Integrate

A guide to integrating psychological support for common perinatal mental health difficulties into universal services

Anna Freud

Foreword

Across the UK, there is growing recognition of how vital mental health support is during the perinatal period. Yet, for too many women and birthing people, that support still comes too late – or not at all. At Anna Freud, we work alongside professionals, parents, and policymakers who tell us the same story: while specialist perinatal mental health services have transformed care for those experiencing the most severe difficulties, there remains a vast group of women and birthing people struggling with common mental health problems, such as anxiety and depression, who are left without effective help.

These so-called 'mild to moderate' difficulties are anything but mild in their impact. They can shape the earliest bond between parent and baby, strain relationships, and undermine confidence and recovery at a time that should be filled with connection and hope. Each year, over 115,000 women and birthing people across England experience these difficulties yet fall below the threshold for specialist NHS perinatal mental health services. Untreated, they represent a serious and growing public health challenge – one that affects not only individuals, but their partners, babies, and communities.

The evidence is clear: when we intervene early, and when psychological support is integrated into universal services that families already know and trust – maternity, neonatal, health visiting and family hubs – we can change lives. Integration means help is available when and where it's needed most. It prevents escalation, strengthens parent–infant relationships, improves outcomes for babies, and reduces pressure on overstretched specialist and acute services. Importantly, it also reflects what both professionals and women and birthing people consistently tell us they want.

This report, *Integrate*, sets out a practical, evidence-based roadmap for how that can be achieved. It calls for a single point of access for all perinatal mental health needs, and for the introduction of around 600 new psychological practitioners trained to provide early, accessible support for mild to moderate difficulties, embedded within universal services. Together, these steps would create a system that is seamless, equitable, and responsive to the full spectrum of perinatal mental health needs.

We have made enormous progress in recognising the importance of perinatal mental health. Now is the time to complete the picture to ensure that no woman or birthing person is left to navigate distress alone simply because their difficulties don't meet a threshold. Integration is not just an organisational priority; it is an act of compassion, equity, and common sense.

I am deeply proud of the work that has gone into this report, from the voices of lived experience to the expertise of practitioners and researchers, and I am hopeful that it will serve as a catalyst for the next phase of progress: a truly integrated perinatal mental health system that works for every family.

Jess Deighton, Professor of Child Mental Health and Wellbeing, UCL

Foreword

For too long, too many people experiencing common perinatal mental health problems such as depression and anxiety have faced a gap in care. While the development of specialist perinatal services in the UK has transformed outcomes for those women and birthing people and their babies needing specialised multidisciplinary care, the majority still struggle to access timely and effective support and treatment during this critical period for families.

This report shows that change is both needed and possible. The recent establishment of specialist services throughout most of the UK demonstrates what can be achieved when we focus attention and resources on mental health during pregnancy and after birth. Now we must build on that momentum by integrating psychological support and treatment into universal services like maternity, health visiting and family hubs, thus ensuring that this essential care is available and accessible to all women and birthing people who need it, and helping their babies get the best start in life.

The Maternal Mental Health Alliance's Everyone's Business campaign calls for nothing less: that all women and birthing people, their babies, and their families receive the care they need, when and where they need it. We know what works. We know the huge cost of inaction, in suffering, in lost potential, and in economic terms. And we know that integrated, compassionate care is both possible and transformative.

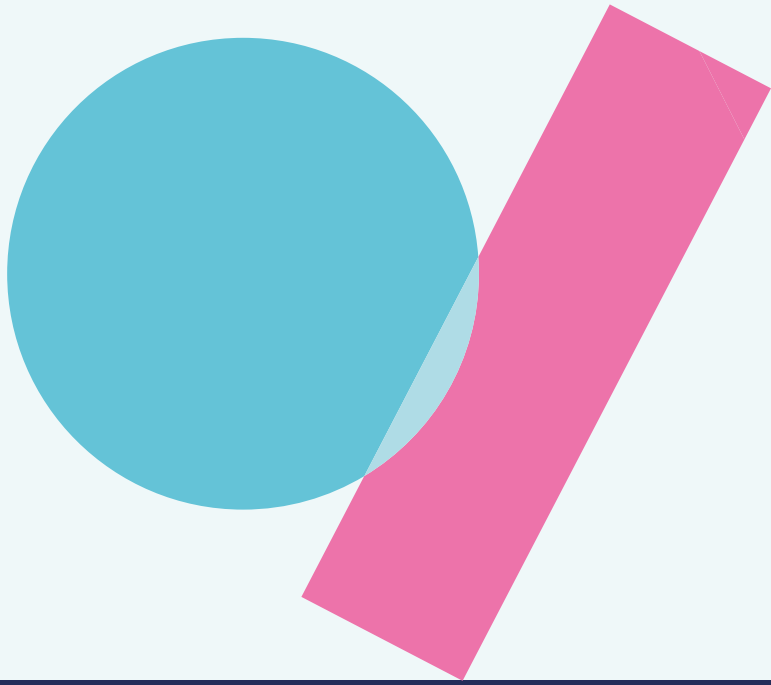
This report offers a positive, practical and timely solution to a major public health challenge. It is a solution that is recommended internationally by the World Health Organisation, and that is welcomed in the UK by all stakeholders, from women and birthing people and their families; to community and voluntary organisations working with and representing families, and to professionals working in maternity and health visiting services. The latter have long wanted to provide holistic mental and physical health care but been held back from doing so by the lack of resources and training. The UK now has a world-beating infrastructure of specialised services, but these are faced with overdemand due to the unmet need for less intense or complex levels of care. How much more effective and, as a recent report from the LSE shows, more cost effective it would be to provide accessible care by building on the existing infrastructure of NHS maternity and health visiting services and using the expertise of specialist services as a support when needed.

No other country in the world is as well placed to implement such a programme. It would truly revolutionise maternity care, with the promise of holistic, equitable, accessible health care, massive improvements in satisfaction for those women and birthing people who are currently the least well served. It could also improve job satisfaction for the currently demoralised workforce who so desperately want to be delivering the care that women and birthing people need.

Together, now, we have an opportunity – and an obligation – to ensure no family is left without the perinatal mental health care and support they need.

Dr Alain Gregoire, Honorary President, Maternal Mental Health Alliance

Contents



Acknowledgements

Anna Freud is a world-leading mental health charity for children and families, which has developed and delivered pioneering mental health care for over 70 years.

Authors:
Camilla Rosan
Kim Alyousefi-van Dijk,
Hannah Hopson,
Lani Richards,
Alice Haynes.

Acknowledgments:
We would like to thank all those who took part in the research, attended the project roundtable and joined the project advisory group.

With special thanks to:
Alain Gregoire & Karen Middleton (Maternal Mental Health Alliance)

Suggested citation: Alyousefi-van Dijk, K., Hopson, H., Richards, L., Haynes, A., & Rosan, C. (2026). Integrate. A guide to integrating psychological support for common perinatal mental health problems into universal services. Anna Freud: London.

Executive summary

Background

This report is a call to action to improve the integration of perinatal mental health psychological support across universal services to ensure women and birthing people get the high-quality care they need, when they need it. In the UK, approximately 26% of women and birthing people are affected by mental health difficulties during pregnancy and the year after birth. Most will experience mild to moderate difficulties, yet current specialist services reach only around 57,000, leaving over 115,000 women without the care they need. In this report, we call these “common mental health difficulties”. Whilst they are not the most complex mental health difficulties, common mental health difficulties can still have a serious and enduring impact to women and birthing people themselves, their partners and their babies. Common mental health difficulties can – if prolonged, unaddressed, and occurring in the presence of other risk factors – lead to long-term disruptions in parent-infant relationships. It is therefore vital that we take them seriously.

Although there are many excellent specialist perinatal mental health services available across the UK for women and birthing people with moderate to severe mental health difficulties, the wider support system can be complex and fragmented. For those with common mental health difficulties, there is often no effective pathway of care that is suited to their needs – and they are left to fall through the gaps. There is clear consensus - in the existing research and amongst the professional and expert by experience stakeholders that took part in this project - that better integrated care is urgently needed.

This guide is intended as a resource for practitioners working in both universal services (such as midwives, health visitors, family hub practitioners and general practitioners) and practitioners working in psychological support services (such as practitioner psychologists, CBT therapists and psychological wellbeing practitioners), service providers, service managers, commissioners, and policymakers who are working to design and deliver more responsive, equitable and compassionate care.

What is service integration and why is it important?

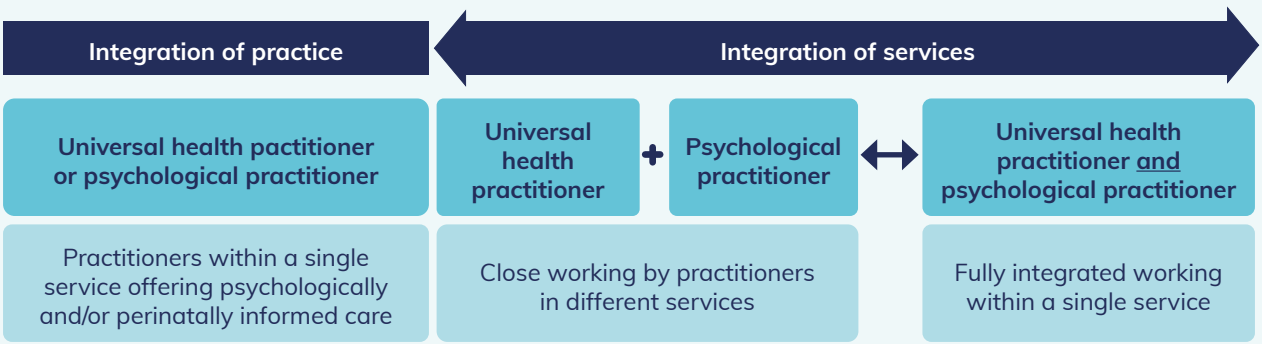
Integrated models are those in which professionals work together across disciplines and organisational boundaries to provide more seamless, coordinated care that reflects the complex realities of people's lives. This report describes how better integration of psychological support services with universal services can improve care for women and birthing people with common mental health difficulties and their families. Integrated models can enable more seamless, coordinated, accessible care. In turn, that leads to improved experiences and outcomes for parents and babies. Integrated services can also enable more efficient use of resources and a greater return on investment.

Some women and birthing people– particularly those facing multiple forms of adversity, and those from marginalised communities – are more likely to experience common mental health difficulties in the perinatal period and at a greater risk of a range of poor outcomes. Integrated care is especially important for these women and birthing people, who are also disproportionately likely to be affected by stigma, as well as systemic issues in accessing and benefiting from psychological support in the perinatal period.

What integration looks like

Around the UK, there are many different models of how maternity, health visiting, third sector and psychological support services can work together to serve communities with different needs, in different geographical footprints with different service infrastructure. These can be categorised as:

- **Integration of practice**, which involves integrating aspects of practice, typically reserved for one service, into the practice of another professional. This includes the integration of psychologically-informed practice into universal services and perinatally-informed practice into psychological support services.
- **Integration of services**, which involves different professionals, who deliver specific types of care or intervention, working closely together. Integration of services can take different forms. These include close working of practitioners in separate services, co-location of services and creating a multidisciplinary service.



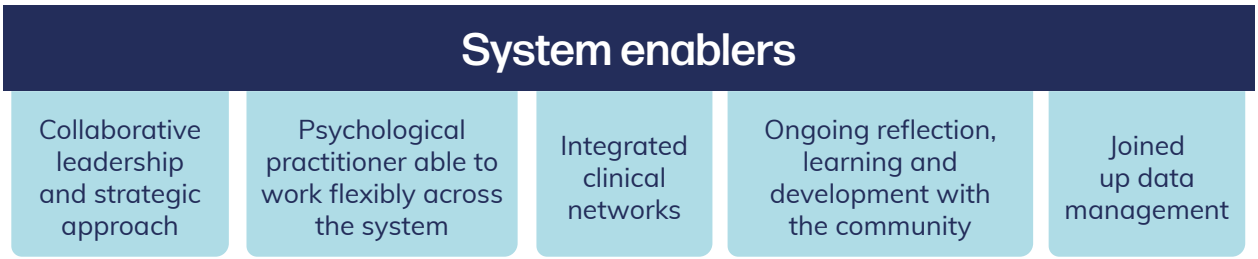
In the report, we describe and provide examples of different types of integration. Drawing on these approaches, we also set out a model of gold standard practice for integrated care, in which **one** perinatal mental health service is established to work flexibly across the system to support and provide evidence-based care for **all** women and birthing people experiencing mild to severe difficulties.

However, gold standard integration is not achievable without a dedicated workforce to support common perinatal mental health problems. We have calculated that in addition to the current specialist perinatal mental health services staff, approximately 518 WTE dedicated psychological practitioners would be required to provide evidence-based, integrated care for all women and birthing people experiencing mild to moderate perinatal mental health difficulties.

