

MOTHERHOOD AT FRONT OF MIND

A 10-year vision for maternal
mental health in England

Executive summary

As many as one in four¹ – or 150,000² – women in England experience maternal mental illness each year (occurring in the *perinatal* period from pregnancy to the first year after birth).³ Suicide is still a leading cause of maternal death between six weeks to a year after birth.⁴ The ripple effects of maternal mental illness reach far and wide, from children and partners to wider society.^{5,6,7} There is clear evidence that prolonged maternal mental illness can lead to poorer mental and physical health for the child, and worse social and educational outcomes well into adolescence.⁸

Improving maternal mental health care is not just urgent: it is a social imperative. While the establishment of new specialist services in local communities⁹ has led to more women being treated than ever before¹⁰ – which should be celebrated – we cannot rest on our laurels. Women face long delays to access support.⁹ Specialist services are struggling to stay afloat and in some cases are closing altogether,⁹ amounting to an unacceptable “*rationing of care*”.¹¹ For some women, the consequences are fatal.^{12,13,14}

Our call to action is simple: all women experiencing maternal mental illness should have access to timely, high-quality and equitable care. In direct response to the Government’s *10 Year Health Plan*,¹⁵ we are making nine recommendations for policy change over the next decade that we believe can help make this vision a reality.

Join us to put motherhood at front of mind.



Recommendations

Early diagnosis and referral



1 SHORT-TERM
(starting now, completed by 2027)

The Government and the NHS should use their new **10 Year Workforce Plan** to strengthen the workforce across the maternal mental health pathway.

2 MEDIUM-TERM
(starting now, completed by 2030)

The Government and the NHS should proactively monitor women's experiences of key mental health touchpoints in the perinatal period.

3 LONGER-TERM
(starting now, completed by 2035)

The Government and the NHS should explore ways to raise awareness of maternal mental health among healthcare professionals and the public.

Timely and consistent access to care



4 SHORT-TERM
(starting now, completed by 2027)

The Government and the NHS should establish senior national leadership for maternal mental health care.

5 MEDIUM-TERM
(starting now, completed by 2030)

The Government and the NHS should publish clear guidance on what good maternal mental health care should look like.

6 LONGER-TERM
(starting now, completed by 2035)

The Government and the NHS should monitor local performance of specialist maternal mental health services more closely.

Targeted, inclusive and equitable support



7 SHORT-TERM
(starting now, completed by 2027)

The Government and the NHS should renew their focus on addressing inequalities in maternal mental health.

8 MEDIUM-TERM
(starting now, completed by 2030)

The Government and the NHS should improve education on inequalities in maternal mental health for healthcare professionals.

9 LONGER-TERM
(starting now, completed by 2035)

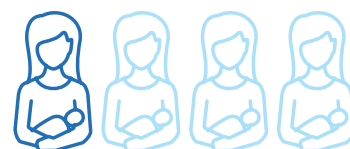
The Government and the NHS should listen to women from disadvantaged or marginalised groups with lived experience of maternal mental illness.

Introduction

What is maternal mental illness?

Having a baby is a significant life event which can cause a range of emotions during pregnancy and beyond, from love and joy to tearfulness and stress.^{16,17} For some women, these emotions are mild and temporary – during the first few weeks after birth, this is often referred to as the ‘*the baby blues*’.¹⁸ For other women, these emotions can be symptomatic of, or develop into, more severe and prolonged mental illness. This can be caused by a range of factors, including but not limited to hormonal changes, traumatic birth, physical illness, familial history and stressful life events.¹⁹

Maternal mental illness – which occurs in the *perinatal* period from pregnancy to the first year after birth³ – is not rare, affecting as many as one in four women.¹ This equates to a possible 150,000 women in England each year.²



Maternal mental illness can have a dramatic impact on the women who experience it. Suicide is the leading cause of maternal death related to pregnancy between six weeks to a year after birth, accounting for 39% of deaths.⁴ Maternal mental illness is often stigmatised, leading to feelings of shame and reluctance to seek help,²⁰ and can have a long-term impact on women’s self-esteem and relationships.²¹

Beyond the direct effects on the mother, maternal mental illness has been linked to wide-ranging consequences for the child, including poorer mental and physical health, and worse social and educational outcomes throughout childhood and adolescence.^{5,8} Partners and other loved ones are also affected through increased stress, burden of caregiving and financial worries.⁶ This all comes at a significant financial cost, with lack of timely access to good-quality care estimated to cost the NHS and social care £1.2 billion per year; the cost to society is even higher at £8.1 billion, with almost £6 billion of this driven by the impact on children.⁷

Language



in this report, we use ‘*maternal mental health*’ to refer to the health and wellbeing of women throughout the perinatal period – during pregnancy and in the first year after having a baby. We use ‘*maternal mental illness*’ as an umbrella term for the range of specific mental health conditions which occur during this period. Only some women experience maternal mental illness, but good maternal mental health is important for all women.

