MATRIx Study

May 2022

INFORMING PERINATAL MENTAL HEALTH CARE

Summary of findings and recommendations for practice and policy

CITY UNIVERSITY OF LONDON EST 1894

MATRIx

FUNDED BY

NIHR | National Institute for Health and Care Research

This project is funded by the National Institute for Health and Care Research (NIHR) Health Services and Delivery Research Programme (NIHR 128068). The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care.

Contents

Written by Rebecca Webb, Abigail Easter, Judy Shakespeare, Jennifer Holly, Elizabeth Ford and Susan Ayers for the MATRIx study.

Online PDF version

Cite as Webb, R., Easter, A., Shakespeare, J., Holly, J., Ford, E. M., & Ayers, S. (2022). *The MATRIx study – Informing perinatal mental health care: Summary of findings and recommendations for practice and policy*.

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Executive summary

Perinatal mental health difficulties can occur during pregnancy and after birth. Up to 20% of women will develop a mental health problem during the perinatal period. They commonly consist of anxiety disorders, depression, post-traumatic stress disorder (PTSD), and stress-related conditions such as adjustment disorder.

Not all women who need support for their mental health during the perinatal period receive the care they need. This is likely to be due to a range of factors at individual, health professional, interpersonal, organisational and social levels. Understanding the barriers and facilitators to identification, assessment, referral and treatment for perinatal mental health difficulties is therefore important for health and social care services working with perinatal women.

The MATRIx study therefore aimed to identify potential barriers and facilitators to identification, assessment, referral, and treatment of perinatal mental health difficulties across the care pathway, both in terms of women accessing care or treatment, as well as in terms of NHS services implementing new assessment and treatment initiatives.

There were two main parts to the study:

PART 1

Identifying the barriers and facilitators to accessing care.

This was done by conducting two systematic reviews of the evidence for barriers and facilitators to:

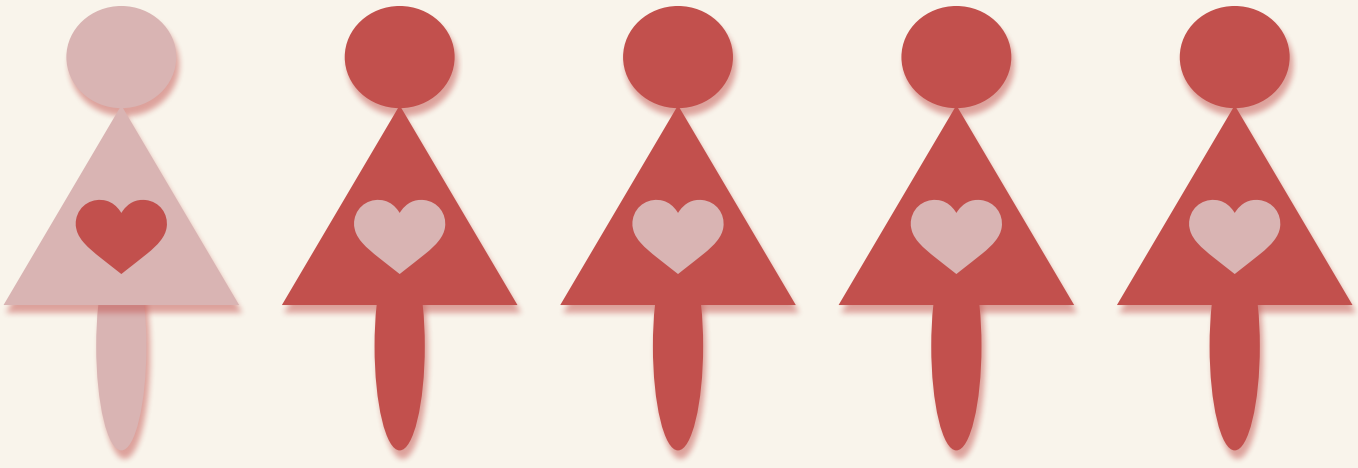
a. implementing perinatal mental health care

b. women accessing perinatal mental health care

PART 2

Summarising these into conceptual frameworks and developing evidence-based recommendations for policy and practice.

The frameworks and recommendations were developed in consultation with various stakeholders and based on the evidence reviews in Part 1.



PART 1

Barriers and facilitators to perinatal mental health care were identified on multiple levels:

- individual;
- HCP;
- interpersonal;
- organisational;
- commissioner;
- political;
- societal.