Enablers of integration

A set of **practice enablers** support the effective delivery of integrated practice and integrated services in local systems: (1) mindset; (2) knowledge and skills; and (3) relationships. These enable front-line practitioners (and their managers) to work across traditional boundaries, in order to deliver the best outcomes for women and birthing people, and their families – ideally seeing themselves as part of "one team" across professions, services, and commissioning and funding lines, with shared language and goals.

These practice enablers underpin a set of **system enablers** that support the effective design, commissioning and operation of integrated services. These system enablers describe the structures, processes, governance and ways of working which assist successful integration in local systems.



Implementing an integrated offer in your area

This report provides examples of integration of support and proposes a gold standard model, as inspiration to local systems. The 'Good Practice Checklist' can be used to help you review how successful your service or system is in integrating perinatal mental health support across the system. We hope it can support efforts to develop a more integrated and effective system of care, so that women and birthing people, and their families can access the care they need.

1 Introduction

This report explores the integration of perinatal mental health psychological support across universal services and the wider existing care systems for women and birthing people experiencing common mental health difficulties. It is a call to action, to encourage decision-makers across the system to improve integration within, and between, services so that more women and birthing people can access evidence-based psychological support for mild-moderate perinatal mental health difficulties.

Research suggests there is a continued gap in evidence about effective approaches to integration of care, particularly for common mental health difficulties.[1] This report sets out why and how integration benefits women and birthing people, and services. It provides examples of integration of support and proposes a gold standard model, as inspiration to local systems.* It is intended as a resource for practitioners working in both universal services (such as midwives, health visitors, family hub practitioners and general practitioners) and practitioners working in psychological support services (such as practitioner psychologists, CBT therapists, psychological wellbeing practitioners), service providers, service managers, commissioners, and policymakers who are working to design and deliver more responsive, equitable and compassionate care.

What are common mental health difficulties?

Perinatal mental health difficulties refer to new or worsening mental health difficulties during pregnancy and the year after birth. Services typically label perinatal mental health difficulties as "mild", "moderate" or "severe and complex".[2] Difficulties are categorised in this way based on the number of symptoms, the level of distress caused by the intensity of the symptoms, the extent to which they impact on a woman's or birthing person's functioning and the level of care that is required to support the family. This report focusses on mild to moderate depression or anxiety during the perinatal period, which we refer to as "common perinatal mental health difficulties" as these are experienced more frequently than severe or complex difficulties such as postpartum psychosis.[3]

* The case studies in this report show promising practice in areas where progress has been made in improving care for women. We do not claim that they show "best" practice – they do not all have strong evidence of impact.

Understanding the prevalence of perinatal mental health difficulties[4]

Overall, in the UK approximately 26% of women and birthing people will experience mental health difficulties in the perinatal period. The vast majority of these will experience common mental health difficulties.

The incidence of perinatal mental health difficulties is as follows:

- Common (mild to moderate) mental health difficulties: 16%
- Moderate to severe and complex mental health difficulties: 10%

Specialist NHS perinatal mental health services (community perinatal mental health services and mother and baby inpatient units) aim to reach these 10% of women and birthing people experiencing moderate to severe and complex mental health difficulties. This report focuses on support for women and birthing people whose difficulties might be defined as mild or moderate difficulties, and who fall below the threshold for these specialist NHS services.

The impact of common perinatal mental health difficulties

Whilst common mental health difficulties are not the most complex mental health difficulties that women and birthing people can experience, their impact can still be serious and enduring. If left untreated, these difficulties can persist and/or escalate in severity.[5,6,7] When these mental health difficulties are experienced alongside other challenges – such as poverty, insecure housing, or limited social support – it increases their risk of poor outcomes for parents and their babies.

The impact of perinatal mental health difficulties on the important relationship between women and birthing people, and their babies does not correlate neatly with the severity of mental illness. Common mental health difficulties can – if prolonged, unaddressed, and occurring in the presence of other risk factors – lead to long-term disruptions in parent-infant relationships.[8] For example, women and birthing people who have a history of depression often experience longer periods of postnatal depression than other new parents. They may also experience more repeated or prolonged episodes of depression throughout their child's early life, which are associated with poorer outcomes for their children.[9] These disruptions can be as great as (or even greater than) those caused by complex mental illness alone. It is therefore vital that we take common mental health difficulties seriously and ensure that timely, effective care is available and accessible.

Risk factors for common perinatal mental health difficulties

Some groups of women and birthing people, particularly those facing multiple disadvantages and those from marginalised communities, are more likely to experience common mental health difficulties in the perinatal period. They are also more likely to experience mental health difficulties alongside other adversities, which increase the likelihood of poor health and social outcomes for them and their babies.[10]

Groups of women and birthing people at greater risk of mental health difficulties and other poor outcomes in the perinatal period include those who: [11, 12, 13, 14, 15, 16, 17, 18]

- Experienced adversity such as maltreatment in their childhoods and those who have been in care
- Became parents at a young age
- Are from racially marginalised groups
- Recently arrived in the UK, particularly those who are refugees or asylum seekers
- Have low incomes, are in insecure employment and shift work, and those in economically deprived areas
- Are neurodivergent (specifically those with ADHD or ASD) and those with an intellectual disability
- Experience insecure housing or homelessness
- Experience substance misuse difficulties
- Have marginalised gender identities and/or sexual orientations
- Experience a difficult birth, fertility issues and/or an unwanted pregnancy
- Parent alone and/or who lack social support (e.g., consistent, reliable support from family, friends and communities)
- Experience domestic abuse
- Are involved with the criminal justice system.

Service provision and accessibility

Over the last 10 years, considerable progress has been made across the UK in expanding access to specialist perinatal mental health care in the NHS for women and birthing people with serious mental health difficulties or at greatest risk of serious illness.[19] Our specialist NHS services are now some of the best in the world. However, there is still work to be done to ensure that there are fully operational specialist perinatal mental health services in all areas, with sufficient capacity to meet demand.[20]

The services landscape for women and birthing people with common mental health difficulties is more complex and less well-developed. Across the UK, there are a range of services aiming to support those with common mental health difficulties. These include enhanced health visiting and maternity offers, NHS Talking Therapies, and other offers in the statutory and voluntary sector (such as the Start for Life programme in England, the Perinatal and Infant Mental Health programme in Scotland and Flying Start in Wales). Although some excellent services exist, a significant proportion of common mental health difficulties go undetected, and women and birthing people do not receive appropriate, timely, evidence-based care[21,22,23]. Services also do not consistently attend to the parent-infant relationship, as well as parents' mental health.[24] The landscape of care for those with common mental health difficulties is inconsistent, fragmented and patchy, and the care available often changes over time because of changes in policies and funding.

Some groups of women and birthing people, and their babies are consistently under-served by the care available. Those experiencing multiple adversities and those from marginalised communities are often doubly disadvantaged: they are not only at risk of poor outcomes, but also often less likely to receive the high-quality care they need.[25] The data show that women and birthing people facing these additional risk factors are often less likely to access help, for example:

- Those with low incomes, in areas of deprivation and from racially marginalised groups are less likely to access antenatal care – and more likely to initialise antenatal care late if they do access it.[26]
- In England, families are more likely to miss out on a mandated health visiting contact if they are living with a low income, come from racially marginalised groups and/or have English as a second language.[27]

Furthermore, women and birthing people from marginalised groups, in particular racially marginalised groups, report experiencing discrimination and bias, and feeling that professionals are judging them or treating them differently because of their identities and experiences. For example, 25% of Black women surveyed through the Five x More Black Maternity Experiences Survey reported experiencing discrimination due to issues around race.[28]

What is service integration and why is it important?

This report explores the integration of perinatal mental health psychological support across universal services and the wider existing care systems, focusing on support for those experiencing common mental health difficulties. Integrated models are those in which professionals work together across disciplines and organisational boundaries to provide more seamless, coordinated care that reflects the complex realities of people's lives. There is clear consensus - in the existing research and amongst the professional and expert by experience stakeholders that took part in this project - that better integrated care is urgently needed.

In this report, we focus on integration with "universal services and the wider existing care systems with psychological support services".

Universal services refer to health and social care services that are offered to everyone (i.e. universally) in the perinatal period, including maternity, health visiting, primary care and/or Best Start for Life services within family hubs.

Psychological support services refer to mental health services that primarily deliver evidence-based, NICE-recommended psychological interventions for mild to moderate mental health difficulties such as NHS Talking Therapies. These services could be delivered by a range of multi-disciplinary professionals that are trained to deliver an evidence based psychological intervention such as low or high intensity cognitive behavioural therapy (CBT), eye-movement desensitisation reprocessing (EMDR) therapy, interpersonal therapy (IPT), or prolonged grief disorder (PGD) therapy. Typically practitioners would include psychologists, psychological wellbeing practitioners and accredited CBT, IPT, PGD or EMDR therapists. To note, this could also be a universal practitioner (i.e. a health visitor) who has gone on to complete further training in the delivery of an evidence-based psychological intervention.

The report describes the integration of services occurring in two broad ways:

- **Integration of practice**, which involves integrating aspects of practice, typically reserved for one service, into the practice of another professional. This includes the integration of psychologically-informed practice into universal services and perinatally-informed practice into mental health services.
- **Integration of services**, which involves different services, who deliver specific types of support or intervention, working closely together. Integration of services can take different forms, ranging from close working of practitioners in separate services, to co-location of services or a fully integrated multidisciplinary service. We also set out a model of gold standard practice for integrated care, in which one perinatal mental health service is established which works flexibly across the system to support and provide evidence-based care for all women experiencing mild to severe difficulties.

Integration can result in earlier identification and intervention, improved outcomes for parents and babies, and a more efficient use of resources. Whilst integration of services can benefit all women and birthing people in the perinatal period, it can have the most impact those at risk of the poorest outcomes.[29]

How was this report developed?

The INTEGRATE project was conducted between October 2024 and December 2025. The project comprised of two stages:

1. a rapid scoping review of the barriers, facilitators and models of promising practice when integrating psychological support into universal care for birthing parents with common mental health difficulties.

2. a series of fifteen professional and ten expert-by-experience interviews to understand gaps in the perinatal mental health service delivery landscape, explore new models of integrated care, and scope what it would take to implement such a model within universal services in England. (See Appendix A).

The report was also shaped by a joint roundtable discussion with local and national leaders. Quotes and learnings from the interviews, as well as learnings from the scoping review, are used throughout the report.

2 The case for change

Summary of section

- The integration of perinatal mental health psychological support into universal services and wider systems of care offers an opportunity to improve the availability, accessibility and quality of care for women and birthing people. It also has a range of benefits for professionals and for the services they work in.

- The integration of services can be of particular benefit to women and birthing people at risk of the poorest outcomes, particularly those facing multiple disadvantages and those from marginalised communities.

- Benefits of integrated services for women and birthing people include:
  - reductions in mental health difficulties,
  - improved identification of difficulties,
  - more accessible services and a reduction in stigma associated with mental health services,
  - more timely, appropriate care provision.

- Benefits for professionals and services include:
  - improved professional relationships and collaboration,
  - increased confidence, skills and consultation,
  - increased efficiency and reduced pressure on services,
  - economic savings.

The integration of perinatal mental health support into universal services and wider systems of care offers a vital opportunity to improve the availability, accessibility and quality of care for women and birthing people, and their families, as well as improving outcomes for professionals, services and the wider health system. Integration enables services to provide care that is responsive, coordinated and in line with needs. This, in turn, leads to better experiences, outcomes and efficiencies.[30] Such integration of perinatal mental health services is recommended by the World Health Organization (WHO).[31]

Integration of services can be of particular benefit to those at risk of the poorest outcomes.[32] Recommendations emanating from a 2025 survey of Black women's experiences of maternity services call for increased integration to avoid fragmented and poor care, and the need for women and birthing people to repeatedly explain their history.[33] The risk of perinatal mental health difficulties occurring and persisting, and of poor outcomes for women and birthing people, and their children increases when common mental health difficulties occur at the same time as other challenges or protected characteristics.[34] Some risk factors, such as being a young parent, are likely to co-occur with other forms of adversity (such as having experienced childhood trauma, being care-experienced and/or living in poverty). Evidence shows that when families face an accumulation of risk factors, their likelihood of poor outcomes rises significantly. Through this research, we heard how women and birthing people from marginalised communities or with complex needs can feel that professionals do not listen to them, understand them, or respect their views, values and culture. When women and birthing people do not see other people like them accessing services or delivering support, they may feel less comfortable – and less confident - that the service can understand and meet their needs.

Different types of integration bring different benefits. The extent and nature of benefits secured depends on the type, quality and depth of integration. Integration alone is also not a panacea: achieving better outcomes also relies upon individual services functioning well, having sufficient capacity to meet needs, and operating compassionately and effectively.

