FIVEXMORE



UNDERSTANDING BLACK MATERNAL MENTAL HEALTH IN THE UK: FINDINGS FROM THE FIVE X MORE BLACK MATERNITY EXPERIENCES REPORT

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CONTENTS

Foreword 3

Acknowledgements 4

Introduction 5

Methods 10

Results 12

Discussion 24

Closing words 25

References 31

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FOREWORD



Atinuke Awe and Clotilde Abe

Co-founders of Five x More

There is a particular kind of loneliness that comes from suffering in silence while surrounded by people who are meant to be caring for you. That loneliness sits at the heart of this report.

When we published the last Black Maternity Experiences Report in 2025, mental health was present in almost every experience we were told, but it was not given its own space. Women spoke of it in passing either through a difficult birth, a dismissive appointment or a fear they couldn't quite name and we knew then that it deserved a spotlight. This is why we decided to publish these findings so that Black women's maternal mental health experiences had their own dedicated space.

Five hundred and twenty seven Black women told us they had experienced a mental health problem before, during, or after pregnancy. That is not a small number, and yet formal diagnosis, timely information, and consistent support remained the exception rather than the rule. Many were never asked how they were feeling. Some were asked in a way that felt like a box being ticked. Others carried real distress and said nothing at all, weighing up whether being honest was worth the risk of being seen as unstable, or unfit to keep their own baby.

What we heard from Black women in this survey reflects wider experiences of inequality, mistrust and barriers to accessing services that shape how Black families engage with mental health services. Understanding this context is essential if we want to support Black families.

At the same time, this report holds real hope. Whenever women encountered a midwife who showed compassion and kindness or someone who simply took the time it had a real lasting impact. These experiences prove that good care already exists and can be built into the system rather than left to chance.

We are publishing these findings alongside a growing wave of national attention on Black maternal health from ongoing enquiries and taskforces, to reports like the recent National Maternity and Neonatal Investigation. We see these findings as a valuable contribution to sit alongside what already exists and to make it harder to ignore the experiences of Black women.

As ever, we are grateful to the Black women who trusted us with these experiences, many for the first time. We acknowledge that this is built on the courage and honesty of these Black women and it is an honour to not only serve them but to represent them in front of policy and change makers.

Our sentiment is clear. Fix it for Black women, fix it for all women.

ACKNOWLEDGEMENTS

This report exists because of the many people who believed in its importance and gave generously of themselves to make it happen.

To the Black women who opened up to us through this survey: you are at the heart of this report. You shared not only your experiences, but you also trusted us with your highs and lows. We don't take that trust lightly, and your stories will continue to move through the world, creating understanding and demanding change.

To everyone else who made this work possible from our expert panel who shared their passion and expertise, the health professionals for sharing their knowledge and the reviewers who pushed us to ask more questions. Our special thanks go out to Dr Michelle Peter and Reyss Wheeler, our researchers who took the numbers and quotes and brought the data to life. Thank you for believing in the power of these stories and helping us tell them with the care they deserve. We would also specially like to thank Danielle Bridge and Darlington Zvionere from Black Minds Matter who dedicated extra time to ensure the questions in the survey for the mental health section were accurate.

We would also like to acknowledge the team at Clifford Chance who have supported us right from the beginning.

Finally, to our wider community thank you for continuing to believe in us and for all your support.

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INTRODUCTION



1 INTRODUCTION

For many, pregnancy and motherhood are transformative. Yet, for a number of women, this time also presents a challenge to their emotional and psychological wellbeing. Whilst some women enter pregnancy already living with mental health conditions, others encounter these problems for the first time during pregnancy or in the year after giving birth – a time referred to as the perinatal period.

Mental health problems experienced during this time (known as perinatal mental health problems (PMH)) are not unusual and are experienced by up to 1 in 5 women[1]. With symptoms that include persistent worry, trouble forming an emotional attachment to the baby, and low mood[2]. Perinatal depression (PND), which affects around 11% of women[3] can significantly disrupt a woman's quality of life and ability to function day to day. At its worst, PND can be fatal, and suicide is one of the leading causes of death for women between six weeks and one year after the end of pregnancy[4]. Perinatal anxiety (PNA), affecting around 21% of women worldwide[5], can manifest in a range of ways, including difficulty relaxing, disrupted sleep, cycles of overwhelming or intrusive thoughts, and sudden feelings of panic[6]. As well as this, 25,000 women a year experience post-traumatic stress disorder (PTSD) after giving birth and 10% are affected by tokophobia – a fear of childbirth[7]. Crucially, the impact of PMH problems may extend beyond the perinatal period, with long-term consequences for both mothers and their babies[8].

A key issue, however, is that although these challenges affect many women, the burden of PMH problems is not felt equally.



The crisis facing Black women



Black women are at greater risk of developing PMH problems largely because they are more often exposed to the very factors that give rise to them. Bereavement following stillbirth or neonatal death is a risk factor for mental health problems[9], and Black women are significantly more likely than women from other ethnic groups to experience both stillbirth and having their baby die within the first 28 days after birth[10,11,12,13]. Experiencing racial discrimination is known to harm mental health[14], and Black women report facing it all too often in maternity care, with lasting consequences for their wellbeing[15].

Yet, despite these heightened risks, Black women are less likely to have their mental health needs recognised or adequately supported[16,17]. This disparity is driven by multiple factors. Systemic issues, such as a lack of cultural competence and harmful assumptions from healthcare professionals can lead to Black women's symptoms being misinterpreted or overlooked entirely. Our own study[18], and elsewhere[19], highlight that Black women are frequently perceived by professionals as naturally resilient or able to cope with pain, reflecting the deeply ingrained and damaging stereotype of the "strong Black woman".