Factors on all levels were impactful across the care pathway.

Decision to consult was mostly impacted by individual level factors such as women not understanding the roles of health professionals, and not understanding what perinatal mental illness is. Contact with health professionals was impacted by health professionals being dismissive or not recognising the woman was looking for help during their contact with her.

Assessment/screening was affected by individual level factors such as presence of family member; health professional factors such as carrying assessment out in a tick box way; and interpersonal factors such as open and honest communication between women and health professionals. The decision to disclose was impacted by individual level factors such as the fear of being judged to be a bad mother, and societal level factors such as stigma, culture and maternal norms.

Referral was affected by service manager level factors including collaborative working and clear referral procedures. Women's ability to access care was influenced by individual level factors such as lack of childcare, and service manager factors such as lack of culturally sensitive care. Provision of optimal care was impacted by service manager factors such as providing health professionals with high quality training, and providing care that meets women's needs. Women's experience of care was impacted by health professional factors such as health professionals who provide hope to mothers and are caring, supportive and empathetic.

PART 2

The MATRIx conceptual frameworks are two pictorial representations of 39 facilitators and 66 barriers to perinatal mental health care that intersect across the care pathway and at multiple levels. Evidence-based recommendations for the government include (i) continued policy support from NHS England and Scotland related to perinatal mental health care; (ii) a comprehensively researched and adequate budget; (iii) clear and easy to access funding structure; (iv) reduction of health inequalities through a fair welfare and economic system; (v) prevention of penalisation of refugee or migrant women using maternity services by removing NHS charging regulations; and (vi) development of an NHS public mental health campaign aimed at raising awareness and reducing stigma of perinatal mental illness.

RECOMMENDATIONS FOR COMMISSIONERS INCLUDE:

- Commissioners to work with health professionals, service managers, third party organisations and those with lived experience to develop clear and concise care pathways;
- Commissioners to provide adequate funding for perinatal mental health services.

RECOMMENDATIONS FOR SERVICE MANAGERS INCLUDE:

- provision of high quality training for all people who come into contact with perinatal women;
- provision of an adequate number of workers;
- recruitment of staff with a positive interest in providing high quality physical and psychological care;
- encouragement of team working within and across services;
- development of clear and easy to use referral guidelines;
- employment of a liaison person who has access to all IT systems;
- provision of care that meets women's needs;
- provision of continuity of care;
- reduction of language barriers by providing translators or interpreters;
- ensuringpsychological or psychosocial assessment tools are easy to understand.

RECOMMENDATIONS FOR HEALTH PROFESSIONALS INCLUDE:

- attend training on perinatal mental health;
- provide assessment and care in a woman centred way;
- take women's concerns seriously and validate them;
- consider participating in continuing professional development activities related to perinatal mental health;
- communicate clearly and openly with other health professionals, work collaboratively with them.

RECOMMENDATIONS FOR WOMEN AND FAMILIES INCLUDE:

- seek help if something doesn't feel right;
- go back if you feel your concerns haven't been fully addressed the first time round;
- families to provide practical and emotional support where possible.

The MATRIx study identified barriers and facilitators to perinatal mental health care. These highlight the need for women-centred, flexible care, delivered by well trained, knowledgeable, and empathetic health professionals working within an organisational and political structure that enables them to deliver quality care.

Introduction and background

Perinatal mental health difficulties can occur during pregnancy or after birth. They commonly consist of anxiety disorders, depression, post-traumatic stress disorder (PTSD), and stress-related conditions such as adjustment disorder. Some disorders are co-morbid and severe postnatal mental illness is one of the leading causes of maternal death[1]. It is therefore important to identify and assess perinatal mental health difficulties quickly so that women who need treatment can access it.