Benefits for women and birthing people

Integration can lead to reductions in mental health difficulties

Evidence suggests that integrated services can deliver improvements in women's and birthing people's mental health outcomes. For example, studies have shown that collaborative, psychological support teams within maternity services can help to reduce the symptoms of anxiety and depression among expectant and new parents[35,36,37,38]. Research on the use of Behavioural Activation by health visitors in Blackpool has shown a statistically significant reduction in scores of anxiety and depression by the end of the programme.[39] Another randomised controlled trial – in which health visitors were trained to systematically identify postnatal depression and deliver psychologically informed interventions – was shown to result in a statistically significant reduction in the proportion of women with high scores on the EPDS measure of depression.[40]

Integration can help professionals to identify difficulties

All parents we interviewed felt that the responsibility of looking after their mental health was not held jointly by all the professionals they saw in the perinatal period, and that discussions about mental wellbeing were not encouraged. Parents who felt unable to initiate a conversation about their mental health wished that their midwife, GP or health visitor had asked them how they were.

"Yeah, I think if [the professional] initiated it, it would have been less pressure for me to have to build up the courage to say it. And I probably would have discussed it [at] an earlier appointment before I'd got so far in the pregnancy." **Expert by Experience**

Many parents felt that professionals' attention was focused solely on baby after birth, meaning that parents' symptoms of perinatal mental health difficulties are being missed.

"In that whole conversation in hospital, there wasn't any conversation about how I was feeling. […] I'd walk into a room full of consultants, sometimes four or five of them, and they'd be looking at the graphs, the baby's heart rate and everything else. But no one ever took a moment to ask me how I was feeling, mentally or emotionally." **Expert by Experience**

Integration can support maternity and health visiting professionals' understanding of perinatal mental health, their confidence in discussing these issues with families, and their knowledge of referral pathways. This can support increased routine enquiry about mental health within universal health services. Routine enquiry – if conducted sensitively and empathetically – has been shown to reduce the stigma associated with mental health during pregnancy, encouraging women and birthing people to disclose and seek support for their mental health. This facilitates early intervention, leading to improved mental health and treatment satisfaction.[41]

"I was often sort of tearful and upset during appointments, but no one ever seemed [to] ask why I was upset or dig deeper as to why." **Expert by Experience**

Integration can help reduce stigma and make services more accessible

For those who are struggling with their mental health, stigma and shame are significant factors, with 70% of women and birthing people hiding or underplaying the severity of their difficulties.[42] Nearly all the parents and professionals we spoke to as part of this research mentioned stigma and the importance of language around mental health as barriers to accessing perinatal mental health support. Parents who grew up in families or communities where mental health was not discussed, and who do not have ready access to language to describe how they feel, told us they struggled to get their concerns across to professionals.

> *"I think I didn't really know what it was myself or how to put it into words, so I don't know how I'd have explained it to somebody else. [..] I didn't like the idea of being referred to mental health services. I didn't really know what mental health services were in all honesty."* **Expert by Experience**

One parent noted that some of the screening tools used by health visitors and midwives to identify mental health difficulties did not seem to be specifically relevant to the perinatal period, or capture some of the unique challenges around sleep and eating. They suggested a more tailored tool might feel more relevant to families in the perinatal period and therefore capture difficulties more effectively.

Some parents described being fearful that opening up about perinatal mental health difficulties may result in the involvement of social services.

It was suggested that locating psychological support services within everyday parenting support environments could help to de-stigmatise and normalise support for mental health difficulties in the perinatal period. Integration can mean that psychological support services are located in local spaces and settings (such as family hubs) that are practically accessible, welcoming, familiar and comfortable for parents and babies. This reduces logistical and psychological barriers to access. When women and birthing people are referred for additional support, clear relationships between the professionals in services (e.g., discussing each other with familiarity) can help to make the experience more comfortable. Some professionals talk about "introducing" women and birthing people to other professionals, rather than "making referrals", which can feel more reassuring and less stigmatising.

The stigma associated with perinatal mental health difficulties may be greater in particular families and communities. Some racially marginalised communities, for example, have beliefs and attitudes around mental health that can make it more difficult to talk about mental health difficulties. For women and birthing people facing drug addiction, there is an intense stigma around pregnancy, birth and the postnatal period. Some women and birthing people face the trauma of having their children removed, whilst being left without adequate support for their mental health.[43]

Integration can ensure women and birthing people receive the most appropriate care, in an easier and more timely way

"I think there's a lot missing in the system when it comes to connecting the right support. There are so many links that need to be made, but right now, they just aren't there. It feels like a real gap in care and compassion that needs to be addressed." **Expert by Experience**

Many of the parents we spoke with experienced services as fragmented and confusing. Some shared that they had to repeatedly ask multiple health professionals for support, particularly when they did not meet thresholds for secondary services. The absence of, or a delay in, a helpful response often contributed to a deterioration in their mental health, which many parents felt was preventable. In this research, and other research we have conducted on the accessibility of services, we heard that parents, and sometimes professionals, do not know what services are available in a local area.

Clear referral pathways, simplified referral processes and/or the introduction of a single front door and multi-disciplinary triage processes make it easier for women and birthing people to be referred to the right place, so they are more likely to get the care they need relatively quickly and easily. This reduces parents' stress, as well as the frustration of not knowing how to get support (or being referred to inappropriate services). Joint working between services can also mean that families experience smoother pathways between care.[44]

The system can be particularly hard to navigate for some groups of women and birthing people. For example, refugee and asylum-seeking women and birthing people may be less familiar with the UK system, and those with English as a second language or difficulties around literacy may need more accessible information. Women and birthing people with multiple support needs are likely to be required to navigate more services, whilst simultaneously having less capacity to do so because of the challenges they face.

Integration can support continuity of relationships

Women and birthing people often need the opportunity to build trusting relationships to feel comfortable talking about their mental health. Whilst integration does not guarantee continuity of care, it can support it. For example, if a midwife can receive support and supervision from a specialist mental health clinician, this may enable them to continue to support a woman or birthing person without making referrals to other services – so that they do not have to form new relationships.

This is particularly important for women and birthing people with complex needs, from marginalised communities or with a history of trauma. When professionals are not rushed and have the time to listen and connect to parents, it helps parents to discuss the challenges they are facing.[45] There is compelling evidence to show that continuity of care is associated with improved outcomes when there are a range of social risk factors (including poverty).[46]

"I saw so many different people – I didn't build up any relationship with anybody during that time." **Expert by Experience**

Integration enables better information sharing and reduces the number of times women and birthing people must tell their story

Integration of services can enable smoother transitions between services. Formal and informal information sharing between professionals can mean services are better prepared to meet the needs of those referred to their care and can reduce the need for women and birthing people to repeat their experience and needs to multiple professionals – an experience which is a known barrier to care in the perinatal period.[47, 48]

Some parents find themselves "repeatedly explaining [their] situation to [their] GP, having to go over everything again and again because they didn't fully understand what had happened. It's frustrating, and it highlights the need for better communication between services." **Expert by Experience**

Integration can enable more flexibility

When services exist in a fragmented system, they often have strict boundaries, thresholds and service models linked to diagnostic criteria, severity of symptoms or specific experiences. Integrated services can be more person-centred and led by the needs and preferences of the woman, birthing person or family as they move through their perinatal journey. See Case Study 4.

The need for broader integration

This report focuses on the integration of perinatal mental health support into universal services. However, these services alone may not be able to deal with all the challenges facing women and birthing people, and their families. Therefore, wider integration with a range of other services that can address other needs that the woman or birthing person and their family might have – such as physical health services, parent-infant relationship teams, social care, substance misuse or domestic violence services is crucial. This will be particularly important for those facing multiple disadvantages.

To ensure that babies and young children get the care they need to thrive, services must attend to the quality of the relationship between parents and their babies. Addressing a woman or birthing person's mental health difficulties will not, on its own, necessarily repair any challenges there might be in their relationship with their baby.[49] It is important that services identify any such issues quickly and refer families for additional support to strengthen these vital relationships (for example, the support provided by specialist parent-infant relationship teams).

"I needed something quite specialised that was relational. Not just with me, but relational with my son. And none of that got picked up or referred to, because they never saw us interact." **Expert by Experience**

Improving support for families from racially marginalised communities

Based on this research, and other research with women and birthing people, and families in the perinatal period,[50] we know that a key barrier to accessing services for racially marginalised communities is a mistrust of services and a fear of racism.

"Mental health staff are white, so there's that fear of racism, even though they probably aren't. But it's that fear. So that's probably another reason. Dads don't engage with all sorts of services due to the fear racism, which you don't blame them really, because you don't really want to face that." **Expert by Experience**

Here, a woman describes how important it can be for staff to be representative of local communities:

"She was a black woman like me. I remember thinking, I wish she was my mama, she was just so, like, nice and she refused to discharge me until there was something in place and it was getting her into trouble....[What] made it be easier was I think, knowing that there was someone there that could advocate for you or help you do it." **Expert by Experience**

We heard about the importance of working to adapt services to meet the needs of specific communities, through conducting outreach work and developing approaches through co-production. At the same time, we heard about the importance of avoiding seeing the needs of racially marginalised groups as homogenous, and rather taking a curious and 'not-knowing' stance.

"You may get people from the Bangladeshi community who have actually come from Bangladesh but are sort of the younger generation from Bangladesh, which is very different from the younger generation who are born and brought up here, who are again very different from older mothers or, you know, people from the older Bangladesh community. So you can't put it all into a blanket, and say OK, this is the Bangladeshi population and we can just give something, it actually has a lot of nuances. So the barrier is there."

It is important that professionals have the skills, training and supervision to work with women and birthing people from marginalised communities and those facing multiple disadvantages, including skills in cultural humility and trauma-informed practice. Professionals also need a good understanding of how perinatal mental health difficulties display in different groups, of barriers to access, and of what constitutes appropriate support.

"We offer lots of different types of services to try and step down into the mild-moderate space. Some of those include peer support groups and some of which are targeted towards groups that are more likely to experience marginalisation or discrimination. [...] 'Service name' is all about how we support Black and Asian mums to feel supported to access support that they might not otherwise access, have targeted parenting programmes that are for them, and that they feel are for them too, as well as a peer support programme." **Voluntary, Community and Social Enterprise (VCSE) service manager**

Benefits for professionals and services

Integration of practice or services has a range of benefits for professionals and for the services they work in. Together, these factors all contribute towards job satisfaction, and can improve retention in professions that have struggled to recruit and retain staff in recent years.

Improvements in communication, relationships and collaboration

Co-location and integration of services can help to build increased understanding, trust and cooperation between professionals from across services.[51] Being based in the same physical location for some or all of the time, or joining together for regular meetings or training, provides greater opportunity for the vital informal interactions that strengthen relationships between professionals. This fosters mutual understanding, shared learning, and greater collaboration between professional groups.

Increased confidence, skills and consultation

Integration enables professionals to learn from each other, either through formal channels (such as receiving training or supervision from specialist professionals) or through more informal observation and discussion between professions. This increases professionals' knowledge and confidence in psychologically-informed practice.[52,53,54]

Working in integrated ways, such as being co-located, can help professionals to feel as if they are part of a team, supporting one another through informal interactions as well as formal opportunities to discuss the needs of women and birthing people, and their families and jointly plan care. This can leave professionals feeling less isolated, particularly when supporting those with more complex care or support needs.

Increased efficiency

Well-functioning integrated systems can increase the efficiency of services. They can also reduce professionals' workloads, through reduced duplication of work across agencies and simplified processes. For example, joined-up referral processes reduce professional workload by eliminating the need for multiple referrals and follow-up conversations. Integration can reduce the risk that professionals will spend time repeatedly referring, advocating for and supporting women and birthing people with unmet needs. Integrating care has been shown to result in efficiencies that increase much-needed capacity in stretched maternity and health visiting services.[55]

Better care and increased job satisfaction

The research underpinning this report found that increased capacity resulting from integration allows professionals time to engage with women and birthing people, and their families more holistically – including time to ask about and address mental health difficulties – whilst maintaining sustainable workloads. Professionals can also be more confident that women's and birthing people's needs for support will be met. All of this reduces their own stress levels and improves job satisfaction.[56]

Reduced pressure on services

If integrated services lead to more accurate and appropriate referrals into mental health services, and more women and birthing people having their needs for support met across the system, this can reduce pressures on services (including specialist services). These services can then focus more time and resource on those who most need their support. Several of the parents and professionals we spoke to described current challenges with workforce capacity which meant that conversations around mental health were deprioritised.

"...with my midwife, they kind of asked you, oh, how are you? And then by the time you even have the opportunity to say, oh, I feel really low, it's like, oh, let's check baby's heart rate. Let's measure your stomach. You don't really have the opportunity to really talk about." **Expert by Experience**

Reducing need

Addressing common mental health difficulties will avoid difficulties persisting, escalating or becoming entrenched – which can in turn lead to wider difficulties, such as challenges in parenting. Early identification of, and responsive care for, common perinatal mental health difficulties therefore has the potential to reduce the need for more intensive and expensive services later. It can also avoid the poor outcomes that bring costs for other public services.