The language we use in this report reflects the importance of women-centred language. Whilst most people seeking support for their maternal mental health are women, we also recognise that services are accessed by gender diverse individuals and people whose gender identity does not align with the sex they were assigned at birth. Inclusive language is an evolving practice, and Biogen is committed to adapting our approach based on best practice and community feedback.

Types of maternal mental health conditions



There are many mental health conditions with varying symptoms and severity which fall under the umbrella of maternal mental illness, including but not limited to:

- **Postnatal depression:** type of depression which develops in the year after giving birth; symptoms can include persistent sadness and low mood, withdrawing from contact with other people and frightening thoughts.²² Postnatal depression affects up to 20% of women²³
- **Perinatal anxiety:** intense worry or fear, often centred on the health and wellbeing of the baby; symptoms can include difficulty relaxing, nausea and panic attacks.¹⁹ Perinatal anxiety affects around 20% of women²⁴
- **Postpartum psychosis:** serious mental illness which should be treated as a medical emergency; symptoms can include hallucinations, delusions, mania and low mood.²⁵ Postpartum psychosis affects around 0.1% of women after giving birth²⁵
- **Perinatal obsessive compulsive disorder (OCD):** anxiety disorder characterised by obsessions and compulsive behaviours; symptoms can include intrusive thoughts about harming the baby and fear of making wrong decisions.²⁶ Perinatal OCD affects between 2% to 3% of women²⁷
- **Postnatal post-traumatic stress disorder (PTSD):** anxiety disorder usually triggered by a traumatic event related to giving birth; symptoms can include vivid flashbacks, intrusive thoughts, nightmares and physical pain.²⁸ Postnatal PTSD affects between 3% to 7% of women²⁹

The case for policy change

Significant progress has been made in recent years by the Government and the NHS to improve access to care and outcomes for women experiencing maternal mental illness in England. Women's health has risen up the national policy agenda with the publication of a dedicated national strategy,³⁰ which the Labour Government has committed to implementing,³¹ and awareness of maternal mental health is growing.³² New specialist services providing dedicated support for women experiencing maternal mental illness have been set up in every area across England⁹ and record numbers of women are receiving care.¹⁰ The UK has been identified as a leading European nation in maternal mental health by having dedicated policies and services, compared with many other countries where specialist care is still in its infancy, such as Spain and France.³³

However, thousands of women are still falling through the cracks and are waiting months to receive specialist support, because there is significant variation in access to care across the country and services are struggling to keep up with demand.⁹

In 2022, an estimated 18,953 women in England who sought help from the NHS were denied care altogether.¹¹ For some women, the consequences have been fatal.^{12,13,14} **Urgent policy intervention is needed to help women access potentially life-saving care, set children up for the best possible start in life, and reduce the burden of unrecognised and untreated maternal mental illness.**

Now is the time for decisive policy action and to think differently as the wider system evolves, following publication of the Government's *Fit for the Future: 10 Year Health Plan for England* and with the abolition of NHS England underway.¹⁵ The Government has set out a clear vision to shift the NHS from hospital to community, sickness to prevention, and analogue to digital, building on the promises in their election manifesto to deliver health system reform and prioritise women's and mental health.³⁴ The *10 Year Health Plan* makes promising commitments on both mental health (including the development of a *Modern Service Framework* on mental health in 2026) and maternity care (including the establishment of a national independent investigation into services).¹⁵ However, detail on the delivery of these commitments is lacking and maternal mental health is not explicitly referenced in the *10 Year Health Plan*. Without dedicated and urgent focus on maternal mental health at the highest level, we will miss our opportunity.