Key facts and figures

Prevalence

Up to **20%** of women **develop a mental health problem** during pregnancy or within a year of giving birth[2]

Anxiety affects between **9-15%** of pregnant women and mothers[5]

Adjustment disorders and distress affect between **15-30%** of pregnant women and mothers[3]

Post-traumatic stress disorder after birth affects around ***4%*** of mothers[6]

Depression affects around **11%** of pregnant women and mothers[4]

Postnatal psychosis affects between **0.1-0.2%** of mothers after birth[7]

Access to care

An online survey found that **23%** of women living in the UK **had not sought professional help** for their symptoms[8]

Less than **10%** of women with perinatal mental health problems are **referred to specialist care**[10]

Only **30-50%** of women with **perinatal mental health difficulties** are identified[9]

There are still gaps in perinatal mental health care provision, with around **20% of England**, **70% of Wales** and **85% of Scotland** lacking specialist perinatal mental health provision[11]

Not all women who need support for their mental health during the perinatal period receive the care they need. This is likely to be due to a range of factors at individual, health professional, interpersonal, organisational and societal levels. For example, health professionals not asking about mental health, lack of effective assessment, barriers to women seeking help or attending treatment, clinician barriers to diagnosis and treatment, lack of services to refer onto, or limited understanding of effective treatments. Understanding the barriers and facilitators to identification, assessment, referral and treatment for perinatal mental health difficulties is therefore important for health and social care services working with perinatal women.

The case for change

The economic case

Perinatal mental health problems affect up to one in five women and the cost to the UK is estimated to be £8.1 billion for every annual cohort of women[12]. 72% of this cost is attributable to the long-term impact on the child. More specifically:

One case of perinatal depression costs around

£74,000

One case of perinatal psychosis costs around

£53,000

One case of perinatal anxiety costs around

£53,000

Improving access to treatment for common perinatal mental health problems could have a net economic benefit of £490 million over ten years and save the NHS £52 million.[13]

The psychosocial case

Perinatal mental health problems can have negative impacts on women, their children and their families:

Women

Perinatal mental health problems are associated with:

- Poverty and interpersonal violence[1]
- Maternal suicide. This is a leading cause of death during the perinatal period in higher-income countries (accounting for 5 to 20% of maternal deaths)[1]

Families

Perinatal mental health problems are associated with:

- A greater decline in relationship satisfaction[14, 15]
- Increased strain on the couple relationship[16]
- Relationship breakdown[17]

Babies and children

Perinatal mental health problems can impact on babies' and children's:

- Cognitive development[18]
- Language development[19]
- Behavioural development[20]
- And increases the risk of children developing mental health difficulties themselves[21]

The case for change (*continued*)

The political case

Research, strategy, policy and clinical guidelines have all called for improvements to perinatal mental health services:

- A perinatal mental health services commissioning brief called for research to improve perinatal mental health services[22]
- The Five Year Forward View pledged £365 million to be spent on perinatal mental health services from 2016-2021[23]
- The NHS Scotland Mental Health Strategy: 2017-2027[24] which pledged to fund the introduction of a Managed Clinical Network to improve the recognition and treatment of perinatal mental health problems
- The NHS Long-Term Plan pledged £2.3 billion a year to perinatal mental health services, stating that by 2023/24, 66,000 women with moderate to severe mental health difficulties would have access[25]
- Antenatal and postnatal mental health: Clinical management and service guideline[26]
- Scottish Intercollegiate Guidelines Network 127: Management of perinatal mood disorders[27]

"There is a massive stigma attached to being depressed."

"I didn't want anyone to think I was a bad mum and take my baby away."

"I felt shuttled from service to service."

Structure of this report

Part 1: Identifying the barriers and facilitators to accessing care

1a. Review of barriers and facilitators to implementing perinatal mental health care

1b. Meta-review of barriers and facilitators for women accessing perinatal mental health care.

Lancet Psychiatry, 2021

Under review

Part 2: Conceptual frameworks and developing evidence-based recommendations for policy and practice

2. Frameworks of barriers and facilitators to accessing perinatal mental health care.

Manuscript in preparation

Definitions

Perinatal: Conception to 1 year after birth

Perinatal mental health care: identification, assessment, care and treatment of perinatal mental health problems.

Systematic review: A summary of all published research on a specific topic. This research has been identified using rigorous and repeatable methods.

Conceptual framework: A pictorial representation of different concepts (things) that shows how they related to one another.

Barrier: Something the prevents something from happening.

Facilitator: Something that helps something to happen.

Implementation: Putting something into place, such as a health service.

Objectives

Part 1

To identify the barriers and facilitators to accessing care in terms of (a) implementing perinatal mental health care and (b) women accessing perinatal mental health care

PART 2

To summarise the evidence into conceptual frameworks and to develop evidence-based recommendations for policy and practice.