Assumptions like these are compounded by a broader failure to proactively ask Black women about their mental health, alongside a lack of training in identifying PMH problems[20]. For example, a recent report commissioned by the Maternal Mental Health Alliance found that, without specific training, midwives and health visitors often lacked the confidence and skills to ask about mental health and had limited awareness of the support available through primary mental health services. The report also highlighted how inappropriate screening procedures can make it harder to identify mental health problems, particularly amongst Black women and women from other racially minoritised groups. In line with this, healthcare professionals have been shown to be less likely to initiate conversations about emotional wellbeing with women from racially minoritised backgrounds[21] and less likely to offer treatment after birth[22].

Our 2025 report further corroborated these findings. Many Black women told us they were never asked how they were feeling emotionally during their care. Some were met with indifference when they raised concerns and others recalled being asked in a "tick-box way", with no meaningful follow-up even after disclosing distress. Notably, only a quarter remembered being asked about their mental health at their six-week postnatal check - a critical point of contact where GPs are expected, according to NICE guidelines[23], to assess both the mother's physical and emotional wellbeing. However, many women in our study described this appointment as rushed, impersonal, or overly focused on the baby.

The consequences of this lack of early support can be severe: Black women are more likely to reach mental health services only at crisis point, often through involuntary admissions (despite high levels of engagement when services are available) precisely because they have lower access to community mental health care during the perinatal period[24].

Alongside structural barriers, individual and cultural factors may also play a role. Some Black women report a lack of awareness about mental health issues, both personally[25] and within their families[26], as well as limited knowledge of available services[27]. Research has also found that some Black Caribbean women living in the UK do not view their post-birth distress as a mental health problem but instead feel pressure to normalise it and embody the "strong Black woman" ideal[28]. Stigma and fear of judgment from family may also make it difficult to seek help early[29]. Clearly, there is an urgent need to improve access to PMH services - particularly for those who are at greatest risk of poor outcomes and also least likely to receive timely, appropriate care.

What is being done to close the gaps in perinatal mental health care?

The need to improve PMH services has been acknowledged at national level for some time: The 2019 NHS Long Term Plan[30] committed to expanding specialist PMH services, reflecting growing awareness of both the human and economic costs of PMH problems - estimated to be around £1.2 billion per year[31], due in part to prolonged sick leave and increased healthcare use[32]. However, the government's Fit for the Future 10-Year Health Plan[33], launched in July 2025, has shifted focus towards prevention and digital transformation without explicitly prioritising PMH. With previous targets removed from national planning guidance, we are left wondering: Will perinatal mental health receive the attention, resources, and strategic direction it requires?

In response to this policy gap, organisations across the maternity and mental health sectors have stepped up to highlight what is urgently needed. The Maternal Mental Health Alliance has called for greater investment, earlier intervention, and culturally sensitive care as essential steps toward ensuring that all women - especially those most at risk - receive the support they need throughout pregnancy and after birth[34]. Tommy's, the pregnancy charity, has also made maternal mental health an important pillar of its work[35]. Through its Mental Health and Wellbeing Plan, the organisation has committed to improving outcomes through access to compassionate, timely, and culturally safe support throughout pregnancy and after birth.

Yet, despite these efforts, there remains little understanding of how these gaps affect Black women in particular - women who face some of the highest risks for perinatal mental health problems but who are among the least likely to have their needs recognised or met. Without targeted evidence, policy and service improvements risk overlooking the specific barriers and inequalities that Black women face. This is why this report is vital.

Focusing in: Black women's perinatal mental health experiences

The 2025 Five X More national survey on Black women's maternity experiences[36] made clear that mental health is an important factor in how Black women experience pregnancy, birth, and postnatal care[37]. The voices of women in our study highlighted how emotional wellbeing was too often overlooked with negative consequences for both mothers and babies.

For this reason, the 2025 survey included a dedicated section specifically for Black women who had experienced mental health difficulties before, during, or shortly after pregnancy. In the current report, we focus exclusively on the experiences of these women, examining the nature of their mental health challenges and the support they were offered. By doing so, we aim to shine a light on how mental health intersects with maternity care for Black women in the UK, and to identify where change is needed.

Language and inclusivity

Throughout this report, we use the term "women" to describe those who have accessed maternity services. We recognise that not all people who become pregnant or give birth identify as women. We have chosen this approach for readability and to reflect the language used by the majority of participants, while acknowledging the need for gender-inclusive care and language in all aspects of maternity services.

We are mindful of the importance of representing the views of all pregnant women and birthing people and the survey was open to anyone in the UK who identified as Black or Black mixed heritage, including people from LGBTQIA+ or non-binary backgrounds. For consistency, we felt it important that the language used in this report reflects the language used in the survey. We therefore refer to "Black women" and "Black mixed heritage women" throughout this report.

Disclaimer

Please note that this report includes discussion of traumatic and uncomfortable birthing experiences which some readers may find distressing.

METHODS



2 METHODS

Study design

This report presents findings from a subset of questions within the 2025 Five X More national survey on Black women's maternity experiences in the UK[38]. The survey described in that report explored a range of issues across antenatal, labour and delivery, and postnatal care. A detailed account of the overall study design and recruitment strategy is provided in the 2025 Five X More report.

Participants

At the end of the survey described in the 2025 Five X More report, respondents who self-identified as having experienced mental health problems before, during or after pregnancy were routed to a further section of the survey that asked questions about their mental health. Only those who had already met the survey's eligibility criteria (identifying as Black or Black mixed heritage; pregnant between July 2021 and March 2025; living in the UK at the time of their maternity experience) and who indicated that they had experienced mental health problems were taken to the mental health section in the survey.