About this 10-year vision

At Biogen, we are a leading biotechnology company with a bold mission to deliver scientific breakthroughs. Our growing focus on maternal mental health reflects this ambition; we are committed to researching and pioneering new solutions to address unmet need in postnatal depression, revolutionise standards of care and tackle social stigma. We want to improve patient pathways by partnering with the NHS and supporting services.

Biogen has developed this 10-year vision to ensure there is a focus on maternal mental health at the highest level of Government and NHS, building on the principles of the *10 Year Health Plan* to shape what good care looks like and embed this over the next decade. Our nine policy recommendations are categorised by the length of time it will take to see clear progress:

SHORT-TERM

starting now, completed
by 2027 with measurable
improvements

MEDIUM-TERM

starting now, completed
by 2030 with measurable
improvements

LONGER-TERM

starting now, completed
by 2035 with measurable
improvements

We recognise that sustainable, meaningful change cannot be realised alone. Our 10-year vision is informed by insights and experiences the community has shared with us, including leading healthcare professionals and patient organisations. We believe that our on-the-ground experience in other disease areas make us a strong partner for the NHS to deliver long-term system transformation, but we also want to lend our voice to support the existing policy calls made by the community. Genuine collaboration across Government, the NHS, the community and industry is the way forward to put motherhood at front of mind.

Early diagnosis and referral



Why this matters

Women can experience mental illness in the perinatal period for a range of reasons, including experiencing mental illness in the past, stigma, abuse, stressful living conditions, traumatic life events, lack of support and disillusion with motherhood.³⁵ For some women, their mental health may decline over a period of months¹² whereas for other women, this can happen in a matter of days.³⁶ Women with pre-existing mental health conditions are often at increased risk of maternal mental illness,³⁵ but sometimes there may be no history of prior mental illness.³⁷

Half of women who experience maternal mental illness are never diagnosed.¹⁰ If unrecognised and untreated, maternal mental illness can adversely affect the relationship between a mother and her baby, and cause symptoms to worsen to the point of hospitalisation, self-harm or suicide.^{38,39} Early detection of the symptoms of maternal mental illness can help women to secure an accurate diagnosis and timely referral for care, which is essential in improving outcomes for both mother and child, and preventing long-term harm.⁵

Key progress to date

Vital steps have been taken in England in recent years to increase early diagnosis and referral. GPs have an essential role in spotting symptoms of maternal mental illness after birth and referring women for specialist care. In 2023, the NHS published updated guidance for GPs on the six-to-eight-week maternal postnatal consultation, which all new mothers should be offered to check on her and her baby's health.³⁷ The refreshed guidance made it mandatory to ask every new mother about her mental health and general wellbeing during these consultations, using open questioning and never assuming she has already been asked or disclosed how she is feeling to another healthcare professional.³⁷ Identifying signs of serious maternal mental illness – including severe depression and psychosis – should take priority above all other areas of the consultation.³⁷



Midwives and health visitors also have a key role in supporting the wellbeing of new mothers and identifying symptoms of mental illness, especially in the days and weeks after birth. Midwives spend more face-to-face time with women during their birth journey than any other healthcare professional, meaning women may feel more comfortable in disclosing how they are feeling.⁴⁰ Health visitors also provide an ongoing touchpoint, including conducting a new baby review within 10 to 14 days of birth, held at home or in a healthcare setting.⁴¹ Whilst the focus of the review is largely on the baby's health, the guidelines state it should also encompass the wellbeing of the mother.⁴¹ Although loved ones have a key role to play in noticing day-to-day changes in mood, ensuring women are regularly seen by healthcare professionals is essential for early identification and referral, particularly in cases of more complex mental illness.⁴²