Methods and findings

Part 1: Two systematic reviews were carried out

Title	Review 1 – Barriers and facilitators to implementing perinatal mental health care	Meta-Review 2 – Barriers and facilitators to women accessing perinatal mental health care – a meta review
Searches	Pre-planned searches carried out on Medline, Embase, PsychInfo, and CINAHL.	Pre-planned searches carried out on Medline, Embase, PsychInfo, and CINAHL, Scopus and Cochrane Database
Inclusion criteria	Studies that examined factors that facilitated or impeded the implementation of perinatal mental health care. Qualitative and case studies were included.	Reviews with a PRISMA search strategy of literature on barriers and facilitators for women in the perinatal period to access assessment, care or treatment.
Methodological quality appraisal	Joanna Briggs Critical Appraisal Tools[28]	AMSTAR 2[29]
Analysis	Thematic synthesis	Thematic synthesis

The multi-level model

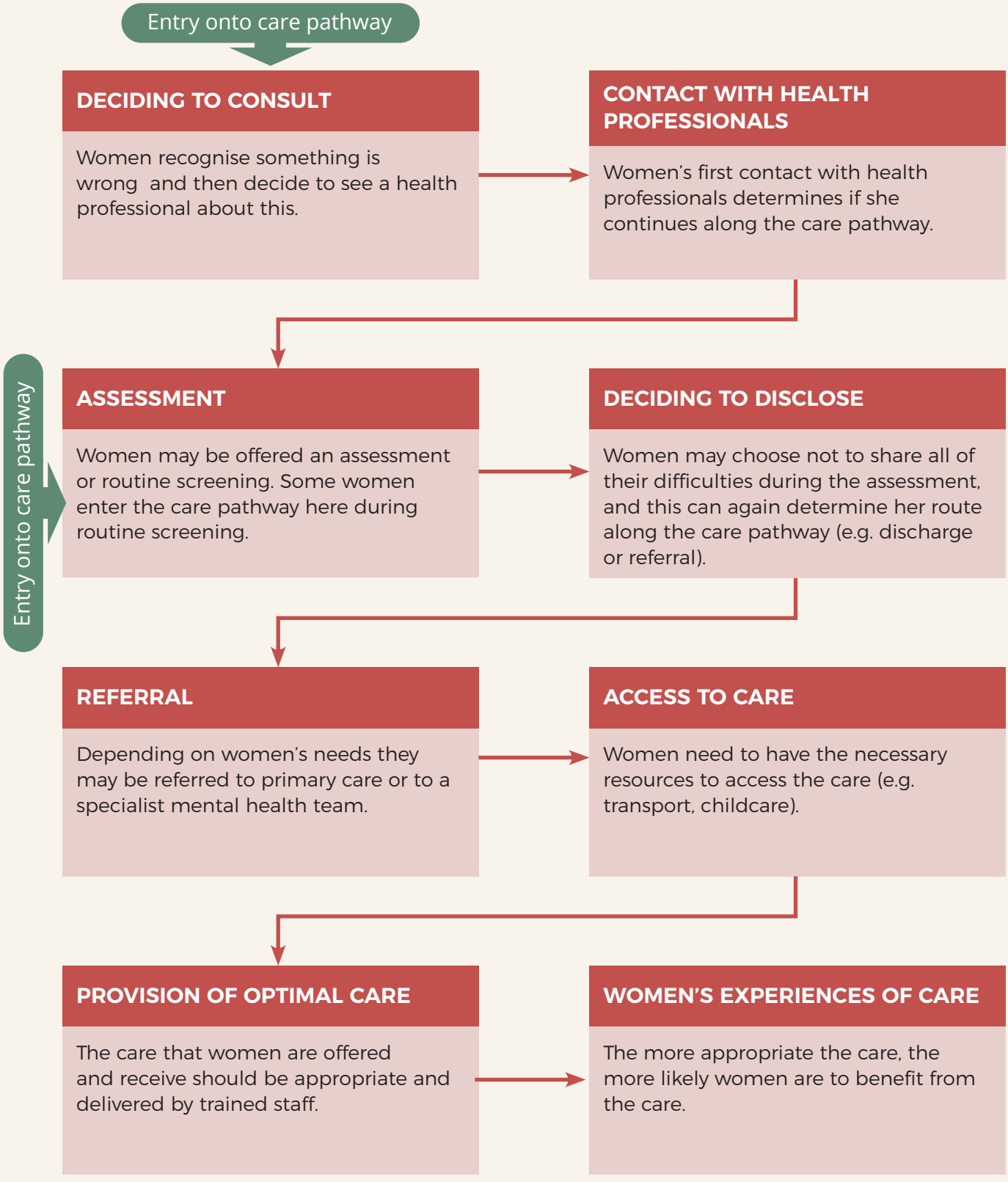
We mapped themes onto a systems level model adapted from **Ferlie and Shortells' (2001) Levels of Change framework**[30].