Recruitment and data collection

Recruitment to the main survey was through a targeted social media campaign, using platforms such as Instagram, TikTok, newsletters and LinkedIn. Posts were shared by community groups, national maternity organisations, health professionals and social media influencers. Recruitment messaging emphasised the importance of centring Black women's voices.

The survey was open from 5th February 2025 to 4th April 2025 and was hosted on a secure digital platform accessible via a web link. Before beginning the survey, participants were provided with an online information sheet and asked to give informed consent. The mental health section of the survey included mostly closed-test questions, with three open-text questions. Questions covered: 1) Self-reported mental health status before, during and after pregnancy; 2) Whether women were asked about their mental health by healthcare professionals; 3) Whether women had disclosed mental health concerns, and how these were received; 4) Access to specialist support, treatment, or counselling; 5) Barriers to seeking help; and 6) Perceptions of how mental health influenced women's overall maternity experience.

Data analysis

Quantitative responses were summarised using descriptive statistics to provide frequencies and proportions. Responses from the three open-text questions were used primarily to add context and depth to the quantitative findings rather than to form a standalone qualitative dataset.

RESULTS



3 RESULTS

Participant demographics

Of the 845 respondents who provided responses to the main survey, 527 (62%) reported experiencing a mental health problem and went on to complete the mental health section of the survey.

For those who provided it, demographic information is provided below.

Ethnicity

All respondents identified as Black or Black mixed heritage. The largest ethnic group was Black African, accounting for 38% of respondents (n = 202), followed by Black Caribbean respondents, who comprised 27% (n = 144) of the sample. A further 20% (n = 106) identified as Mixed Black Caribbean and White heritage. The remaining participants reported other Black or mixed Black heritage backgrounds (Table 1).

Table 1. Participant ethnicity

Ethnicity	%	N
Black British / African	38%	202
Black British / Caribbean	27%	144
Mixed Ethnicity – Black British Caribbean and White	20%	106
Black Mixed Other	6%	29
Black British / African and Caribbean	5%	23
Mixed Ethnicity – Black British African and White	2%	12
Black Other	2%	11
Total	**100%**	**527**

Region

Women reported receiving maternity care across 87 NHS trusts throughout the UK. Just over half of respondents (51%; n = 270) were based in or around Greater London, while a further 16% (n = 82) reported receiving care in the South East of England. The remaining received their care across other regions of the UK, reflecting a range of maternity service contexts (Table 2).

Table 2. The region participants lived in at the time of their pregnancy

Region	%	N
London / Greater London	51%	270
South East of England	16%	82
West Midlands	8%	42
East Midlands	5%	27
East of England	5%	26
North West of England	5%	25
Yorkshire and Humberside	4%	20
South West of England	3%	16
North East of England	1%	8
Wales	1%	6
Scotland	1%	3
Northern Ireland	0%	2
Total	**100%**	**527**

Age

Around three quarters of respondents (74%; n = 388) reported being between 26 and 35 years old at the time of their pregnancy. A further 19% (n = 100) were between 36 and 45 years old (Table 3)

Table 3. The age of participants at the time of their pregnancy

Age	%	N
26-35	74%	388
36-45	19%	100
18-25	7%	37
11- 15	<1%	2
Total	**100%**	**527**

Pregnancy history and outcomes

Sixty-four percent of respondents (n = 336) reported having had one pregnancy between July 2021 and March 2025, and 36% (n = 191) reported two or more pregnancies during this time. At the time of completing the survey, 87% of respondents (n = 459) were not pregnant. Thirteen percent of women (n = 60) reported that the pregnancy they were referring to in the survey had resulted in a loss, including ectopic pregnancy, molar pregnancy, medical termination, stillbirth, or neonatal death (Table 4).

Table 4. The outcome of the participants pregnancy

Pregnancy outcome	%	N
Full-term birth (39 weeks 0 days - 40 weeks 6 days)	46%	210
Early-term birth (37 weeks 0 days - 38 weeks 6 days)	18%	84
Late-term birth (41 weeks 0 days - 41 weeks 6 days)	15%	69
Miscarriage (loss of pregnancy before 23+6 weeks)	7%	32
Premature birth (before 37 weeks)	6%	28
Stillbirth (loss of pregnancy after 24 weeks)	2%	11
Post-term birth (after 42 weeks)	2%	8
Neonatal death (within 28 days of birth)	2%	7
Ectopic pregnancy (when the embryo attaches outside womb)	1%	5
Termination for medical reasons	1%	4
Molar pregnancy (when embryo doesn't form properly)	0%	1
Total	**100%**	**459**

Education

Participants were generally highly educated with the majority holding an undergraduate degree or higher qualification (86%; n = 454). Fewer than 1% (n = 4) reporting having no formal qualifications (Table 5).

Table 5. The highest level of education of the participant at the time of their pregnancy

	%	N
BA / BSc	56%	296
MA / MSc	28%	150
Post-16 Certificate or Diploma	6%	32
A-Level (1+)/ Or equivalent e.g. Scottish Higher level	5%	25
GCSE (5+)/ Or equivalent e.g. Scottish N5	2%	11
PhD	2%	8
No formal qualification	1%	4
Level 4	0%	1
Total	**100%**	**527**

Household income

Nearly three quarters of respondents (74%; n = 388) reported household incomes above the UK national average, while 12% reported household incomes below £40,000 (n = 121).

Religion

Christianity was the most commonly reported faith, with 64% of respondents (n = 339) identifying as Christian. Almost one quarter (24%; n = 124) reported having no religion, while 8% (n = 40) identified as Muslim. Smaller numbers of participants reported other religious affiliations (Table 6).