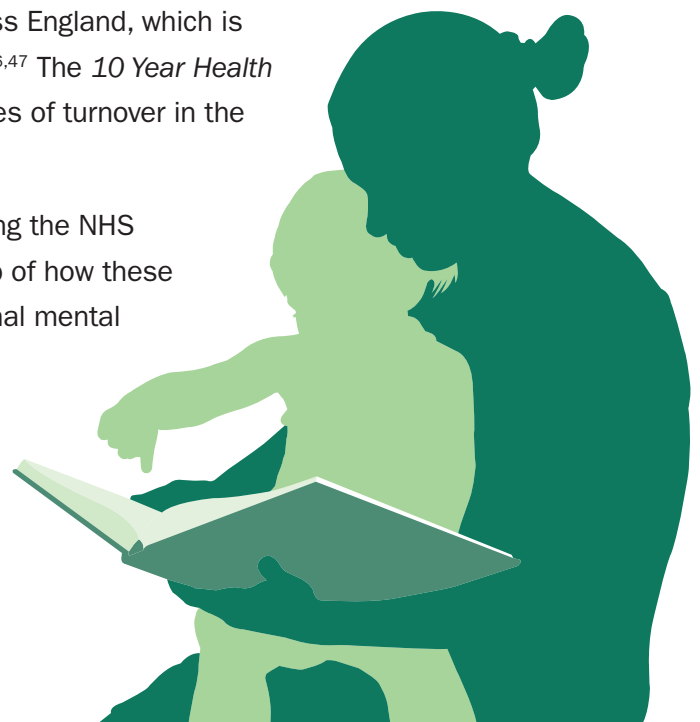
Barriers still to overcome

However, there are still significant barriers to early diagnosis and referral. Stigma and harmful beliefs can lead to feelings of shame and make women reluctant to seek help due to the fear of potential consequences, such as being perceived as an unfit mother and losing child custody.²⁰ These harmful beliefs can be caused by lack of understanding among both healthcare professionals and the wider public of the distinction between a normal, temporary emotional response and mental illness.

Even if women are able to make the difficult step to seek out help, nearly a fifth of women report they are not told who to contact if they need advice about their mental health after birth.⁴³ We do not yet have any evidence on whether the refreshed guidance on the six-to-eight-week consultation is being effectively implemented and benefitting women in practice. Before the refreshed guidance was published, 44% of women felt their GP did not spend enough time on mental health during their consultation, while 30% said that their GP did not mention mental health at all.⁴⁴

The increasingly over-burdened state of primary care in England and limited capacity among GPs⁴⁵ could be impacting the quality and consistency of the six-to-eight-week consultation, with 16% of women not receiving the consultation at all.⁴⁴ The *10 Year Health Plan* commits to restoring GP access as a first step in reforming NHS care.¹⁵ Additionally, there is an estimated shortfall of 2,500 midwives and 5,000 health visitors across England, which is having an “inevitable” impact on quality of care and safety.^{46,47} The *10 Year Health Plan* also acknowledges the impact of burnout and high rates of turnover in the midwifery profession.¹⁵

Recognition of the challenges and commitments to improving the NHS workforce are important, but we are still missing a roadmap of how these changes will improve early diagnosis and referral for maternal mental illness specifically.



Recommendations

Removing these barriers will help to ensure women experiencing symptoms of maternal mental illness are treated with sensitivity and understanding, diagnosed at the earliest possible opportunity, and referred for specialist support in a timely way. We believe this can be achieved over the next 10 years by:



1 **SHORT-TERM** (starting now, completed by 2027)

The Government and the NHS should use their new 10 Year Workforce Plan to strengthen the workforce across the maternal mental health pathway. This should include: freeing up primary care capacity to ensure GPs have sufficient time to deliver the six-to-eight-week consultation comprehensively for all women; and addressing workforce shortages for midwives and health visitors, including adoption of the Royal College of Midwives' recommendation to provide funding and training for 350 additional specialist maternal mental health midwives, saving the NHS £8.1 billion each year.⁴⁰

2 **MEDIUM-TERM** (starting now, completed by 2030)

The Government and the NHS should proactively monitor women's experiences of key mental health touchpoints in the perinatal period. This should include: surveying women on whether their 10-to-14-day new baby review and six-to-eight-week consultation sufficiently covered their mental health and wellbeing; publishing and monitoring this data through the existing National Maternity and Perinatal Audit (NMPA);⁴⁸ and intervening when a trend of poor performance within a GP practice or hospital is observed.

3 **LONGER-TERM** (starting now, completed by 2035)

The Government and the NHS should explore ways to raise awareness of maternal mental health among healthcare professionals and the public. This should include: ensuring women and their loved ones are told where they can go for help within both the NHS and the charity sector; improving sensitivity training for healthcare professionals with guidance on how to effectively affirm women's experiences and encourage them to seek help; and delivering dedicated social media campaigns which can reach new audiences by partnering with public figures with lived experience of maternal mental illness.