Their model includes individual level factors, health professional factors, organisational factors and larger system factors.

The MATRIx multi-level model is adapted to fit in with NHS structures and has the following levels:

The care pathway

We then mapped each theme onto the different stages of the care pathway. We used an adapted pathway from Goldberg and Huxley's (1992) **Pathways to Care model**[31]. Their model has four stages: (i) deciding to disclose, (ii) assessment, (iii) access to care, (iv) treatment. The MATRIx care pathway has been expanded to fit with referral structures within the NHS, and to fit with the literature about women's ability to attend treatment, and has the following stages:



FINDINGS

Key facts and figures

Review 1

21,535 citations were screened by title and abstract

931 citations were screened by full text

46 primary papers included in the review

Implementation occurred in a **wide range of settings** including hospitals (n=14); primary care (n=12); and community-based care (n=12).

Most studies (n=22) looked at the **implementation of comprehensive care services** (including screening, referral and treatment).

Most studies (n=44) had a **quality rating above 70%** suggesting that studies were well conducted with low risk of bias.

Review 2

2,028 reviews were screened by title and abstract

66 reviews were screened by full text

32 reviews included in the meta-review

Reviews were conducted between **2006 and 2021**.

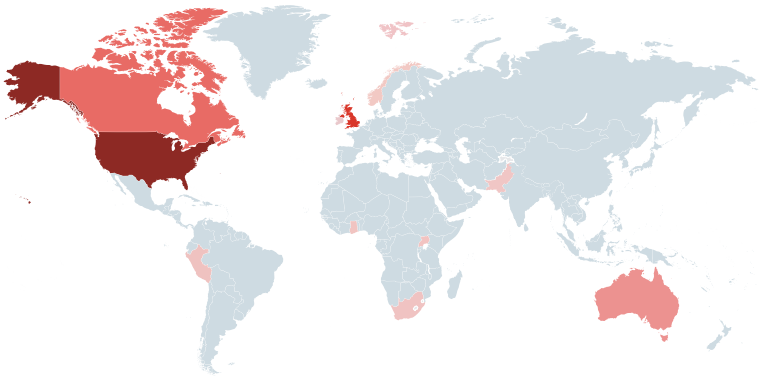
The **number of studies** included in each review varied from 4 to 40 with a total of 344.

Results from the **quality rating** suggests the data can be interpreted with reasonable confidence.

Geographical distribution of research

Most research was carried out in the USA, UK and Canada.

- 1–5 paper
- 6–10 papers
- 11–15 papers
- 16–20 papers
- 21+ papers



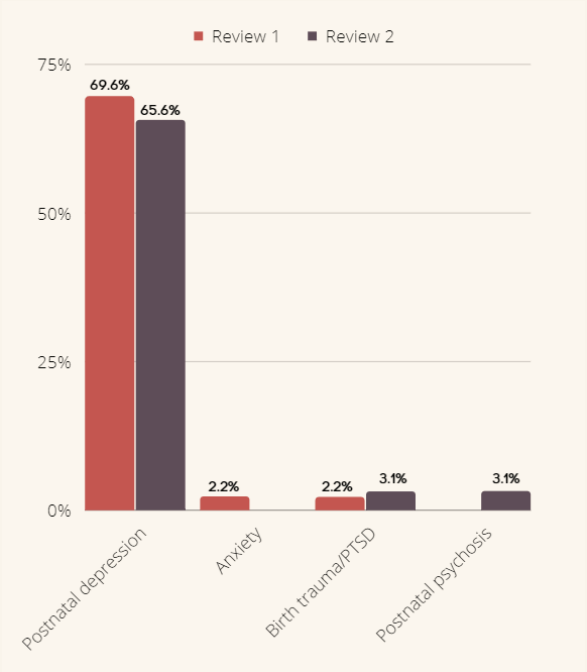
Implementation occurred in a wide range of settings