Table 6. The religion of the participant at the time of their pregnancy

Religion	%	N
Christian	64%	339
No religion	24%	124
Muslim	8%	40
Prefer not to say	2%	13
Any other religion	2%	9
Buddhist	<1%	2
Total	**100%**	**527**

Disability and learning needs

Eight percent of respondents (n = 41) indicated that they had a disability, and 5% reported having a learning need (n = 25).

Survey findings

This section presents the quantitative and qualitative findings from the mental health survey which asked questions relating to experiences of mental health difficulties across the maternity journey, including prevalence of self-reported mental health concerns, the extent to which these concerns were recognised within maternity services, and the types of support offered or accessed. Although 527 people took part in the survey, not all respondents answered every question. As a result, the sample size (n) varies across analyses and reflects the number of participants who provided a response to each individual item.

1. When in the maternity journey mental health conditions were experienced

Respondents were first asked to indicate when in their maternity journey they had experienced mental health problems: Before, during, or after birth. Respondents could select more than one answer to reflect the length of time experiencing their mental health condition (Figure 1).

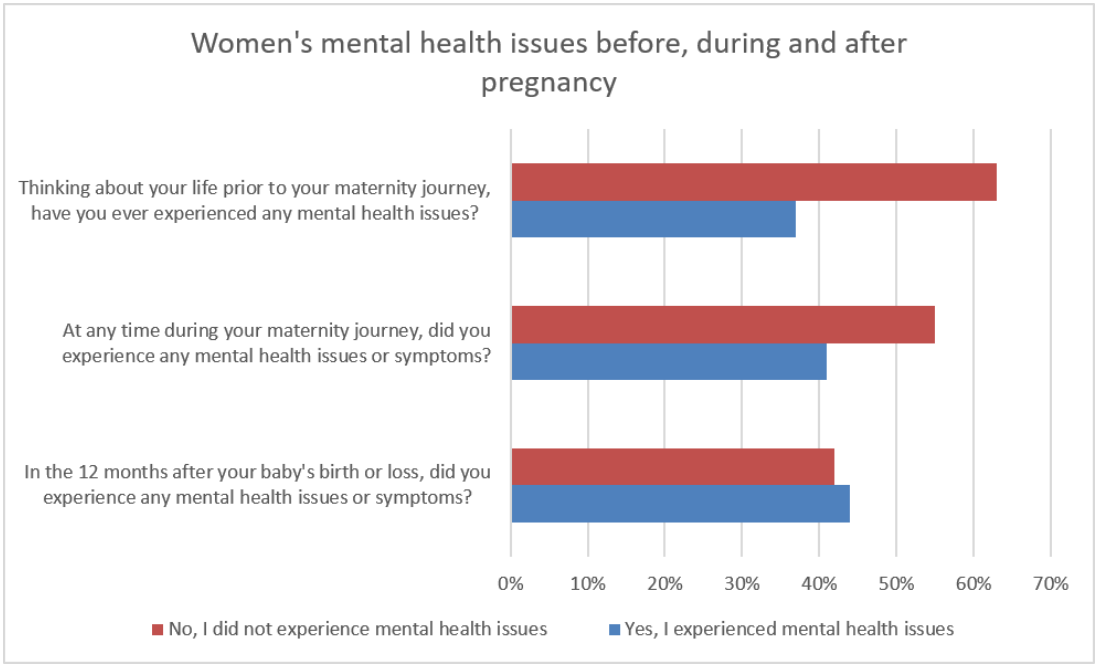


Figure 1. Percentages of women who reported experiencing a mental health condition before, during and after their pregnancy

Of the 527 included in this survey, 59% (n = 311) reported that they had experienced mental health issues prior to becoming pregnant. Within this group, 13% (n = 40) said that they had received medication to manage their mental health condition before pregnancy. For two thirds of respondents (66%; n = 348), mental health problems were experienced during pregnancy and for 71% (n = 372), mental health problems were experienced during the postnatal period.

Despite the relatively high prevalence of self-reported mental health concerns, only a small proportion reported receiving a formal clinical diagnosis from a healthcare professional (Figure 2).

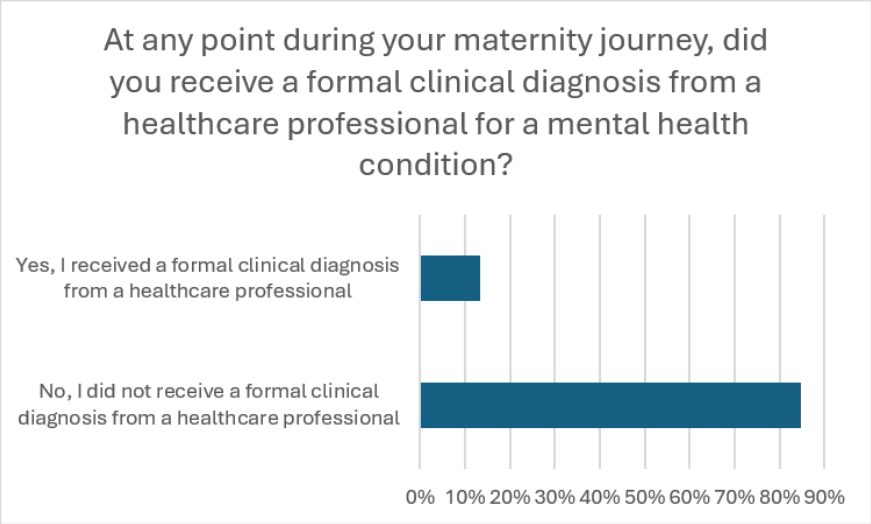


Figure 2. Percentage of women who reported receiving a clinical diagnosis from a healthcare professional for a mental health condition during their pregnancy

Amongst the 53 respondents who described receiving a diagnosis, 70 mental health conditions were reported, indicating that some were diagnosed with multiple conditions (Table 7). Depression made up just over half of diagnoses (52%; n =36) whilst anxiety made up a third (33%; n = 23).