Economic savings

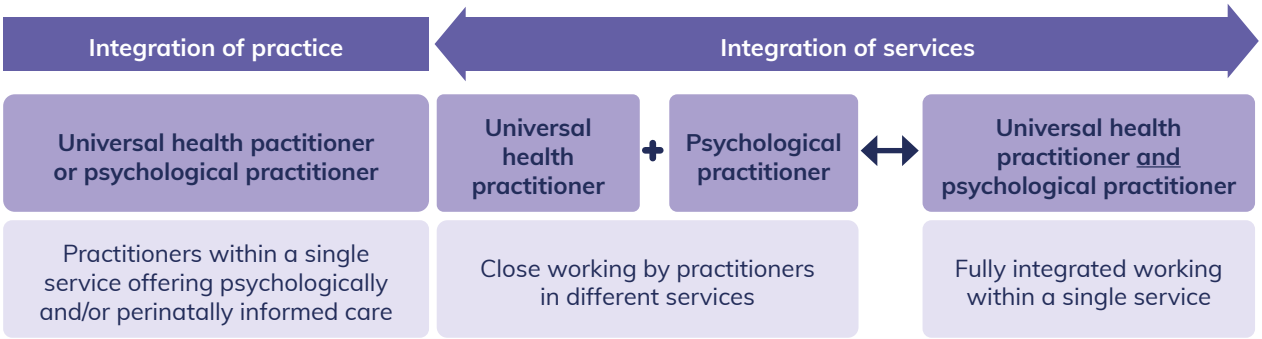
There is some emerging evidence on the economic impact of integrated models. Previous economic modelling has indicated that an integrated model of care – comprising integration of practice, with trained midwives and health visitors routinely enquiring about and assessing mental health needs, and offering low-intensity treatment – could save £490 million over a 10-year period. While the largest proportion of net benefit was attributable to quality-of-life improvements, the modelling also indicated £52 million of direct savings for the NHS (linked to reductions in clinical assessments and healthcare use).[57]

3 What integration looks like

Summary of section

- There are many different models of how maternity, health visiting, VCSE and psychological support services can work together with NHS specialist mental health services (for moderate to severe mental health difficulties), to serve communities with different needs, in different geographical footprints with different service infrastructure. These can be categorised as:
  - **Integration of practice**, which involves integrating aspects of practice, typically reserved for one service, into the practice of another professional. This includes the integration of psychologically-informed practice into universal services like health visiting and midwifery, and the integration of perinatally-informed practice into mental health services.
  - **Integration of services**, which involves different professionals, who deliver specific types of care or intervention, working closely together. Integration of services can take different forms. These include close working of practitioners in separate services, co-location of services and creating a multidisciplinary service.
- We offer an illustration of gold standard integration, based on the concept of one perinatal mental health service which provides evidence based care to all women with mild to severe mental health difficulties.

Around the UK, there are many different models of how maternity, health visiting, VCSE and mental health services can work together with specialist services, to serve communities with different needs, in different geographical footprints with different service infrastructure. These can be categorised as **integration of practice** and **integration of services**.



In this section, we describe and provide examples of different types of integration. Drawing on these approaches, we also set out a model of gold standard practice for integrated care, in which one perinatal mental health service is established to work flexibly across the system to support and provide evidence-based care for **all** women experiencing mild to severe difficulties.

Integration of practice

Integration of practice involves the adoption of approaches typically used by one service into the work of another practitioner.

Midwifery and health visiting – routine good practice

Universal maternity and health visiting services have regular points of contact with women and birthing people, and their families in the perinatal period and are often seen as a trusted and familiar source of support. At its most basic, integration of practice involves incorporating routine enquiry about mental health into maternity and health visiting contacts and the use of screening measures. Without effective screening in universal services, it is not possible to identify who might need psychological support services – integrated or otherwise.

Routine functions include:

- **Population-wide promotion and prevention:** Maternity and health visiting services can promote good mental health, tackle stigma and improve early identification and prevention of mental health difficulties – both through psychoeducation, and by facilitating self-care and social support. These services can ensure that women and birthing people understand the normal emotional changes of pregnancy and the postpartum period, how perinatal mental health difficulties might present, how to look after their mental health, and when and how to seek help. Receiving high-quality, compassionate, respectful, trauma-informed, skilled care from professionals in these services itself promotes good mental health – and can promote feelings of psychological safety, choice and control.[58,59]

- **Screening and identification:** Maternity and health visiting services can identify mental health difficulties and risk factors through routinely, collaboratively and sensitively asking about mental health, using validated screening tools, and making observations about women and birthing people through their contacts.

- **Referral for evidence-based psychological support**: Maternity and health visiting services can make referrals for women and birthing people with mental health difficulties to the most appropriate psychological support service (where they exist), and to additional services – such as parent-infant relationship teams – to address any additional challenges facing the family.

Many maternity and health visiting services offer a “stepped care” or “progressive universal” model of care. These models offer all women and birthing people some support and information to promote mental health and prevent difficulties, and identify those with difficulties or at high risk of difficulties. They also offer increasing care and/or referral to additional services for those who need more support.[60]

All women and birthing people should be asked about their emotional wellbeing and mental health at each routine and antenatal and postnatal contact. We recommend using validated measures such as the CORE-10 or the Edinburgh Postnatal Depression Scale. [61, 62]

Some key considerations for integrating mental health screening in universal settings:

- use evidence-based screening measures that have have cross-cultural validity and have been widely translated, are freely available to use without license, and have been validated in antenatal and postnatal populations, as well as in both birthing and non-birthing parents;
- include holistic measures that look beyond one specific diagnosis to tools that explore global mental health difficulties and/or psychosocial risk factors; and
- invite women and birthing people to self-complete these measures ahead of contact appointments, either in the waiting room or online. This will save time in the appointment and allow practitioners to focus on difficulties highlighted in the measures, if and when they are indicated.

However, while there is broad consensus that maternity and health visiting services should universally screen for mental health difficulties at all contact, this is not achieved in a consistent or high quality way in all areas.[63,64] Mental health screening is currently recorded on the Maternity Services Dataset (a national NHS dataset that records key information about maternity care for all women and birthing people in England). Data from NHS England on this dataset (NHS England, 2025) shows that 36% of women and birthing people were not asked any mental health screening questions during their first antenatal maternity appointment and that there is no data for a further 13% of parents.[65] More work is required to ensure effective integration of practice for all women and birthing people who might benefit from it.

In addition to identification of need and referring on to perinatal mental health services, some practitioners working in universal have received additional training to deliver more intensive support and case-load women and birthing people with common mental health difficulties. However, capacity is extremely limited and practice varies significantly across areas, and to fully integrate mental health support, a dedicated additional workforce is needed..[66,67]

Specialist perinatal mental health midwifery and health visiting roles

Specialist mental health midwives and health visitors in maternity and health visiting services have the potential to play an important role in supporting the mental health of women and birthing people through a range of direct and indirect work.[68,69] Their role can include:

- Working at a strategic level to support development of local strategies, care pathways and services;
- Case-loading women and birthing people with perinatal mental health difficulties and providing continuity of care;
- Offering short term, low-intensity, evidence-based psychological interventions to a small number of women and birthing people (when trained and supervised by a qualified psychological practitioner);
- Being a "link person" to liaise with other services, such as specialist perinatal mental health services, at both a strategic and operational level to support referrals and case management;
- Providing education, training, advice and supervision on perinatal mental health to their colleagues;
- Leading work to raise awareness and tackle stigma across their service and local system; and
- Ensuring robust quality assurance through accurate data collection, analysis and audit

These roles exist across the UK nations, but not in all local areas: in 2024 the Institute for Health Visiting identified a total of 72 specialist health visitors currently employed in a specialist post relating to perinatal and infant mental health. The function and capacity of these health visitors varied.[70] Similarly, the Royal College of Midwives (RCM) reported that in 2022, 79% of maternity units had a perinatal mental health specialist midwife. However, RCM members described "a range of role title ambiguities and a wide variation in the hours employed, from half a day a week to full time hours".[71]

Case Study 1: Health visitors offering behavioural activation (a low intensity CBT intervention)

Blackpool

Behavioural Activation (BA) is a low-intensity evidence-based psychological intervention for depression. It has been adapted successfully, in partnership with local parents and professionals, to suit the needs of parents in Blackpool with postnatal depression and is delivered by health visitors in the town.

Health visitors in Blackpool use the Whooley screening tool with all women and birthing people from the first antenatal contact and then repeat at each contact to determine if further depression or anxiety screening should be undertaken (GAD7 and PHQ9). Behavioural Activation is offered to those with a baby under 12 months old, who score between 10 and 19 on the PHQ9, indicating moderate depression.

Trained health visitors deliver the Behavioural Activation programme face-to-face with women and birthing people in their homes over six to eight weekly sessions. The pilot phase of the programme was positive, showing that women and birthing people found the intervention beneficial in a number of ways, and that it reduced their symptoms of depression.

Alongside this specific intervention, health visitors in Blackpool have been trained more widely to better understand and address perinatal mental health needs. This has been part of a wider reform of the health visiting service, which also means that all families get eight routine contacts with their health visitor in pregnancy and early childhood (rather than the standard five mandated contacts offered in other parts of England).

The health visiting model in Blackpool has been able to reduce demand for additional services and resources to address perinatal mental health in the town. And, importantly, parents and babies get timely care from a trusted professional with whom they already have an established relationship.[72]

The role of the Voluntary, Community and Social Enterprises sector

Voluntary, Community and Social Enterprises (VCSE) organisations can play a critical role in enabling the integration of mental health support with universal services. VCSE organisations can support women and birthing people to overcome barriers of access by providing outreach to engage marginalised groups. VCSE practitioners who are skilled in community outreach play an important role in providing a trusted bridge into psychological support via signposting and referring.

"In Bradford [NHS parent infant relationship service], there was a community engagement worker alongside the specialist NHS roles, which was really helpful. That community engagement worker was employed by Family Action but embedded within the NHS. I think that sort of model can work really nicely from an accessibility point of view." **VCSE Service Manager**

Voluntary sector and grass roots organisations can be particularly important for women and birthing people from marginalised communities and with additional needs. These services can play an important role in providing a trusted and non-judgemental space, offering targeted and tailored peer support, advocating for parents, and supporting them to navigate the landscape.[73]

Perinatally-informed NHS Talking Therapies

Just as maternity and health visiting services can be psychologically-informed, mental health services can operate in a perinatally-informed way. This means understanding the needs of women and birthing people in the perinatal period and adapting and enhancing support accordingly. NHS Talking Therapies are intended for all adults. To support therapists working with new or expectant parents, the NHS Talking Therapies Perinatal Positive Practice Guide sets out recommendations to help them to tailor their work to meet the specific needs of this group.[74] These include allowing babies to be present during treatment, and being aware of the unique impact of pregnancy, birth and early parenthood on parents and families. The research conducted for this report highlighted how variable this practice can be, and yet how vital perinatally-informed practices are to enable women and birthing people to benefit from these services. Again, highlighting the importance of a dedicated, ring-fenced workforce to ensure women and birthing people with common perinatal mental health difficulties receive the care they need.

"We don't really talk about babies here because they've got a manualised intervention to follow. And sleep disturbances look really different when you're caring for a baby than when you're not. [...] So sometimes that perinatal frame isn't available." **Strategic Lead for Mental Health Services**

"[NHS Talking Therapies in some areas have a] really brilliant offer that holds that perinatal mental health frame of mind... but other areas don't have that." **Strategic Lead for Mental Health Services**

"Sometimes in Talking Therapies, the therapist themselves may not be perinatally trained. So, they're not necessarily thinking to include the baby, and sometimes the venues don't accommodate the baby to be present as well. So that's a difficult thing for mums to be managing, you know - what to do with the baby." **Health Visitor**

Case Study 2: Perinatally-informed talking therapies

Tower Hamlets

Tower Hamlets Talking Therapies (THTT) is available to anyone over 18 years who lives (or is registered with a GP) in the borough. The service offers a range of low- and high-intensity psychological interventions, as well as workshops and group programmes. The service has continued to make concerted efforts to improve the care they provide for women and birthing people in the perinatal period.

Each of the modalities of support offered by the service has been adapted to meet the specific needs of women and birthing people in the perinatal period. For example, perinatal-focused online modules and workshops explore key topics such as sleep difficulties, parenting skills, fatherhood, and overall perinatal wellbeing.

The service also offers a "Raising Happy Babies" group, an eight-session group for first-time parents and their babies up to the age of six months, which is strategically co-located within Family Hubs to enhance accessibility and engagement.

The integration of perinatally-adapted practice was introduced through a champion system: designated clinicians in the service received specialised perinatal training and disseminated this knowledge within their teams.