Hospitals (n=14)

Primary care (n=12)

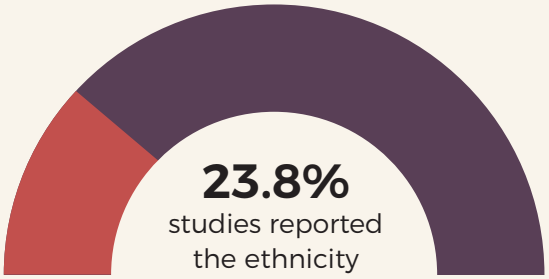
Community-based care (n=12)

Most studied mental illness



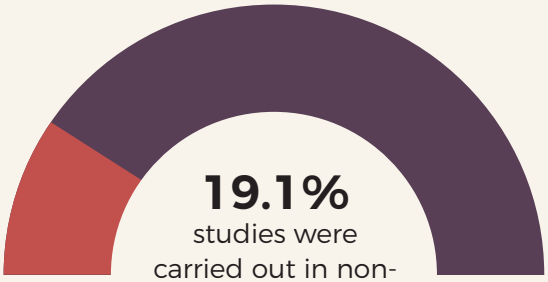
Population studied

Review 1



23.8%
studies reported the ethnicity of participants

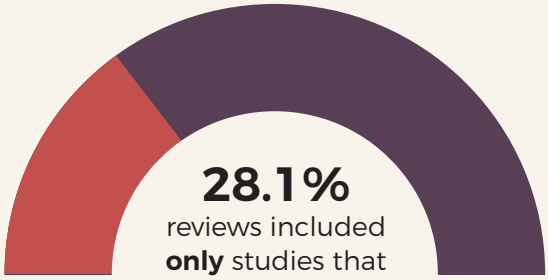
11.9%
studies carried out in Western countries recruited ethnically diverse samples



19.1%
studies were carried out in non-Western countries

Review 2

50%
of reviews included at least one study where some of the population recruited were women from diverse backgrounds



28.1%
reviews included **only** studies that recruited women from diverse backgrounds

Most cited barriers and facilitators in different healthcare settings and countries

Hospitals

- ✘ Lack of time or a heavy workload
- ✔ Health professionals' positive opinion of care being implemented

Primary care

- ✘ Stigma about perinatal mental illness
- ✘ Family presence

Community settings

- ✔ High quality training
- ✔ Health professionals who provide hope to mothers, are caring, supportive and empathetic

Low-income countries

- ✘ Stigma about perinatal mental illness
- ✘ Lack of high quality training for health professionals

High income countries providing care for women from a refugee or different cultural background

- ✘ Stigma about perinatal mental illness
- ✘ Lack of high-quality training for health professionals
- ✘ Heavy workload for health professionals
- ✘ Lack of collaborative working between health professionals.

Most common barriers and facilitators across the care pathway

The most cited barriers and facilitators across all studies and across the care pathway are presented in this figure.

DECIDING TO CONSULT

Individual level factors

✘ Not understanding health professionals roles

✘ Not understanding what perinatal mental illness is

✔ Recognising something is wrong

CONTACT WITH HEALTH PROFESSIONAL

Health professional level

✘ Being dismissive or not recognising help-seeking

ASSESSMENT

Individual level

✘ Presence of family and friends with negative beliefs about mental illness

Health professional level

✘ Carrying out assessment in a tick box way

Interpersonal level

✔ Open and honest communication

Service manager level

✔ Acceptability of assessment or screening for both health professionals and women.

DECIDING TO DISCLOSE

Individual level

✘ Fear of being judged as a bad mother

Health professional level

✘ Appearing too busy

Interpersonal level

✘ A lack of a trusting relationship between women and health professionals

Service manager level

✘ A lack of continuity of carer

Societal level

✘ Stigma, culture and maternal norms

REFERRAL

Service manager level

✔ Collaborative working

✔ Clear referral procedures

ACCESS TO CARE

Individual level

✘ Practical barriers such as lack of childcare

Interpersonal level

✘ Language barriers

Service manager level

✘ Lack of culturally sensitive care

Commissioner level

✘ Lack of appropriate or timely services

Political level

✘ Lack of financial resources

PROVISION OF OPTIMAL CARE

Health professional level

✔ Health professionals having valued characteristics such as being trustworthy and caring