Table 7. Mental health conditions where a formal clinical diagnosis was received.

Clinical diagnosis	%	N
Anxiety	33%	23
Depression	26%	18
Postnatal depression	23%	16
Post-traumatic stress disorder (PTSD)	8%	6
Birth trauma	4%	3
Antenatal depression	3%	2
Agoraphobia	3%	2
Total	**100%**	**70**

2. Feelings on being asked about thoughts or feelings of suicide

When reflecting on how they felt being asked about thoughts or feelings of suicide, 53% of women (n = 239) stated that they had not been asked at any point during their maternity care. Amongst those who did discuss this with a healthcare professional, views on being asked varied but were largely neutral to positive. The most common response was that women were "fine" with being asked (30%; n = 40). A further 20% (n = 26) viewed the question as standard practice, recognising it as a routine part of maternity care:

> ***"I understand that these types of questions have to be asked just in case."***
> (F333, Mixed heritage – Black British Caribbean and White, 36-45)

Almost a quarter of respondents (24%; n = 32) reported feeling pleased to be asked, describing the experience as one in which they felt "seen" and that the healthcare professional "cared." For these women, the question signalled attentiveness and emotional awareness, and they valued being given explicit space to discuss their mental wellbeing. One respondent said:

> ***"I'm glad it was asked as there are moments when the journey has been difficult."***
> (F733, Black British African, 26-35)

Another reflected:

> ***"I felt that my midwife was paying attention and taking her job seriously."***
> (F1061, Black British African, 26-35)

Notably, a small number of women (9%; n = 12) reported feeling scared when asked, expressing concern that disclosing suicidal thoughts could result in negative consequences. These fears included worries that social services might remove their baby from their care, as well as concerns that simply being asked about suicide - or becoming more aware of such thoughts - might heighten their own vigilance or vulnerability, potentially triggering or intensifying suicidal feelings. Others feared that they could be judged as unsafe or unstable, but at the same time, recognised the importance of honesty in order to access appropriate support:

> ***"I had a fleeting thought that perhaps if I admit to these thoughts then I would be seen as a danger to myself. This made me hesitate to answer but I know it's important to be transparent to get the right help."***
> (F923, Mixed heritage – Black British Caribbean and White, 36-45)

Others described feeling uncomfortable and "awkward" (6%; n = 8), highlighting the sensitivity of the topic.

3. Information about emergency mental health support and contact with specialist mental health professionals

Those who experienced mental health difficulties during their maternity journey were asked whether they were given information about how to access emergency mental health services. Thirty percent (n = 128) reported that they were given information about how to access urgent support. However, 56% (n = 238) stated that they were not told how to access emergency mental health services (Figure 3).

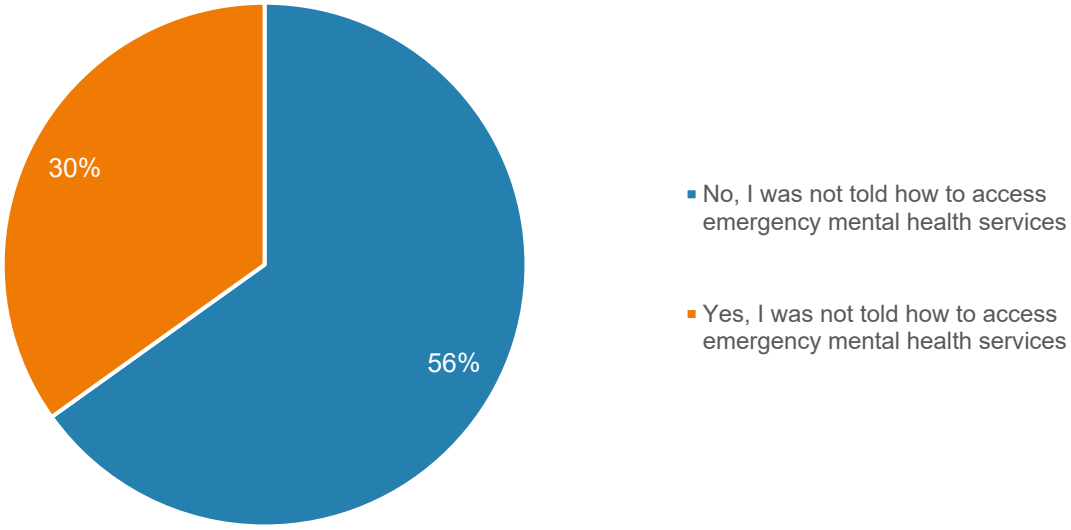


Figure 3. Percentage of women who were told how to access emergency mental health services during their maternity journey

When asked whether they had seen a mental health midwife at any point during their maternity care, the majority - 88% (n = 317) - said that they had not. When reflecting on whether they had been referred or signposted to a mental health support service, 39% (n = 159) stated that they were referred or directed towards a support service or organisation whilst 61% (n = 248) were not.

4. Comfort discussing mental health with healthcare professionals

The survey also explored comfort in disclosing mental health concerns to healthcare professionals involved in their maternity care. Almost a third of respondents (30%; n = 130) said that they felt uncomfortable sharing information about their mental health with a healthcare professional. Amongst those who reported discomfort, several key concerns were identified (Figure 4).