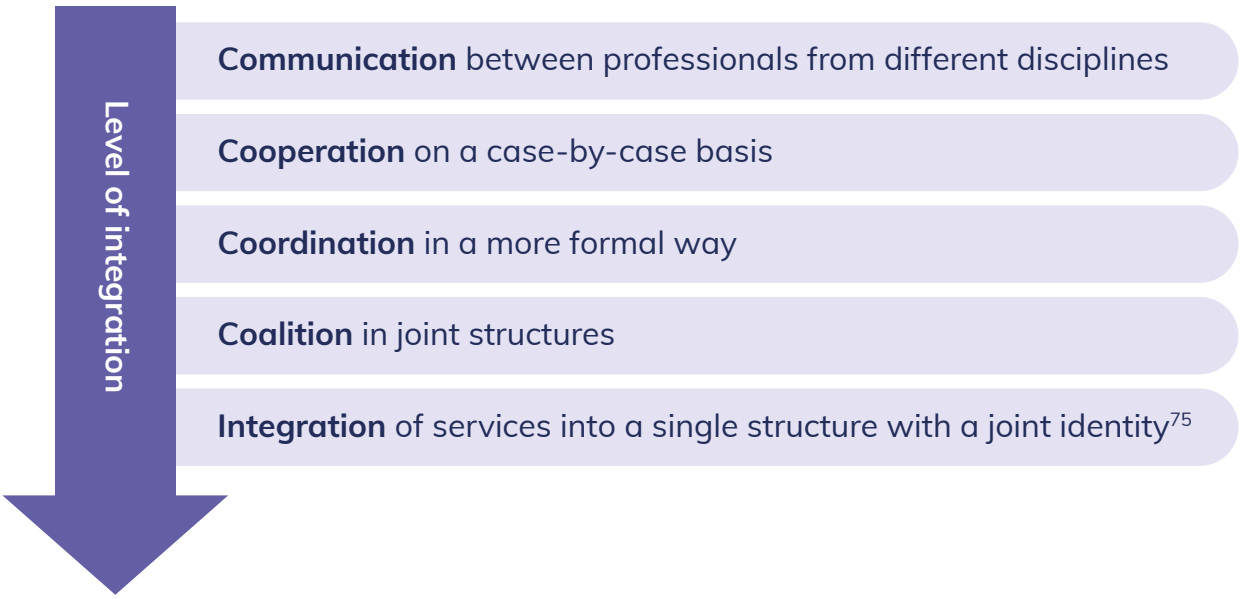
Referrals to the service are made via maternity wards, health visitors, GP practices, and the local specialist Perinatal Mental Health Services, as well as directly from those who self-refer. To ensure a coordinated approach and suitable referral, the THTT model incorporates multidisciplinary case discussions, held weekly or fortnightly, with NHS teams such as the Community Perinatal Mental Health Service, Neighbourhood Mental Health Teams, Maternal Mental Health Service, and the Complex Emotional Needs Service. Creating shared IT system access between these teams has significantly improved inter-service collaboration, allowing staff to better understand a parent's history at the point of referral and to plan suitable support.

The service has worked hard to embed awareness of its offer among other services, including voluntary and community organisations. A dedicated community engagement team enhances service visibility by distributing digital leaflets, liaising with relevant professionals (including GPs, health visitors, midwives, and breastfeeding support workers) and conducting in-person visits to share information about the THTT service and its integrated referral pathways.

Integration of services

The integration of services involves different services (or different professionals) working closely together.

Joint working between professionals from different services can take many forms, from communication to structural integration, as illustrated below.



The following examples illustrate what the integration of services can look like in practice.

Integration of referral processes

Integration "at the front door" can be an effective approach to addressing some of the challenges of a disjointed perinatal mental health support landscape. This might involve having a single referral process or a single point of access to services, with referrals reviewed by an individual in the receiving service (or by a multidisciplinary team) and then directed to the most appropriate care. A single point of access for mental health care in the perinatal period has been shown to be beneficial for women and birthing people, and families, as well as for professionals – and can provide a starting point for more comprehensive integration of services across the care pathway.

> *"Wholeheartedly, I think there's got to be some kind of single point of access. And that's got to have the holistic overview and the knowledge of all the different sorts of services and interventions that might be needed on that woman's particular journey. […] I think that can only really be achieved by a single point of access and that would be, in my mind it would be a cross-agency, single point of access and involving the voluntary sector. […] And then within those agencies that are involved, they can integrate their teams and their services as appropriate to interface with that single point of access."* **Perinatal Provider Collaborative Manager**

Co-location of services in the community

Mental health services in the UK have historically been based in healthcare settings such as hospitals, mental health team offices and GP surgeries. In recent decades, co-location in a community setting – such as SureStart Centres and (more recently) Family Hubs in England, and similar spaces in the other nations – has become a popular model. A wide range of support for babies, children and families can be brought together in these settings. Co-location can be used to bring together universal health services such as community midwifery clinics and health visitor drop-ins; mental health support such as NHS Talking Therapies and peer support groups; and other voluntary and community sector-run services such as baby banks, benefits advice and domestic abuse services.

"Health visitors do offer baby weighing within the Family Hub so that parents can go there. They can get the baby weighed, but they can also go for a coffee, and do you know what, sometimes I think that's where it all starts to feel like the fragmentation is less noticeable. [...] And then those midwives also then get the benefit of if they're concerned about someone, then they can say, oh, well, did you know that just down the corridor, there's a Circle of Security group."
VCSE Service Manager

"So, the community midwife was doing her clinic there, and there'd be somebody there from perhaps the support agency, somebody there from IAPT [NHS Talking Therapies]. There'd be all sorts of people. And then it wasn't a forced thing. [...] It's like, you're here to see the midwife today but do you need anything with this? Do you want to talk to anybody about your benefits? There is a clothes bank there and equipment and things." **Maternity Practitioner**

Case Study 3: Integrated perinatal mental health referral process and pathway, joint training and co-location of services

Norfolk & Waveney

Norfolk & Waveney Integrated Care System has introduced an integrated process for referral and mental health assessment across multiple healthcare services to increase access and continuity of care. The referral pathway spans three maternity services, NHS Talking Therapies, the parent-infant relationship service, the Maternal Mental Health Service, the specialist perinatal mental health service, and the Family Hubs Team.

Community midwives are trained in mental health, and screen for mental health at all antenatal appointments using a standardised, person-centred approach and the Whooley questions. Anyone who is identified as having concerns is then referred for additional support. Integration between primary care and NHS Talking Therapies has also been supported through an integrated referral system, which allows GPs to share their clinic notes and to make referrals through one click of a button.

There is a shared triaging process across services in the pathway, so if any service is working with someone who they feel is better suited to one of the other services, they can make a “warm handover” without the woman or birthing person having to be re-assessed or re-referred.

The integrated care pathway is supported by liaison link roles, who promote referrals and joint working across services.

The link between these services is furthered by the co-location of NHS Talking Therapies and the parent-infant relationship service clinics within Family Hubs. This has encouraged co-working, sharing knowledge and learnings, and smooth transition for families between levels of care.

Professionals embedded within services

Across the UK there are an increasing number of psychological practitioners working in universal services such as in maternity, neonatal and health visiting services. They offer direct support to service users, and provide advice, training and support to other universal professionals.

Case Study 4: Mental health professional within a maternity service

Hillingdon

Hillingdon Hospital in West London is a district hospital with a maternity service that covers around 4,000 births a year. The Hillingdon Hospital NHS Foundation Trust funds a clinical health psychologist who is employed (through a service level agreement) by the local mental health trust. The psychologist sits with the clinical health psychology team but has a physical office in the gynaecology department.

In their role, the psychologist offers both direct and indirect psychological support to the maternity and gynaecology departments, their staff and their patients. The direct support offered is highly flexible and needs-led, so the psychologist can support those who do not necessarily meet the diagnostic thresholds for other services but are often still psychologically complex.

The psychologist helps to upskill colleagues, contributing to mandatory training for maternity staff, in partnership with the specialist midwife.

The psychologist also acts as a psychological and perinatal specialist across the wider mental health system, a role that includes providing clinical supervision to the lead perinatal psychological practitioners in NHS Talking Therapies and Maternal Mental Health Services.

They work closely with a range of other mental health professionals – and are strategically and operationally linked into various obstetrics and gynaecology leadership and practice meetings, as needed, to support psychological thinking and practice across the wider system.

Gold standard integration: one perinatal mental health service for all

There are many examples of existing promising practice in integrating perinatal mental health psychological support into universal services, to improve support for women with common mental health difficulties. However, in reviewing the evidence collected to develop this report, it emerged that as well as integration between universal services and psychological support services, there also needs to be integration with the already established specialist perinatal mental health services. This would create one perinatal mental health service for all women and birthing people; one service with one front door for everyone that needs it.

Step one: Create a new dedicated perinatal psychological workforce for common mental health difficulties

To achieve the goal of providing one perinatal mental health service for all women and birthing people, we must first address the current gap in provision for the 16% of the birthing population experiencing mild to moderate mental health difficulties (whose needs are not currently being met by NHS specialist perinatal mental health services). A new dedicated workforce of low and high intensity psychological practitioners needs to be established to meet their needs. This new workforce would be trained and supervised to deliver evidence-based psychological interventions to women and birthing people with common perinatal mental health difficulties, based on the established competencies of *NHS Talking Therapies For Anxiety And Depression Perinatal Positive Practice Guide.*[76]

We are proposing that a number of members from the new dedicated team would be co-located within a range of key universal services, such as maternity, health visiting, family hubs and parent-infant relationship teams. These team members would be nominated to hold a lead link role for facilitating integration with a particular universal service. Through this model, women and birthing people would receive joined up treatment for common perinatal mental health difficulties.

This new workforce could be employed and sit in a number of places in the system based on the needs, opportunities and maturity of the local system. The two locations that emerged most prominently in the research were:

1. **NHS Talking Therapies.**
   The new workforce could be an expanded version of the current perinatal champion model. However, clear benefits were outlined of dedicated ring-fenced time and KPIs linked to perinatal cases, with a clearer training pathway similar to the NHS Talking Therapies pathway for those with Long Term Conditions and Medically Unexplained Symptoms.[77]

2. **NHS Perinatal Provider Collaboratives.**
   The new workforce could also be employed by the same NHS mental health trust that is involved in providing specialist perinatal mental health services.

But most importantly, this new team would also sit within the wider one perinatal mental health service (1PMHS) that is designed to work collaboratively with the system to meet the needs of all those experiencing perinatal mental health difficulties.

Step two: Establish one perinatal mental health service (1PMHS) for all

To establish 1PMHS for all, a virtual leadership board should be created that works across the local geographical footprint (i.e. ICB) with multi-service and multi-disciplinary representatives including:

- A diverse group of service users and those from the VCSE;
- Local Maternity and Neonatal Services including specialist mental health midwives, specialist GPs or equivalent
- Community Health Providers including specialist health visitor or equivalent
- NHS Perinatal Provider Collaboratives and inpatient mother and baby units
- NHS Specialist Community Perinatal Mental Health Services
- NHS Maternal Mental Health Services
- NHS Talking Therapies
- Local Authority Start for Life Teams
- New perinatal psychological workforce for common mental health difficulties.

This 1PMHS leadership team would hold joint responsibility for all women and birthing people experiencing mild to severe and complex perinatal mental health difficulties, and work flexibly and collaboratively across the system to provide a range of services and interventions to meet the full spectrum of need. Their responsibilities would include:

- establishing a shared understanding of a seamless care pathway with agreed service thresholds for all women and birthing people with perinatal mental health difficulties so no-one falls through the gaps
- providing an equitable single point of access, referral and triage for women and birthing people experiencing all perinatal mental health difficulties
- ensuring integrated, person-centred, trauma-informed, equitable and compassionate care is provided for women and birthing people with all perinatal mental health difficulties across the system, and
- providing training, supervision and consultation to staff in universal services and the VCSE.

One perinatal mental health service (1PMHS)

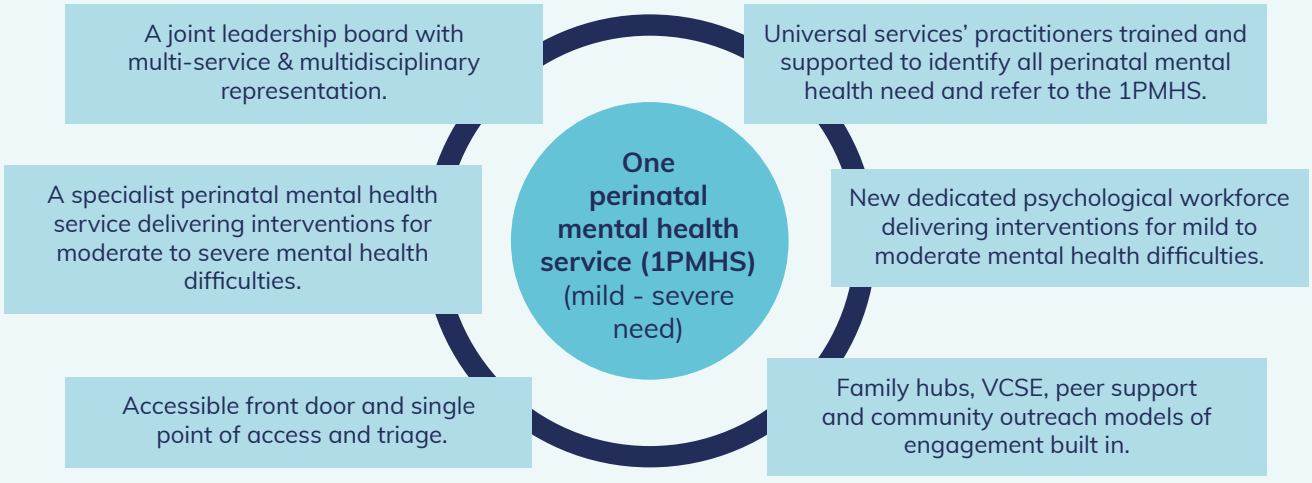


Figure: Model of gold standard practice for integrated care

4 Enablers of integration

Summary of section

A range of factors enable the effective integration of care. There are two levels of enabling factors:

- Practice enablers, which support professionals to work together in different models of integration. These are:

  1. A shared (perinatal) mindset,
  2. System knowledge and perinatal practice skills,
  3. Collaborative relationships.
- System enablers, which support the effective design, commissioning and operation of integrated services. These are:

  1. Collaborative leadership and strategic approach,
  2. Psychological practitioners able to work flexibly across the system,
  3. Integrated clinical networks,
  4. Ongoing reflection, learning and development with the community,
  5. Joined up, strategic data management and use.