Timely and consistent access to care



Why this matters

Timely access to specialist support and care for maternal mental illness can make a significant difference in long-term health outcomes for both women and children.⁴⁹ Treatment options for women experiencing maternal mental illness can include talking therapies, medication or inpatient care.⁵⁰ Guidance from the National Institute for Health and Care Excellence (NICE) states that women experiencing mental illness during pregnancy or after birth should be assessed for treatment within two weeks of referral and receive psychological interventions within one month of assessment.⁵¹

Delays to appropriate care increases the risk of harm for mother and child,⁷ which can be fatal.^{12,13,14} Long waiting times also increase the financial burden on the NHS and wider services.⁷ As well as timeliness, ensuring that specialist care is accessible close to home rather than needing to travel long distances can help to alleviate worries, minimise disruption and maintain connection to personal support networks.

Key progress to date

Today, more women are receiving specialist maternal mental health support in England than ever before.¹⁰ When it was published in 2019, *The NHS Long Term Plan* made a commitment to provide care to thousands more women across England by 2024.⁵² This has been achieved, with every part of England now providing specialist services which women can be referred to by a GP, midwife or health visitor and access closer to home.² The implementation of these dedicated services has put England ahead of comparable European nations, including Spain, France, Germany, Denmark and Norway.³³



These specialist services are structured as follows:⁵³

Specialist maternal mental health services

is the umbrella term we use in this report to refer to both types of service

Maternal Mental Health Services

offer evidence-based psychological support for women experiencing moderate to severe mental illness stemming directly from their maternity experiences

Specialist Perinatal Mental Health Services

offer support through psychiatry-led multidisciplinary teams, and can include inpatient treatment in a mother and baby unit, for women experiencing complex mental health conditions before, during and after pregnancy

The available data shows that a record 64,805 women in England accessed *Specialist Perinatal Mental Health Services* in the year leading up to April 2025, an 111.7% increase over the past five years.¹⁰ The *10 Year Health Plan* affirms the Government's long-term commitment to continue to shift care into communities as a core principle of the NHS.¹⁵ This centres around the creation of the Neighbourhood Health Service, which will "bring care into local communities, convene professionals into patient-centred teams and end fragmentation".¹⁵ Ensuring women can access specialist support close to home under this new neighbourhood model and building on the important efforts to date should therefore continue to be a policy priority.

Barriers still to overcome

Despite this significant expansion of services in recent years, demand for support is still outstripping capacity at a rapid rate, leading to long waiting times and a postcode lottery in accessing potentially life-saving care. The most recent analysed data from 2023 shows a sharp 40% rise in the number of women waiting to access specialist services, but only an 8% rise in the number of women actually receiving care.⁵⁴ According to a survey by the Maternal Mental Health Alliance, the average waiting time for women to receive assessment following referral to *Maternal Mental Health Services* is six weeks, and can extend up to six months; the average waiting time for one-to-one therapy following assessment was 16 weeks, and can extend up to 12 months.⁹ This is significantly longer than the NICE guidance mandates, meaning thousands of women could be experiencing worsening symptoms as they wait, leading to poorer long-term outcomes for themselves and their children.⁹



There is also large variation in the support available in different parts of the country, creating a postcode lottery with inconsistent referral pathways and long waiting lists for services.⁹ So extreme is this variation that it has been called a “*rationing of care*”, partly driven by a lack secure funding to recruit and retain staff.^{9,11} For example, 67% of *Maternal Mental Health Services* do not have any dedicated administration support to alleviate clinical capacity and only 50% have a peer support worker.⁹

Despite services struggling to meet demand under current levels of funding, budgets are being slashed further as part of national cuts.⁵⁵ 27 of the 42 Integrated Care Systems (ICSs) in England reportedly reduced spending on specialist maternal mental health services in the 2024/25 financial year – totalling £3.2 million in cuts⁵⁶ – with one *Maternal Mental Health Service* known to have closed completely.⁹ Charities we spoke to say they are having to step in to provide support and fill the gap left by diminishing services. The progress of the last few years is already being undone. Looking further ahead, if services are struggling to stay afloat today, the NHS will not be able to roll out innovative medicines or technologies designed to treat maternal mental illness to women in a timely and equitable way.

The Government’s ambition to create the Neighbourhood Health Service has the potential to change this trajectory, but only if there is clear guidance, which is lacking at present. The *10 Year Health Plan* makes no specific commitments on maternal mental health¹⁵ and there are currently no national quality standards for *Maternal Mental Health Services*.⁹ National guidance on what the optimal patient pathway should look like would help to standardise care, promote best practice and set out how broad changes to the NHS should be reflected in maternal mental health care.⁹ For example, the Government wants to adopt a digital by default model for the NHS,¹⁵ but this may not be appropriate for many women experiencing complex mental illness. Without clarity from above, the postcode lottery will worsen.