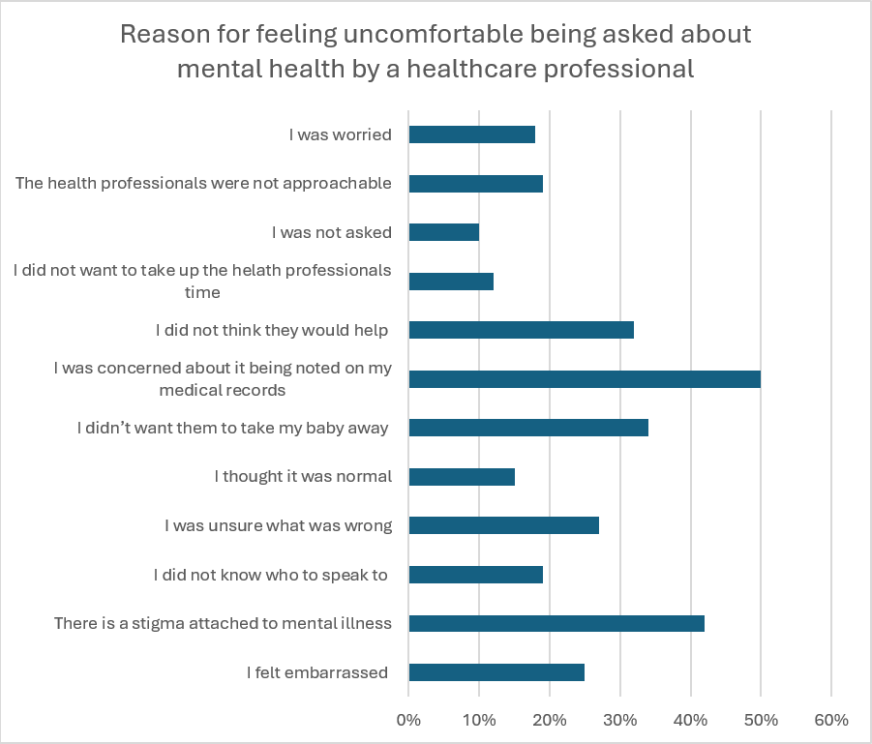


Figure 4. Reasons participants gave for feeling uncomfortable when asked about their mental health by a healthcare professional

The most frequently cited reason for discomfort was concern that their disclosure would be recorded on their medical records (50%; n = 65). This was followed by concerns about the stigma associated with mental illness (42%; n = 42). Other common concerns included worries that their baby might be removed from their care (34%; n = 44), uncertainty about whether disclosing their concerns would result in meaningful help (32%; n = 42), and uncertainty about what they were experiencing or whether it constituted a mental health problem (27%, n = 35).

Participants were next asked to rate the importance of certain characteristics in healthcare professionals that might help them feel more comfortable sharing mental health concerns (Table 8).

Table 8. The importance participants gave to healthcare professionals' personal characteristics when making disclosures about their mental health

Characteristics that support disclosures about mental health	Very important	Somewhat important	Neither important nor unimportant	Somewhat unimportant	Very unimportant
The healthcare professional being the same race as me (e.g., the same physical characteristics).	26%	40%	23%	4%	7%
The health professional being the same age as me.	6%	19%	37%	17%	21%
The healthcare professional having being the same ethnicity as me (e.g., sharing the same culture, customs, heritage).	17%	31%	30%	11%	11%
The health professional being the same religion as me.	8%	16%	37%	15%	24%
The health professional being the same gender as me.	38%	28%	16%	8%	9%
The health professional being the same sexuality as me.	10%	14%	31%	12%	33%

The three characteristics most frequently identified as being somewhat or very important for sharing mental health concerns were being cared for by a healthcare professional of the same race (66%; n = 255), being cared for by a professional who was the same gender (66%, n = 253), and being cared for by a professional who shared the same ethnicity (e.g., culture, customs, and heritage) (48%; n = 180). Only 19% (n = 68) felt that being seen by a healthcare professional of the same religion was important.

5. Sources of mental health support

Respondents were asked to identify the sources of support they accessed for their mental health during their maternity journey. Informal support from friends and family was the most commonly stated source of support, reported by 198 (73%) respondents. Some women sought help outside of NHS services such as private counselling (39%; n = 106). 19% (n = 52) reported using other sources of support including speaking with their midwife , accessing perinatal mental health teams, consulting their GP, and being referred to psychological therapies, such as talking therapies. A notable proportion of women also reported choosing not to seek any support (n = 101; 37%).

6. Views on the mental health support offered and received

Finally, respondents were asked to provide their general views on the mental health support that they were offered or received. The findings revealed a picture of marked inconsistency across maternity services. Experiences varied widely and appeared highly dependent on individual practitioners, local systems, and the persistence of the woman herself in securing support. While pockets of excellent, empathetic, and culturally safe care were described, many women encountered barriers, dismissal, and insufficient follow-up at moments of profound vulnerability.

Of those who answered this question, half described their experience as poor (50%; n = 43), while just over one third reported a good experience (34%; n = 29). Smaller proportions described support as not helpful (3%; n = 3), and highlighted the need for more culturally sensitive care (5%; n = 4) and more intensive or sustained support (3%; n = 3).

Among those reporting poor experiences, common themes included delays, dismissiveness, and difficulty accessing appropriate support. Several women described mental health care as "non-existent," while others felt their concerns were minimised, with one respondent stating that despite being tearful, her GP "was very dismissive and moved on to the next question." Others described referrals that never materialised:

> ***"My midwife said the hospital will get back to me which they never did."***
> (F470, Black British African and Caribbean, 26-35)

Some felt their mental health symptoms were misattributed or overlooked, including one who shared that her symptoms were dismissed as anxiety when she in fact had pre-eclampsia. Others reported being denied perinatal services after being told their sadness was "normal," only to later discover they were depressed. Fragmented communication between services further compounded distress, with one woman describing the lack of joined-up care after miscarriage as "very distressing," having to repeatedly notify services herself.

