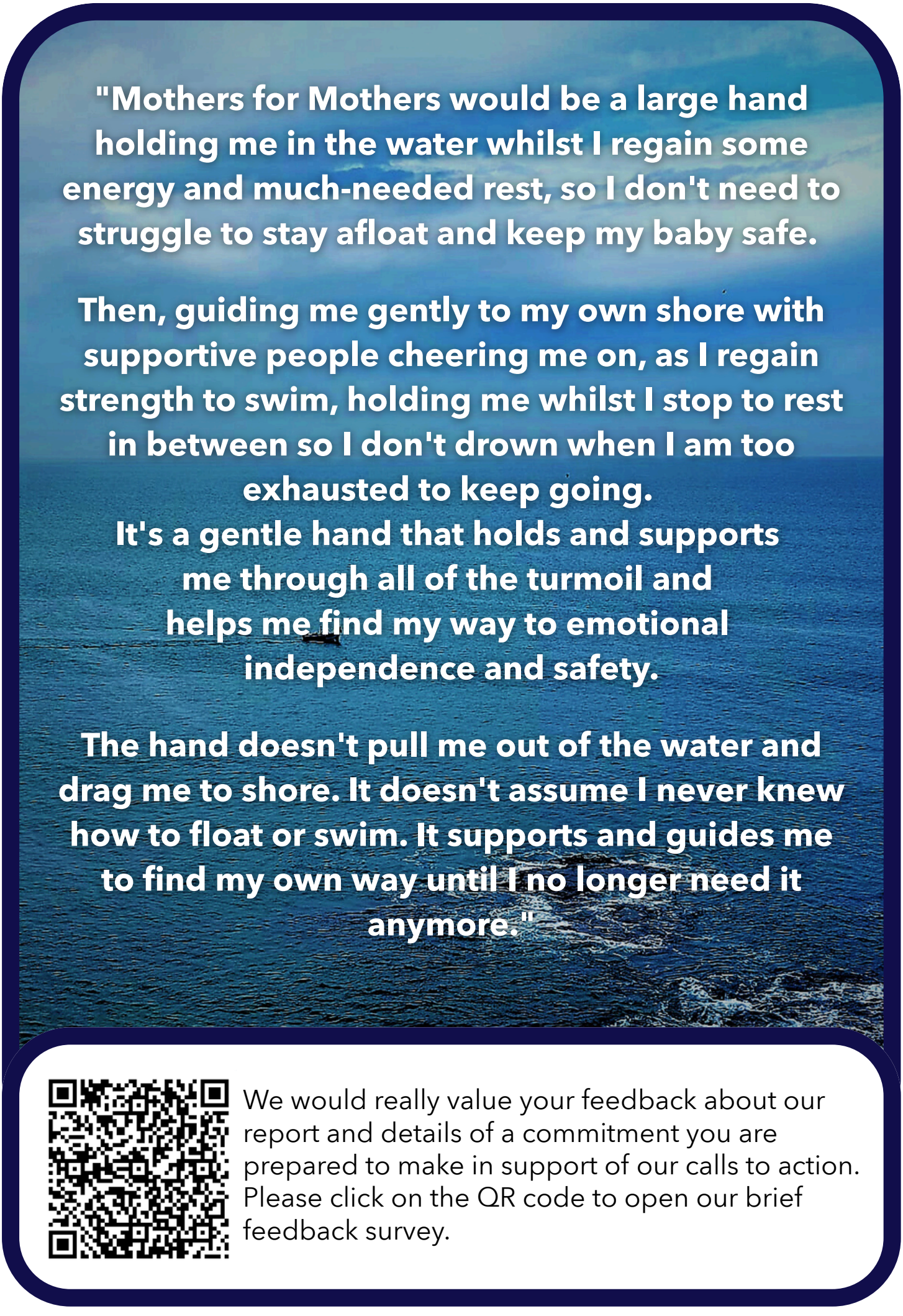

We would really value your feedback about our report and details of a commitment you are prepared to make in support of our calls to action. Please click on the QR code to open our brief feedback survey.

SUPPORTING

FAMILIES SINCE 1981

Charity Commission No: 1185281 Company House: 0876