Recommendations

Building the capacity and resilience of specialist maternal mental health services today can help to meet the growing demand for care, reduce unacceptable waiting times, and ensure the NHS is prepared to respond to future changes in the landscape. Greater national oversight of services and long-term funding commitments, coupled with more accountability for local service performance, should be the sustained direction of travel. We believe this can be achieved over the next 10 years by:



4 **SHORT-TERM** (starting now, completed by 2027)

The Government and the NHS should establish senior national leadership for maternal mental health care. This should include: appointing a named senior lead for maternal mental health – either a National Clinical Director or similar role – who is responsible and accountable for overseeing efforts to improve the timeliness, coverage and consistency of service provision, including ensuring that maternal mental health is adequately included in the new Modern Service Framework for mental health due to be published in 2026.

5 **MEDIUM-TERM** (starting now, completed by 2030)

The Government and the NHS should publish clear guidance on what good maternal mental health care should look like. This should include: clarifying the different remits and responsibilities of *Maternal Mental Health Services* and *Specialist Perinatal Mental Health Services*; and publishing guidance on the optimal patient pathway under the new Neighbourhood Health Service, encompassing primary, community and specialist care.

6 **LONGER-TERM** (starting now, completed by 2035)

The Government and the NHS should monitor local performance of specialist maternal mental health services more closely. This should include: collecting and publishing data on access to *Maternal Mental Health Services* and *Specialist Perinatal Mental Health Services*, including number of referrals, waiting times and outcomes (broken down by geographical area, age, sexuality, ethnicity and gender identity); introducing new accountability mechanisms for ICSs to encourage good performance; and intervening when a trend of poor performance within an ICS is observed.

Targeted, inclusive and equitable support



Why this matters

Any woman can develop maternal mental illness, but certain populations are disproportionately at risk and face greater barriers in accessing care. Notably, Black women face unique challenges when it comes to maternal mental illness.⁵⁷ Black mothers are more likely to experience anxiety, depression and other mood disorders, yet 20% report not seeking professional help for their mental health.⁵⁷ Black women are more than twice as likely to be admitted to hospital for maternal mental illness compared with White women.⁵⁸ These disparities have been attributed to structural inequalities associated with socio-economic status, difficulties accessing services, mistrust of the health system and cultural attitudes towards mental illness.^{57,58}

As well as ethnicity, other groups of women at higher risk of developing maternal mental illness include young mothers, and those experiencing multiple disadvantages such as domestic abuse, poverty, insecure housing and addiction.⁵⁹ These inequalities mean that a one-size-fits all approach to diagnosis, care and support for maternal mental illness will not be effective. Where certain groups of women are disproportionately affected or suffer poorer outcomes, their care must be tailored to their specific needs. This applies to both primary care, where women may first present with symptoms of mental illness, and specialist services, where they receive treatment.

Key progress to date

The NHS has identified inequalities in both maternity and mental health as key priorities in England at the national and local level through the Core20PLUS5 initiative.⁶⁰ Core20PLUS5 targets the most deprived 20% of the national population; within this cohort, individual ICSs then identify disadvantaged or marginalised groups at the local level, which could include people from ethnic minority backgrounds, people with disabilities and people experiencing homelessness.⁶⁰



Maternity and serious mental illness are two of the five priority clinical areas of health inequalities which the initiative aims to address.⁶⁰ For maternity, the aim is to ensure continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups.⁶⁰ Whilst there is little quantitative data on the impact of the Core20PLUS5 to date, prioritisation of the intersection between inequalities, maternity and mental health is a marker of progress.