A small but important proportion of women (5%; n = 4) explicitly called for more culturally sensitive care. Some described feeling that practitioners did not understand the specific anxieties faced by Black women, including fears shaped by widely known disparities in Black maternal and child outcomes. One respondent stated that mental health questions should be "culturally relevant as well as medically relevant."

Despite these concerns, positive experiences did exist. Where care was timely and relational, it was experienced as transformative:

> ***"I got mental health support from a clinical psychiatrist...and it was by far the best therapist I've ever had. She was incredible and so supportive and relatable. We're still in contact now. She really helped me through the darkest times of my postpartum, my daughter's time in hospital and with everything in between."***
> (F878, Black British African and Caribbean, 26-35)

Respondents praised individual midwives and perinatal mental health teams, with emphasis on the importance of proactive identification and referral. In these cases, women described feeling supported through sustained and compassionate engagement. One respondent reflected:

> ***"I will never forget my mental health midwife and how seen I felt by her."***
> (F58, Black British African, 18-25)

DISCUSSION



4 DISCUSSION

In this study, we explored the mental health experiences of Black women in the UK who had participated in the Five X More national survey on Black women's maternity experiences. Our findings revealed a substantial burden of mental health difficulties across the maternity journey, alongside significant gaps in recognition and support within maternity services. Notably, although many women reported experiencing mental health problems before, during, or after pregnancy, far fewer had received a formal diagnosis or consistent access to appropriate care. Our findings also highlight important barriers to disclosure, including concerns about stigma, fear of negative consequences, and uncertainty about how healthcare professionals would respond to Black women's concerns about their mental health. Taken together, our findings signal the urgent need for meaningful action to ensure that the mental health needs of Black women are recognised and supported throughout pregnancy and the postnatal period.

The gap between mental health experiences and clinical recognition

In this study, 527 of the 845 women who completed the main Five X More survey reported that they had experienced a mental health problem before, during, or after pregnancy, highlighting the extent to which emotional and psychological challenges form part of the maternity journey for Black women.

Perinatal mental health problems are already recognised as affecting a substantial number of women[39]. Our findings reinforce the significance of this issue and underline the need for maternity services to treat emotional wellbeing as a core component of maternity care. Given how common these difficulties can be, women should have consistent opportunities to discuss their mental health and access appropriate support throughout pregnancy and the postnatal period. Our findings, however, point to a notable gap between women's mental health experiences and the level of clinical recognition they receive. Although many respondents described experiencing mental health difficulties, far fewer reported receiving a formal diagnosis, and many described having their symptoms dismissed, suggesting that symptoms experienced during the perinatal period are not always recognised or acted upon within maternity services.

Under-recognition of perinatal mental health problems has been documented more widely, with research showing that symptoms of depression and anxiety are frequently overlooked or misinterpreted in racially minoritised women[40,41]. When mental health concerns are not formally identified, women may struggle to understand what they are experiencing or access appropriate support, increasing the risk that difficulties escalate before help is provided.

Addressing this gap requires maternity services to strengthen healthcare professionals' ability to recognise and respond to mental health difficulties in Black and racially minoritised women. Developing greater awareness of how distress may be expressed, challenging biases that can influence clinical interpretation, and ensuring that concerns raised by Black women are taken seriously is essential.

Barriers to disclosure: Stigma, fear, and trust in maternity care

Recognising mental health problems, however, is only one part of the challenge; our findings also highlight barriers that can make it difficult for Black women to disclose mental health concerns in the first place.

One such barrier was the level of comfort women felt in talking about their mental health with healthcare professionals. For instance, women described mixed views on being asked during routine appointments about whether they had experienced suicidal thoughts. While some felt that this line of questioning was appropriate and necessary for helping healthcare professionals identify those who may have a mental health problem, others were alarmed and some, scared. For these women, such questions were interpreted through wider concerns about how disclosures might be documented.

These differing responses highlight the complexity of mental health enquiry for Black women. While routine questions about suicidal thoughts are an important component of perinatal mental health assessment, how these conversations are introduced and contextualised clearly influence how safe women feel in responding openly.

We also observed, amongst women in this study, concerns relating to the stigma of having a mental health condition. Stigma surrounding mental illness is widely recognised as a barrier to help-seeking, with research showing that individuals from Black communities may avoid discussing symptoms for fear of judgement or social consequences[42,43]. Our study too highlighted fears amongst some Black women that disclosing mental health difficulties might have negative consequences, such as their baby being removed from their care.

These concerns must be understood within a broader social context that shapes how families racialised as Black experience engagement with social care services. Fears about involvement with social services and the possibility of children being taken into care have been shown to influence how Black African parents in the UK engage with statutory services[44]. These concerns are not unfounded. Further evidence has highlighted stark ethnic disparities within the UK care system, with Black Caribbean children in England significantly more likely than children from other ethnic groups to be looked after by local authorities[45]. Within this wider landscape of disproportionate state intervention, Black women's worries around mental health disclosure are logical.

Reluctance to discuss mental health difficulties should therefore not be interpreted simply as stigma or lack of understanding about mental health, but as reflecting complex concerns about trust, safety, and how information shared with services may be interpreted or acted upon. Addressing these barriers requires more than simply asking questions about mental health. It requires maternity services to create environments in which women feel confident that disclosure will lead to support rather than judgement or adverse consequences.