Interpersonal level

✘ Lack of trusting relationship

Service manager level

✔ Individualised care that is appropriate to women's needs

✘ Lack of training related to perinatal mental illness and treatment

Political level

✘ Women's immigration status

Societal level

✘ Stigma

✘ Culture

WOMEN'S EXPERIENCES OF CARE

Individual level

✘ Social isolation

Health professional level

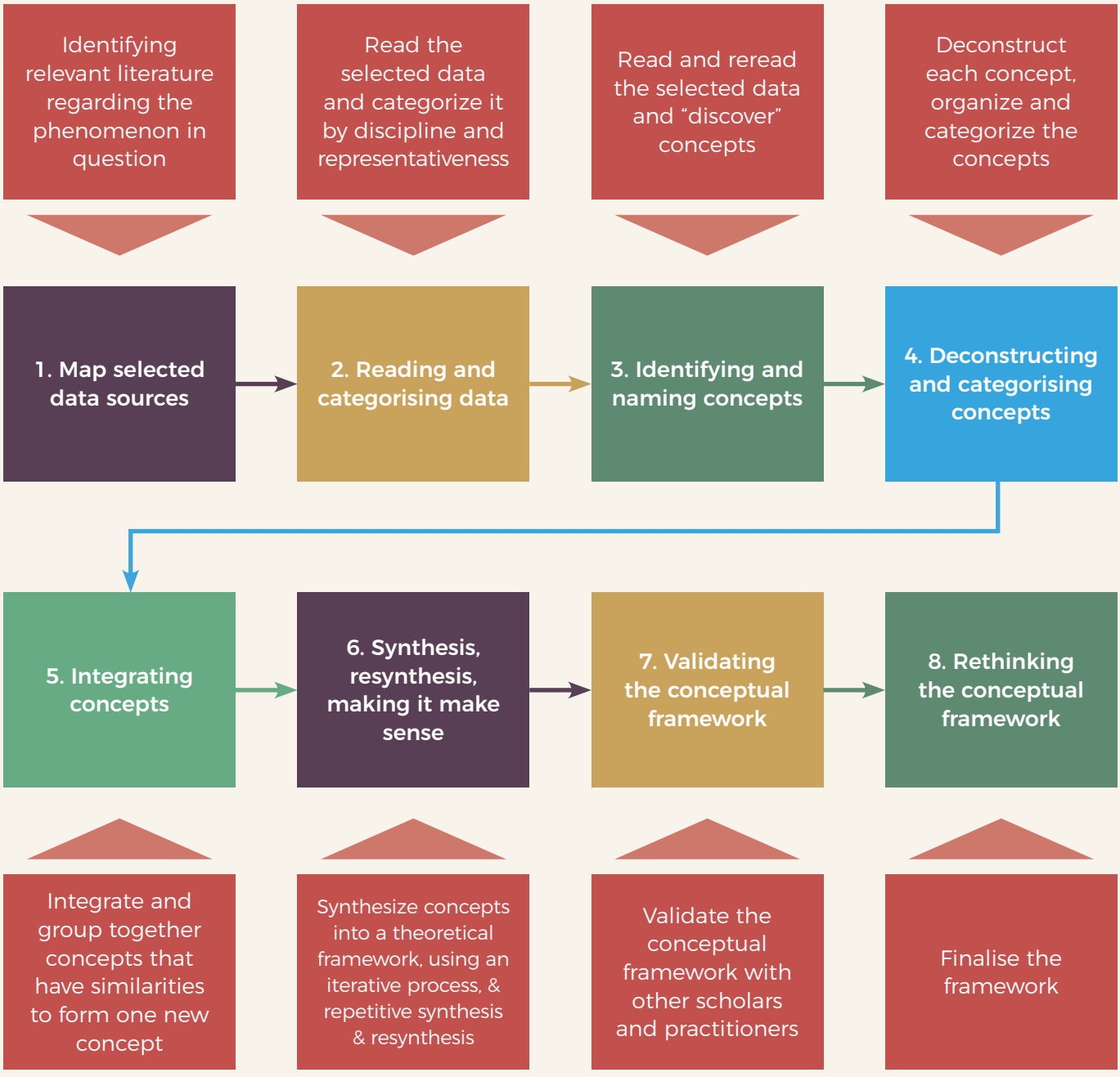
✔ Health professionals who provide hope to women, are caring, supportive, empathetic and go above and beyond