A range of factors enable the effective integration of care. There are two levels of enabling factors: practice enablers, which support professionals to work together in different models of integration; and system enablers, which support the effective design, commissioning and operation of integrated services.

Practice enablers

The research for this report identified values, understanding and approaches that should underpin practice to ensure that women and birthing people, and families experience consistent, cohesive and high-quality support.

Local commissioners and service managers might use this list to consider how they strengthen integration of services in their local area.

Practice enablers		
Mindset	Knowledge and skills	Relationships

A shared (perinatal) mindset

To support integrated models of care, professionals need a shared mindset which recognises the importance of mental health during the perinatal period, and which is committed to delivering patient-focused care – working together to best meet the holistic needs of local women and birthing people, and their families.

Integrated working is enabled when professionals share goals and feel collectively responsible for improving women's and birthing people's outcomes, rather than protecting professional boundaries and inflexible ways of working. To integrate effectively, frontline practitioners and their managers need to be able to work across traditional boundaries to deliver the best outcomes for women and birthing people, and their families: ideally seeing themselves as part of "one team" across professions, services, and commissioning and funding lines

System knowledge and perinatal practice skills

To support integrated models of care, professionals need a range of knowledge and skills, and a shared understanding and language around perinatal mental health. Although different professionals will need different levels of knowledge and expertise, it is important to have a shared foundation of knowledge across the workforce, including:

- Knowledge about perinatal mental health and the appropriate ways to identify and support women and birthing people with different mental health needs (including those with additional needs and facing multiple disadvantage)
- Knowledge about the local system, services available, pathways, referral processes, roles and responsibilities
- Skills to work confidently with women and birthing people in supportive, compassionate, psychologically informed ways
- Skills to work collaboratively with practitioners across professional boundaries.

Research for this report highlighted the importance of mandated and ongoing training for professionals across their learning journeys, with mental health firmly embedded as a core part of professional development in maternity and health visiting services. It is also vital that service managers have the understanding and skills to be able to support their teams in implementing effective practice.

"I would like every midwife to have a basic understanding of what it's like to not feel well, how that presents in different situations. And have cultural awareness of what it means to be the woman that is the warrior and that's coping all the time."
Expert by Experience

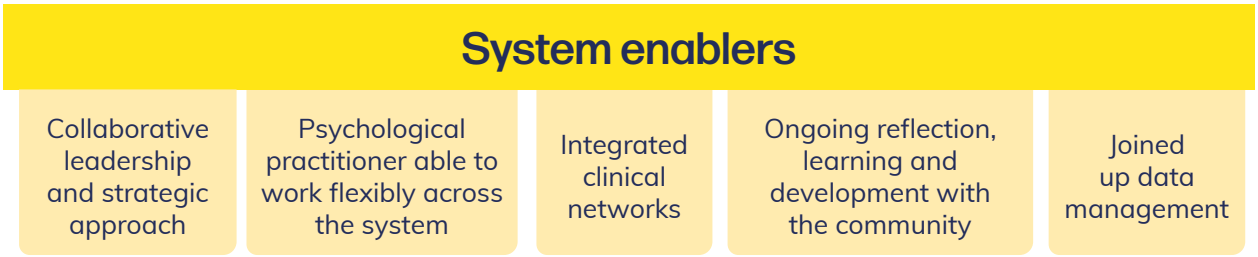
"Without the right sort of senior support or oversight around mental health, then the identification, assessment and formulation might not be appropriate, and people might end up on the wrong pathway."
Psychological Practitioner

Collaborative relationships

Fundamentally, developing the shared foundations of integrated care rests on the relationships between the professionals working in the services across the perinatal system. Any approach to integrated models of care for perinatal mental health difficulties should prioritise activities and ways of working that support the development of these relationships, building trust, mutual respect and shared learning. This means providing opportunities for staff from different teams and disciplines to better understand each other's roles, build trust, and develop ways of working together that take into account the local context and need. Local systems should also ideally nurture a culture of openness to learning – alongside one another – as to improve individual and collective practice.

System enablers

The practice enablers underpin a set of system enablers that support the effective design, commissioning and operation of integrated services. National policy makers, and local commissioners and service managers can build these enabling structures and processes to support integration.



Collaborative leadership and strategic approach

Integration of practice and services "on the front line" is supported by collaborative working at a senior and strategic level. Senior leaders in a system work together, with a clear common strategy and direction, to foster whole-system thinking and shared accountability This, in turn, leads to better outcomes for women and birthing people, and their families.

The system of services around women and birthing people, and families can be fragmented, with different leadership structures, governance and lines of accountability and funding. Integration of services is supported by structures, forums and processes that overcome traditional boundaries and silos. This in turn enables joint leadership and governance, joined-up commissioning and the aligning or pooling of budgets. For specialist perinatal mental health services, provider collaboratives are enabling specialist community and in-patient providers to improve care and develop new pathways and services.

In England, integrated local systems are bringing together a range of national government policies and funding streams, including maternity and perinatal mental health funding (led by ICBs), health visiting (which sits in public health), and the Start for Life agenda and the establishment of Best Start family hubs across England (within local authority children's services). The research for this report found examples of joined-up leadership – such as an ICB maternity lead and mental health lead joining a Family Hub board, and vice versa – so that there are opportunities for shared strategic planning, pooled budget lines and joint commissioning. In another ICB, the lead maternity commissioner is also responsible for perinatal mental health commissioning. This supports joined up thinking and planning at the most senior level, and therefore more opportunities for service integration at the front line.

"Integration works when the leadership is cross-agency and cross-discipline."
ICB Commissioner

The research for this guide also highlighted how national government policies, programmes and funding approaches can – if carefully designed – support and catalyse joint action.

"What worked really well was having that initial investment in the transformation programme where things were centrally funded from NHS England."
ICB Commissioner

Psychological practitioners able to work flexibly across the system

In local systems, integration can be supported when psychological professionals in NHS Talking Therapies and Specialist perinatal mental health teams – are not only in place, but can work flexibly across a local system. That supports the whole system to work better in meeting the needs of women and birthing people, and their families.

This approach means that they can offer training, support, consultation and supervision to professionals in other services, rather than only working directly with women and birthing people who have the greatest levels of need. When specialist teams work in this way, it supports integration of maternity and mental health services by developing expertise, shared language and mindset, as well as a greater understanding of local services and pathways across the system.[78] This way of working – offering advice and guidance across the system – should be part of the operation of specialist perinatal mental health services, but is not delivered consistently in all places.[79]

Integrated clinical networks

Clinical networks can bring clinicians and other key stakeholders in a locality or region to work together, with the shared goal of improving outcomes for women and birthing people, and their families.

Clinical networks can take various forms, with different geographical footprints, areas of focus, and leadership. When working effectively, they link professionals and organisations, building relationships and enabling dialogue at both the practice and strategic level in a local system.

They can support a whole-system approach, which in turn improves the quality of service delivery, improves consistency across the system, and drives action to tackle gaps and issues. Clinical networks enable shared learning that is both informal (dialogue, discussion and problem solving) and formal (spaces and opportunities for shared training).

Ongoing reflection, learning and development with the community

Since there is no one way to start working towards integrated perinatal mental health care that can suit all local contexts and needs, local areas should develop their own approaches to integration, seeking to continually learn and to improve local structures and practices. Incorporating a continuous cycle of learning and development into the design of service delivery models is especially valuable within complex systems that involve numerous participating services and organisations.[80] As the needs of local communities evolve and the characteristics of local systems change over time, it is important that there are opportunities to continually review and improve models of care.

Actively involving women and birthing people, families, and frontline professionals in the process of reviewing, learning and developing services helps local systems to continuously improve their offer.

People with lived experience should be involved in all aspects of reviewing and developing models of service operation and integration, to maximise the likelihood that these models will be designed in a way that promotes access and engagement. Co-production with a wide range of diverse perinatal families in local communities can help services to meet the authentic needs of women and birthing people experiencing common perinatal mental health difficulties. It allows clinical staff to better understand what is relevant, appropriate and engaging to different groups of parents, from a range of backgrounds and experiences. Co-production is not a one-off process to design services, but an ongoing approach of listening to communities and observing engagement and outcomes.

"I'm trying to talk to as many parents and carers as possible. It's when you hear this kind of real-life experience from a parent that really chimes with the evidence base, it's where the magic happens, isn't it?" **Psychological Practitioner**

Joined up, strategic data management and use

The design, effective operation and continuous improvement of integrated models of perinatal mental health care requires there to be processes established to support data sharing and use. Data needs to be disaggregated in ways that enable it to be useful and meaningful, for example:

- Adult mental health services, including NHS Talking Therapies should identify if service-users are parents
- Perinatal mental health services should identify if babies have received a mental health intervention alongside their parents, in the form of parent-infant relationship support
- Children's mental health services should identify if service-users are babies or young children who may also be being supported or have been supported by perinatal services
- Data should be disaggregated to understand if service users have protected characteristics and other risk factors.

It is important to ensure that there is good quality data about which population groups are accessing services, and where there are gaps, and how outcomes might vary between groups. This is particularly true for those groups already identified as likely to experience greater discrimination and at risk of poor outcomes. Improving the quality of the data being collected to identify inequalities in prevalence, experience and outcomes in maternal mental health could help ensure services meet the needs of all women and birthing people, and their families.[81] Integration can allow services to build up a better picture of women's and birthing people's characteristics and needs by accessing information from other services, without having to ask them for a lot of additional information.

Good management and use of data in local systems includes:

- **Information management** and governance being considered thoroughly at every point through the design and delivery of integrated models of care
- **Clear data sharing protocols**, including wherever possible using the same patient records systems (or access to such systems in partner organisations) to support joint working both at a service level, and on a case-by-case basis
- **Effective use of data** at a strategic level, to understand the community that the model is designed to support and its needs (e.g., who is and is not engaging with the services in the new system), in order to inform decision-making and monitor progress.