Beyond Core20PLUS5, awareness of inequalities in maternal mental health is growing.⁶¹ This has led to more research funding allocated to racial disparities in maternal health, increased media coverage of Black maternal health, and NHS Trusts implementing cultural competency training for maternity staff.⁶¹ The *10 Year Health Plan* suggests that the reformed NHS will be designed to tackle inequalities in both access and outcomes, including for mental health specifically.¹⁵

Barriers still to overcome

There is still a long way to go to achieve equity in maternal mental health, and improvements are inconsistent across different local areas and services.⁶¹ Training and education for healthcare professionals on equity and inclusion can help to address the barriers Black women often face when accessing services, including institutional racism, lack of cultural competency from care providers and social stigma.⁵⁷ However, only 34% of teams working in *Maternal Mental Health Services* report having time dedicated to training wider maternity teams and other healthcare professionals.⁹

Inconsistent and patchy data collection makes it challenging to drive service improvements and address the unmet needs of disadvantaged or marginalised groups. The Maternal Mental Health Alliance has found that 33% of *Maternal Mental Health Services* do not collect data on sexual orientation, and 38% do not collect data on membership of NHS inclusion groups, which include refugees, sex workers and victims of modern slavery.⁹ This lack of data limits transparency and accountability – compounded by the fact that the evidence on the existence of a data gap has been collected and published by the charity sector, not the NHS.

Whilst the abolition of NHS England and the Government's new vision for the health system present opportunities for progress, addressing inequalities as a priority could get lost in the vast project of structural reform. Beyond its broad ambition to narrow inequalities through the shift to neighbourhood care, the *10 Year Health Plan* lacks concrete detail on the mechanisms the Government will employ to achieve and monitor this in practice.¹⁵ Clear and immediate commitments are needed, or women from disadvantaged or marginalised groups risk falling through the cracks.



Recommendations

Improving the provision of targeted, inclusive and equitable care for women who experience structural and systemic inequalities is vital. Where some women have unique needs which have historically not been met as a result of these inequalities, it is the responsibility of the health system to adapt to redress this imbalance. This requires urgency and should be seen as an essential element of NHS reform over the coming years, not a nice-to-have. We believe this can be achieved over the next 10 years by:



7 **SHORT-TERM** (starting now, completed by 2027)

The Government and the NHS should renew their focus on addressing inequalities in maternal mental health. This should include: setting out plans for the continuation of Core20PLUS5 or a similar initiative beyond the abolition of NHS England, with both maternity and serious mental illness maintained as key priorities; improving local data collection on who is accessing specialist maternal mental health services; and exploring new opportunities to address inequalities in maternal mental health within the Neighbourhood Health Service.

8 **MEDIUM-TERM** (starting now, completed by 2030)

The Government and the NHS should improve education on inequalities in maternal mental health for healthcare professionals. This should include: integrating a focus on cultural competency and the impact of systemic inequalities on maternal mental health into wider training; and ensuring this training is not limited to healthcare professionals working within specialist maternal mental health services, but is also rolled out in primary care, midwifery, social care and other relevant areas.

9 **LONGER-TERM** (starting now, completed by 2035)

The Government and the NHS should listen to women from disadvantaged or marginalised groups with lived experience of maternal mental illness. This should include: actively consulting with women with lived experience when developing and publishing new policies at the national level to ensure a focus on inequalities; and issuing guidance to ICSs and other local providers on how to effectively co-design maternal mental health services with women with lived experience to ensure equity and inclusivity.

Conclusion

The suffering caused by maternal mental illness is impossible to describe until it is experienced – by women, their children, their loved ones and beyond. But it does not have to be this way.

We have already seen how the establishment of new specialist services across England in recent years⁹ has led to more women being treated than ever before.¹⁰ Now, the publication of the *10 Year Health Plan* and ambitions for NHS reform present an unmissable opportunity to go further, faster.¹⁵ If implemented in full, we believe that the nine recommendations in this report – many of which echo existing calls by the community – could go a long way to ensuring that women experiencing maternal mental illness have access to timely, high-quality and equitable care.

In the short-term, we are calling on the Government and the NHS to strengthen the workforce across the maternal mental health pathway, establish national senior leadership and accountability for maternal mental health care, and commit to addressing inequalities in maternal mental health. These foundations will pave the way for longer-term ambitions and ensure that good care is being embedded in practice.

We know that meaningful, systemic and sustained change can only be achieved through a cross-sector collaborative approach, combining the resources and expertise of the Government, the NHS, political champions, patient organisations, clinical leaders, advocates and industry.

By working together, we can put motherhood at front of mind.



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We apply deep understanding of human biology and leverage different modalities with aspirations to advance first-in-class treatments or therapies that deliver superior outcomes. Our approach is to take bold risks, balanced with return on investment to deliver long-term growth.

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