Gaps in information and access to mental health support

Our findings revealed that many Black women were not given clear information about how to access emergency mental health support. This lack of clear guidance is concerning given the importance of timely support in preventing the escalation of perinatal mental health difficulties. When women are not provided with clear information about where to seek help, there is a risk that symptoms may intensify before support is accessed. This is particularly worrying given longstanding evidence that people from Black and racially minoritised communities are more likely to come into contact with mental health services through crisis pathways rather than earlier, preventative routes of care[46,47]. Delayed access to support can therefore contribute to more severe outcomes and reinforce existing inequalities in mental health care.

Critically, in the absence of clear signposting to formal services, many women in this study reported relying on informal sources of support, including family members and friends. While social support has been shown to be an important protective factor against perinatal depression and anxiety[48], reliance on informal networks may also reflect gaps within maternity and mental health services. When clear pathways to professional support are not communicated, responsibility for recognising and responding to distress can shift onto families and communities who may themselves feel ill-equipped to manage these challenges.

Ensuring that women receive timely and appropriate care therefore requires maternity services to provide clear, consistent information about how to access mental health support, including in urgent situations, so that women and their families are not left navigating complex systems alone.

Feeling understood and the importance of shared identity

Finally, alongside the structural gaps in information and pathways to care observed in this study, we noted that the relational dynamics between Black women and healthcare professionals may also shape how comfortable women feel about discussing their mental health.

Over half told us that, when discussing their mental health, it was important to speak to a healthcare professional of the same race, ethnicity and gender. Whilst we did not explore the reasons behind these preferences, they reflect a widely recognised perception that someone who shares aspects of a person's identity or lived experience may be more likely to understand their concerns. For instance, whilst experiences and expectations of discrimination can discourage Black individuals from engaging openly with mental health services or seeking support at earlier stages of distress[49], patients from Black and racially minoritised backgrounds have reported feeling more at ease discussing sensitive health issues when they believe their healthcare professional understands their experiences or recognises the realities of racism and discrimination that shape their lives[50].

In conversations about mental health and emotional wellbeing, feeling understood and taken seriously may therefore influence whether Black women feel able to speak openly about how they are coping during pregnancy and after birth. However, while there are clear benefits to shared identity in facilitating communication and rapport, maternity services cannot rely on racial or gender concordance as the primary mechanism for achieving safe and supportive care. Such an approach would be neither equitable nor sustainable within a national health system, and risks placing a disproportionate professional burden on certain individuals.

Feeling understood and the importance of shared identity (continued)

Evidence from other areas of healthcare suggests that when culturally sensitive care is delivered through informal or individual effort rather than embedded system design, responsibility for this work often becomes unevenly distributed, with staff who share linguistic, cultural or racial backgrounds frequently relied upon to bridge gaps in care. In these contexts, the labour of navigating cultural understanding can fall disproportionately on racially minoritised professionals, creating additional emotional labour that is difficult to sustain[51,52].

Our findings, therefore, highlight the need for culturally sensitive, non-judgemental care to be embedded right across the maternity system, ensuring that all healthcare professionals are equipped to recognise and respond to the concerns and needs of Black women.

When mental health support works well

While much of this discussion has focused on gaps in recognition, disclosure, and access to support, it is important to acknowledge that some Black women also described positive experiences of care for their mental health during their maternity journey. Some reported feeling well supported by individual healthcare professionals who took the time to listen to their concerns and respond sensitively to their emotional wellbeing. In a number of cases, women described healthcare professionals proactively asking about their mental health and facilitating referrals to appropriate services when concerns were identified.

These accounts highlight the critical role that healthcare professionals play in recognising mental health problems and ensuring that women are connected with the support they need. When professionals created a safe space for open conversations and responded constructively to Black women's concerns, women described feeling reassured that their mental health was being taken seriously. Such experiences demonstrate that supportive, responsive care is possible within maternity services and provide important insights into the practices that women value.

Nonetheless, the coexistence of these positive experiences alongside reports of missed opportunities suggests that access to effective mental health support may currently depend on the approach of individual professionals rather than being consistently embedded across maternity services. Ensuring that all women receive this level of care requires moving from pockets of good practice to a system in which proactive, culturally sensitive mental health support is a routine part of maternity care.

CLOSING WORDS



5 CLOSING WORDS



Closing words from Tinuke and Clo

Five hundred and twenty seven women told us they had experienced mental health difficulties before.

Underneath all the percentages and the tables, it says something simple. A lot of these women went through this largely unseen. Surprisingly many women reported experiencing mental health issues during pregnancy and the postpartum period but yet only a handful of women received a formal clinical diagnosis. Black women are acknowledging that they are struggling with their mental health but there seems to be a disconnect in who accesses support for a number of reasons.

We weren't surprised by that, if we're honest. We know how often Black women are expected to hold things together quietly, and we know how often the systems around them fail to notice when they can't. What this report adds to that knowledge is actual evidence.

And still, they spoke to us. In the numbers of women who came forward for this survey, and in the honesty of what they shared, we saw the same thing we saw in our last report. Black women are not reluctant to talk about what they're going through. They just need a safe space to do it.

What gives us some hope reading through these findings, is that the women who received good care described it as life changing. They felt seen and it had a positive impact on their lives. This is the type of care that health professionals should be working towards so that more women can have positive experiences. The problem is that this type of care isn't consistent, and it isn't guaranteed.

We won't close this report with another set of asks as we know most people are experiencing report fatigue and are awaiting action on previous recommendations. Here, we just wanted these experiences written down properly and for them to be seen, heard and acknowledged in one place, for the first time. We also wanted it to be used as a learning tool showing what Black maternal mental health actually looks like right now as told by the women who are and have experienced it.

We hope that health professionals use this report to better understand Black women in their care who may need extra support. We also want them to understand what works for us but also the barriers we may face when trying to access the support. We are hoping this report will be used to give better care to women.

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