"[W]hen we were writing the [perinatal mental health and parent-infant relationship] strategy for [UK County Council], we agreed that first and foremost we need to have good data about who is accessing services to then compare that with the data about who is in that community and understand whether there gaps in access or not. What I mean by data is an understanding of protected characteristics but also additional demographics such as being a child in care or a care leaver, being an asylum seekers or refugees." **VCSE Service Manager**

5 Summary

Summary of section

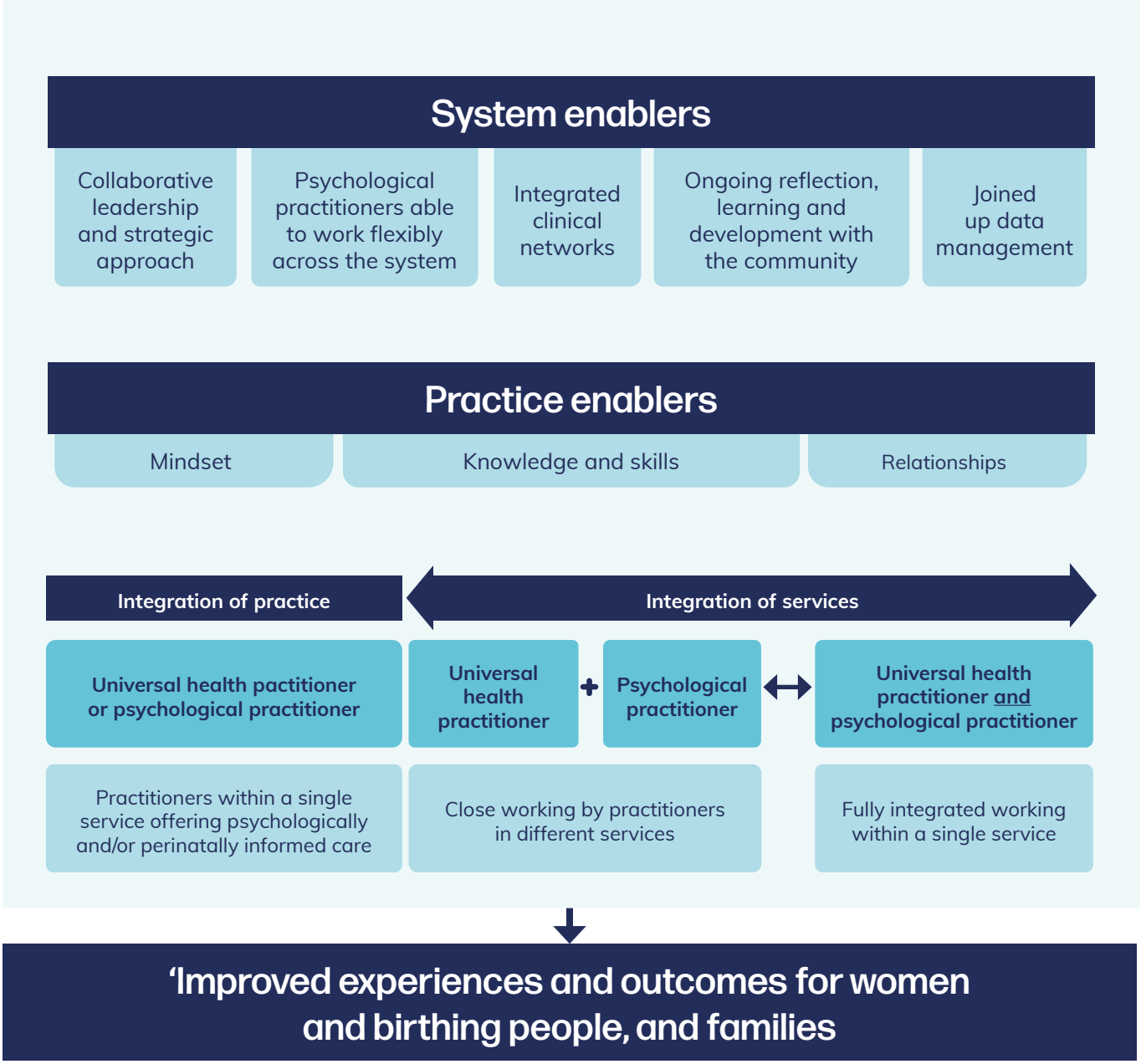
- The Integrate Model – a visual summary
- A good practice checklist

The integration of perinatal mental health psychological support into universal services and the wider system of care offers an important opportunity to improve access to evidence-based interventions for mild and moderate mental health difficulties. Around 16% of women and birthing people who experience common mental health difficulties in the perinatal period do not meet the threshold for specialist services. Some receive treatment through NHS Talking Therapies, however care is not routinely adapted for the perinatal period. Many other women and birthing people are not able to access evidence-based support at all. In the research conducted for this report, we heard about fragmented services, inequities in access to services and new parents feeling isolated and alone.

The integration of practice and services improves the availability, accessibility and quality of care for women and birthing people, and their families. This report proposes a gold standard model of integration, in which one perinatal mental health service (1PMHS) works flexibly across the system to provide evidence-based care for the full spectrum of mild to severe perinatal mental health difficulties. Integration enables services to provide care that is responsive, coordinated and that meets individual need, in turn leading to better experiences, outcomes and efficiencies. It is particularly beneficial for women and birthing people from marginalised communities, who are at greatest risk of perinatal mental health difficulties but who in turn often experience the most significant barriers to accessing services.

To achieve this nationally, a 1PMHS should be supported by a virtual leadership board spanning local geographical footprints (ICBs) with multi-service and multi-disciplinary representation, including service users, maternity and neonatal services, community health providers, specialist perinatal mental health services, NHS Talking Therapies, local authority Start for Life teams, and the new workforce for mild to moderate difficulties. This leadership team would ensure seamless, equitable, person-centred care across the system, provide single-point access and triage, and deliver training, supervision and consultation to staff. Based on 10,000 births adjusted for perinatal loss, around 9.5 WTE psychological practitioners are needed locally to meet mild to moderate needs—equating to an additional 518 WTE psychological practitioners nationally.

The Integrate Model
a visual summary



Good practice checklist

How can you tell if your service or system is succeeding in integrating perinatal mental health support across the system? This checklist can be used to help you assess your progress and consider actions to improve integration.

Area	Consideration	Not at all	Partly	Very much
Practice	Are universal services and mental health practitioners knowledgeable about perinatal mental health and the appropriate ways to identify and support women and birthing people with different mental health needs?			
	Do practitioners know about the local system, services available, pathways, referral processes, roles and responsibilities?			
	Are practitioners confident in delivering culturally-sensitive, psychologically-informed care?			
	Is there an open and collaborative approach to working across services?			
Services	Are referral processes integrated, for example using a single referral process or a single point of access to services?			
	Are community services co-located, for example using a family hub model?			
	Are specialist perinatal mental health teams integrated across the systems, for example offering training, support, consultation and supervision to professionals in other services?			
Systems	Is there joined-up leadership at commissioning-level that supports strategic planning, pooled budget lines and joint commissioning?			
	Are there opportunities for clinicians and other key stakeholders, including the VCSE, to come together to share learning, develop strategic priorities and improve practice, such as clinical networks?			
	Are women and birthing people, and their families routinely involved in service design and delivery, a from diverse communities?			
	Is there good quality data about which population groups are accessing universal and mental health services?			
	Are there clear data sharing protocols across services to support joint working and collaborative care?			
	Is data routinely used to inform strategic decision-making and monitor progress?			

References

1. Howard, L. M. & Khalifeh, H. (2020). Perinatal mental health: A review of progress and challenges. *World Psychiatry*, *19*(313), 313–327.

2. Royal College of Psychiatrists. (2025). What are perinatal mental health services? [Available from: https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/what-are-perinatal-mental-health-services]

3. Bauer, A., Parsonage, M., Knapp, M., Iemmi, V., & Adelaja, B. (2014). *The costs of perinatal mental health difficulties*. Centre for Mental Health and London School of Economics, 44.

4. Royal College of Psychiatrists. (2021). *Perinatal mental health services: Recommendations for the provision of services for childbearing women* (CR232).

5. Pan, A., Keum, N., Okereke, O. I., Sun, Q., Kivimaki, M., Rubin, R. R., & Hu, F. B. (2012). Bidirectional association between depression and metabolic syndrome: A systematic review and meta-analysis of epidemiological studies. *Diabetes Care*, *35*(5), 1171–1180.

6. Paulson, J. F., & Bazemore, S. D. (2010). Prenatal and postpartum depression in fathers and its association with maternal depression: A meta-analysis. *Journal of the American Medical Association*, *303*(19), 1961–1969.

7. Rogers, A., Obst, S., Teague, S. J., Rossen, L., Spry, E. A., Macdonald, J. A., Sunderland, M., Olsson, C. A., Youssef, G., & Hutchinson, D. (2020). Association between maternal perinatal depression and anxiety and child and adolescent development: A meta-analysis. *JAMA Pediatrics*, *174*(11), 1082–1092.

8. Royal College of Psychiatrists. (2021). *Perinatal mental health services: Recommendations for the provision of services for childbearing women* (CR232).

9. Sanger, C., Iles, J. E., Andrew, C. S., & Ramchandani, P. G. (2015). Associations between postnatal maternal depression and psychological outcomes in adolescent offspring: A systematic review. *Archives of Women's Mental Health*, *18*, 147–162.

10. Center on the Developing Child at Harvard University. (2009). Maternal depression can undermine the development of young children: Working Paper No. 8.

11. Cox, J. L., Murray, D. & Chapman, G. (1993). A controlled study of the onset, duration and prevalence of postnatal depression. *British Journal of Psychiatry*, *163*, 27–31.

12. Munk-Olsen, T., Laursen, T. M., Pedersen, C. B., Mors, O., & Mortensen, P. B. (2006). New parents and mental disorders – A population-based register study. *Journal of the American Medical Association*, *296*(21), 2582–2589.

13. Prady, S., Pickett, K., Croudace, T., Fairley, L., Bloor, K., Gilbody, S., *et al*. (2013). Psychological distress during pregnancy in a multi-ethnic community: Findings from the born in Bradford cohort study. *PLoS One*, *8*(4):e60693.

14. Brown, H. K., Cobigo, V., Lunsky, Y., Dennis, C. L., & Vigod, S. (2016). Perinatal health of women with intellectual and developmental disabilities and comorbid mental illness. *Canadian Journal of Psychiatry*, *61*(11), 714–723.

15. Royal College of Psychiatrists. (2021). *Perinatal mental health services: Recommendations for the provision of services for childbearing women* (CR232).

16. Swift, E. R., Pierce, M., Hope, H., Osam, C. S., & Abel, K. M. (2020). Young women are the most vulnerable to postpartum mental illness: A retrospective cohort study in UK primary care. *Journal of Affective Disorders*, *277*, 218–224.

17. World Health Organization. (2022). *Guide for integration of perinatal mental health in maternal and child health services.*

18. Nevin, V., & Jacques, R. (2024). *Opening doors: Access to early childhood services for families impacted by poverty in the UK*. NSPCC and UNICEF.

19. NHS England. (2024, May 2). *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/#:~:text=Around%20600%2C000%20women%20give%20birth,child%2C%20and%20the%20wider-%20family

20. Maternal Mental Health Alliance. (2023). *Specialist perinatal mental health care in the UK 2023.*

21. Ashford, M. T., Ayers, S., & Olander, E. K. (2017). Supporting women with postpartum anxiety: Exploring views and experiences of specialist community public health nurses in the UK. *Health & Social Care in the Community*, *25*(3), 1257–1264.

22. Care Policy and Evaluation Centre. (2022). *A sound investment.*

23. O'Mahen, H., Healy, S., Haycock, N., Igwe, S., Chilvers, R., & Butterworth, R. (2023). *NHS Talking Therapies for anxiety and depression perinatal positive practice guide*. University of Exeter.

24. Hogg, S. (2019). *Rare Jewels: Specialised parent-infant relationship teams in the UK*. Parent Infant Partnership UK.

25. Reed, J., Parish, N., & Baker, S. (2022). *Beyond Boundaries: Research on the integration of early years systems and services in London and how to work better together.* Isos Partnership for London Councils.

26. Nevin, V., & Jacques, R. (2024). *Opening doors: Access to early childhood services for families impacted by poverty in the UK*. NSPCC and UNICEF.

27. Nevin, V., & Jacques, R. (2024). *Opening doors: Access to early childhood services for families impacted by poverty in the UK*. NSPCC and UNICEF.

28. Peter, M., Wheeler, R,.Abe, C,. Awe, A. (2025). *The Five x More Black Maternity Experiences Survey: Continuing the conversation on Black maternal care in the UK*. Five x More.

29. Nevin, V., & Jacques, R. (2024). *Opening doors: Access to early childhood services for families impacted by poverty in the UK*. NSPCC and UNICEF.

30. World Health Organization. (2018). *Integrating health services: Brief.*

31. World Health Organization. (2022). *WHO guide for integration of perinatal mental health in maternal and child health services.*

32. Nevin, V., & Jacques, R. (2024). *Opening doors: Access to early childhood services for families impacted by poverty in the UK*. NSPCC and UNICEF.

33. Peter, M., Wheeler, R,.Abe, C,. Awe, A. (2025). *The Five x More Black Maternity Experiences Survey: Continuing the conversation on Black maternal care in the UK*. Five x More.

34. Royal College of Psychiatrists. (2021). *Perinatal mental health services: Recommendations for the provision of services for childbearing women* (CR232).

35. Bell, K., Ashby, B. D., Scott, S. M., & Poleshuck, E. (2024). Integrating mental health care in ambulatory obstetrical practices: Strategies and models. *Clinical Obstetrics and Gynecology*, *67*(1), 154–168.

36. Goedde, D., Zidack, A., Li, Y. H., Arkava, D., Mullette, E., Mullowney, Y., & Brant, J. M. (2021). Depression outcomes from a fully integrated obstetric mental health clinic: A 10-year examination. *Journal of the American Psychiatric Nurses Association*, *27*(2), 123–133.

37. Young, C. A., Burnett, H., Ballinger, A., Castro, G., Steinberg, S., Nau, M., Hayes Bakken, E., Thomas, M., & Beck, A. L. (2019). Embedded maternal mental health care in a pediatric primary care clinic: A qualitative exploration of mothers' experiences. *Academic Pediatrics*, *19*(8), 934–941.

38. Kruper, A., & Wichman, C. (2017). Integrated perinatal mental health care. *Psychiatric Annals*, *47*(7), 368–373.

39. Research provided by the Centre for Early Child Development, Blackpool. In Press.

40. Morrell, C. J., Warner, R., Slade, P., Dixon, S., Walters, S., Paley, G., & Brugha, T. (2009). Psychological interventions for postnatal depression: Cluster randomised trial and economic evaluation. The PoNDER trial. *Health Technology Assessment*, *13*(30), 1–176.

41. Waqas, A., Koukab, A., Meraj, H., Dua, T., Chowdhary, N., Fatima, B., & Rahman, A. (2022). Screening programs for common maternal mental health disorders among perinatal women: Report of the systematic review of evidence. *BMC Psychiatry*, *22*(1), 54.

42. Boots Family Trust Alliance. (2013). *Perinatal mental health experiences of women and health professionals.* Boots Family Trust, Netmums, Institute for Health Visiting, Tommy's, and Royal College of Midwives.

43. Maternal Mental Health Alliance and Reform. (2024). *Listening to the stories of women who have experienced child removal due to drug and alcohol use.*

44. Reed, J., Parish, N., & Baker, S. (2022). *Beyond Boundaries: Research on the integration of early years systems and services in London and how to work better together.* Isos Partnership for London Councils.

45. Nevin, V., & Jacques, R. (2024). *Opening doors: Access to early childhood services for families impacted by poverty in the UK*. NSPCC and UNICEF.

46. Nevin, V., & Jacques, R. (2024). *Opening doors: Access to early childhood services for families impacted by poverty in the UK*. NSPCC and UNICEF.

47. Barr, K. R., Nguyen, T. A., Pickup, W., Cibralic, S., Mendoza Diaz, A., Barnett, B., & Eapen, V. (2024). Perinatal continuity of care for mothers with depressive symptoms: Perspectives of mothers and clinicians. *Frontiers in Psychiatry, 15*, Article 1385120.

48. Peter, M., Wheeler, R,.Abe, C,. Awe, A. (2025). *The Five x More Black Maternity Experiences Survey: Continuing the conversation on Black maternal care in the UK*. Five x More.

49. Center on the Developing Child at Harvard University. (2009). Maternal depression can undermine the development of young children: Working Paper No. 8.

50. North Central and East London (NCEL) Perinatal Provider Collaborative. (2025). *Strategic Health Needs Assessment*. Anna Freud: London. [Available from https://www.elft.nhs.uk/sites/default/files/2025-05/NCEL%20Perinatal%20PC%20SHNA.pdf].

51. Reed, J., Parish, N., & Baker, S. (2022). *Beyond Boundaries: Research on the integration of early years systems and services in London and how to work better together.* Isos Partnership for London Councils.

52. Myors, K. A., Schmied, V., Johnson, M. & Clearly, M. (2013). Collaboration and integrated services for perinatal mental health: An integrative review. *Child and Adolescent Mental Health*, *18*(1), 1–10.

53. Austin, M. P., Colton, J., Priest, S., Reilly, N., & Hadzi-Pavlovic, D. (2013). The antenatal risk questionnaire (ANRQ): Acceptability and use for psychosocial risk assessment in the maternity setting. *Women and Birth*, *26*(1), 17–25.

54. Schmied, V., Reilly, N., Black, E., Kingston, D., Talcevska, K., Mule, V., & Austin, M. P. (2020). Opening the door: midwives' perceptions of two models of psychosocial assessment in pregnancy – A mixed methods study. *BMC Pregnancy and Childbirth*, *20*(1), 451.

55. Goodson, B. D., Mackrain, M., Perry, D. F., O'Brien, K., & Gwaltney, M. K. (2013). Enhancing home visiting with mental health consultation. *Pediatrics*, *132*(Suppl. 2), S180–S190.

56. Bloxsome, D., Ireson, D., Doleman, G. & Bayes, S. (2018). Factors associated with midwives' job satisfaction and intention to stay in the profession: An integrative review. *Journal of Clinical Nursing*, *28*(3-4), 386–399.

57. Care Policy and Evaluation Centre. (2022). *A sound investment.*

58. World Health Organization. (2022). *Guide for integration of perinatal mental health in maternal and child health services.*

59. Royal College of Psychiatrists. (2021). *Perinatal mental health services: Recommendations for the provision of services for childbearing women* (CR232).

60. World Health Organization. (2022). *Guide for integration of perinatal mental health in maternal and child health services.*

61. Barkham M, Bewick B, Mullin T, Gilbody S, Connell J, Cahill J, et al. *The CORE-10: a short measure of psychological distress for routine use in the psychological therapies. Couns Psychother Res.* 2013;13(1):3–13.

62. Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression. *Development of the 10-item Edinburgh Postnatal Depression Scale.* Br J Psychiatry 1987; 150: 782–786.

63. National Institute for Health and Care Excellence. (2014). *Antenatal and postnatal mental health: Clinical management and service guidance* (Clinical guideline CG192). Last updated 11 February 2020.

64. World Health Organization. (2022). *Guide for integration of perinatal mental health in maternal and child health services.*

65. Royal College of Psychiatrists. (2021). *Perinatal mental health services: Recommendations for the provision of services for childbearing women* (CR232).

66. NHS England, 2025. Enquiry: Mental Health Assessment Recording in MSDS, Jan-Dec 2024. [Available from NHS England or authors upon reasonable request] NICE, 2021. Antenatal care. [Available from: https://www.nice.org.uk/guidance/ng201]

67. Institute of Health Visiting. (2025). *State of Health Visiting, UK survey report. From disparity to opportunity: The case for rebuilding health visiting*. London: IHV.

68. Royal College of Midwives. (2023). *England: State of maternity services 2023*. London: RCM.

69. Royal College of Psychiatrists. (2021). *Perinatal mental health services: Recommendations for the provision of services for childbearing women* (CR232).

70. Beauchamp, H. (2023). *Specialist Health Visitors in Perinatal and Infant Mental Health: Where they are and what they're doing*. Institute of Health Visiting.

71. Beauchamp, H. (2023). *Specialist Health Visitors in Perinatal and Infant Mental Health: Where they are and what they're doing*. Institute of Health Visiting.

72. Royal College of Midwives. (2023). *Strengthening perinatal mental health: A roadmap to the right support at the right time.*

73. First 1001 Days Movement. (2022). *Why Health Visitors Matter: Perspectives on a widely valued service.*

74. Nevin, V., & Jacques, R. (2024). *Opening doors: Access to early childhood services for families impacted by poverty in the UK*. NSPCC and UNICEF.

75. O'Mahen, H., Healy, S., Haycock, N., Igwe, S., Chilvers, R., & Butterworth, R. (2023). *NHS Talking Therapies for anxiety and depression perinatal positive practice guide*. University of Exeter.

76. Horwath, J., & Morrison, T. (2007). Collaboration, integration and change in children's services: critical issues and key ingredients. *Child Abuse & Neglect*, *31*(1), 55–69.

77. O'Mahen, H., Healy, S., Haycock, N., Igwe, S., Chilvers, R., & Butterworth, R. (2023). *NHS Talking Therapies for anxiety and depression perinatal positive practice guide*. University of Exeter.

78. NHS England and NHS Improvement. 2018). *The improving access to psychological therapies (IAPT) pathway for people with long-term physical health conditions and medically unexplained symptoms*.

79. Hogg, S. (2024, March 13). *Rethinking specialist services: The "two triangle" model*. Isos Partnership. https://www.isospartnership.com/blog/two-triangles-model

80. Royal College of Psychiatrists. (2021). *Perinatal mental health services: Recommendations for the provision of services for childbearing women* (CR232).

81. NHS England and NHS Improvement (N.D.). *Online library of quality, service improvement and redesign tools: Plan, Do, Study, Act (PDSA) cycles and the model for improvement.*

82. Maternal Mental Health Alliance. (2024). *Maternal mental health services progress report.*

Appendix

Workforce Model – Integrating Psychological Support for Common Perinatal Mental Health Difficulties

Brief Summary

This workforce model outlines the staffing required to deliver evidence-based perinatal mental health (PMH) support for a population of 10,000 births, adjusted for perinatal losses. The model focuses on mild–moderate PMH cases, incorporates both high- and low-intensity interventions, accounts for planning, dose adherence, and clinical supervision, and includes a clinical lead who contributes to both leadership and patient care.

1. Perinatal Loss Adjustment

To capture the full population potentially requiring support, we adjust births for perinatal losses not already included in live birth statistics.

Event	Per 10,000 births	Source
Miscarriage	1,984	Tommy's / SANDS Joint Policy Unit (2024)
Ectopic pregnancy	198	DHSC Fingertips
Stillbirth	40	ONS
Medical terminations	65	DHSC Abortion Statistics
Total losses	2,287	Combined total

Adjusted population: 10,000 births × 1.2287 ≈ 12,287

2. Interventions Offered by Workforce

Intervention	% Patients	Cases	Clinical hours per patient*	Notes
High-intensity interventions	65%	663	14.625	1 hr assessment + 12 hr treatment, 75% delivered dose, 30 min per hour planning, 20% consultation/training
Low-intensity interventions	35%	357	9	1 hr assessment + 7 hr treatment, 75% delivered dose, 30 min per hour planning
Both	15% of HI	99	Included in both groups	Patients receiving both low- and high-intensity care

*Clinical hours include adjustments for dose adherence and planning/administration.

Total hours: 14,843 hr

3. Proposed Staffing Model based on 10,000 births adjusted for perinatal loss

Role	FTE	Band	Caseload
Low-intensity therapist	2	Band 5	357 patients
High-intensity therapist	7	Band 7	625 patients
Clinical lead	0.5	Band 8a	38 patients
Total	**9.5**	—	**1,020 patients**

4. Key Assumptions

1. Population: 10,000 births, adjusted ×1.2287 for perinatal losses (miscarriage, ectopic, stillbirth, medical terminations). Neonatal deaths excluded.
2. Mild–moderate PMH prevalence: 15.8%.
3. Non-take-up of service: 30% of eligible patients do not engage with service.
4. Dose adherence: 75% of planned treatment delivered (applied to clinical hours).
5. Planning/administration: 30 minutes per clinical hour included.
6. Service mix: 65% high-intensity, 35% low-intensity.
7. Overlap: 15% of high-intensity patients previously received low-intensity care.
8. High-intensity consultation/training: 20% of total high-intensity hours.
9. FTE: 42 working weeks per year × 37.5 hr/week.
10. Staff bands: Low-intensity Band 5, High-intensity Band 7, Clinical lead Band 8a.
11. Clinical lead caseload: 70% of 0.5 FTE available for patient care (~38 patients).

5. National Context: Unmet Need

There were approximately 545,000 births in 2023–24 in England, with an adjusted baseline including perinatal losses of ~670,000. Applying a prevalence of 25.8% for perinatal mental health difficulties, an estimated ~173,000 women and birthing people may experience a mild–moderate mental health problem each year. Current specialist services supported only 57,170 women, leaving an unmet need of over 115,000 people. Scaling the workforce model to cover all births in England would require approximately 518 WTE staff, including 109 low-intensity Band 5 therapists, 382 high-intensity Band 7 therapists, and 27 Band 8a clinical leads. This highlights the substantial workforce expansion needed to meet national demand.

6. Conclusion

This model provides a comprehensive, evidence-informed framework to deliver mild–moderate perinatal mental health support for 10,000 births (adjusted for losses) based on a new workforce comprised of 2 low-intensity Band 5 therapists, 7 high-intensity Band 7 therapists, and 0.5 FTE Band 8a clinical lead

References

Talking Therapies & Workforce

1. Health Education England (2022). NHS Talking Therapies for Anxiety and Depression Workforce Census 2022 – National Report.
   HEE Workforce Census
2. NHS Digital (2023–24). NHS Talking Therapies Annual Reports.
   NHS Digital TT Annual Report
3. Nuffield Trust (2024). *Does the NHS Talking Therapies service have an attrition problem?*
   Nuffield TT Attrition Report

Perinatal Loss and Mental Health Prevalence

4. Tommy's & SANDS (2024). Counting UK Miscarriages – *Joint Policy Unit Report*.
5. Office for Health Improvement and Disparities. (2025). *Hospital admissions for ectopic pregnancy — Fingertips maternal health profile* [Data set]. GOV.UK. https://fingertips.phe.org.uk/profile-group/child-health
6. Office for National Statistics (2022). *Stillbirths and Neonatal Deaths in England and Wales.*
7. Department of Health & Social Care (2022). *Abortion Statistics for England and Wales.*
8. Office for Health Improvement and Disparities. (2025). *Estimated prevalence of perinatal mental health conditions in England, 2016 and 2019*. GOV.UK. https://www.gov.uk/government/publications/perinatal-mental-health-condition-prevalence/estimated-prevalence-of-perinatal-mental-health-conditions-in-england-2016-to-2019

Workforce Productivity

9. NHS England (2021). *Allied Health Professions Productivity Measurement Guidance.*

Economic & Public Health Context

10. Bauer et al. (2014). The Costs of Perinatal Mental Health Problems. LSE / PSSRU.
11. NHS England (2023). *Perinatal Mental Health Programme: Service Expansion Updates.*