Service manager level

✔ Individualised and person centred care

THE MATRIX CONCEPTUAL FRAMEWORKS

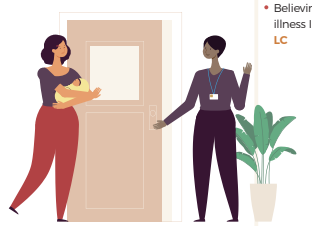
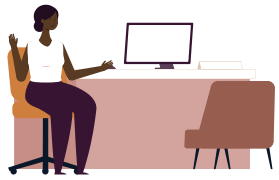
Results from both reviews were synthesised to develop a conceptual framework. Eight stages outlined by **Jabareen (2009)**[32] were followed to develop the framework.



Two MATRIx conceptual frameworks were developed that show the importance of 66 barriers and 39 facilitators to perinatal mental health care at multiple levels that intersect across the care pathway.

Barriers to Perinatal Mental Health Care

FOR ADDITIONAL RESOURCES PLEASE VISIT
www.matrixstudy.org

	DECIDING TO CONSULT	FIRST CONTACT WITH HEALTH PROFESSIONALS	ASSESSMENT	DECIDING TO DISCLOSE	REFERRAL	ACCESS TO TREATMENT	PROVISION OF OPTIMAL TREATMENT	WOMEN'S EXPERIENCE REFERRAL OF TREATMENT
INDIVIDUAL	• Being worried about social services involvement HC or being judged to be a 'bad mum' MC • Being socially isolated MC • Family and friends with negative perceptions about perinatal mental illness MC • Not understanding health professionals' role in relation to perinatal mental health MC • Not understanding what perinatal mental illness is MC, or not having the language to describe it LC • Believing the best way to cope with symptoms is to ignore them MC, minimise them MC, or seek spiritual guidance LC • Believing that perinatal mental illness is a normal part of motherhood MC, or are caused by spiritual MC, external LC, or physical factors LC • Not knowing where to go to seek help LC • Beliefs that services only offer medication LC, are too busy LC, or are too complicated LC • Believing health professionals won't be interested in perinatal mental health LC • Being from an ethnic minority group LC, or being younger VLC	• Believing that perinatal mental illness is caused by physical factors LC 	• Not understanding what perinatal mental illness is MC • Family and friends with negative perceptions about perinatal mental illness MC • Additional personal difficulties MC • Beliefs that services only offer medication LC 	• Being worried about social services involvement HC or being judged to be 'bad mum' MC • Family and friends with negative perceptions about perinatal mental illness MC • Not understanding health professionals' role in relation to perinatal mental health MC • Not understanding what perinatal mental illness is MC • Believing that perinatal mental illness is a normal part of motherhood MC • Believing the best way to cope with symptoms is to minimise them LC • Beliefs that services only offer medication LC, or are too busy LC • Believing health professionals won't be interested in perinatal mental health LC	• Being worried about social services involvement HC	• Not understanding health professionals' role in relation to perinatal mental health MC • Lack of support from family and friends MC • Additional personal difficulties MC • Beliefs that services only offer medication LC, are too complicated LC, or not trusting health services LC • Not knowing where to go to seek help LC • Difficulties finding childcare LC, travelling to services LC, and timing of services LC • Being from an ethnic minority group LC • Current symptoms of perinatal mental illness LC	• Beliefs that services only offer medication LC • Not having the language to talk about perinatal mental illness LC 	• Being socially isolated MC • Lack of support from family and friends MC • Previous negative experiences of mental health care MC • Current symptoms preventing engagement with care LC • Believing that perinatal mental illness is caused by physical factors LC
HEALTH PROFESSIONAL		• Health professionals being dismissive or normalising women's symptoms HC • Health professionals not recognising help-seeking or symptoms MC • Health professionals appearing too busy MC • Health professionals focusing on the infant LC	• Health professionals' poor knowledge about services and referral pathways HC, and perinatal mental health MC • Health professionals having low confidence about carrying out assessments MC • Health professionals not recognising help-seeking or symptoms MC • Health professionals appearing too busy MC • Health professionals carrying out assessment or screening in a tick-box impersonal way MC • Health professionals with poor cross-cultural knowledge of perinatal mental health LC	• Health professionals being dismissive or normalising women's symptoms HC • Health professionals carrying out assessment or screening in a tick-box impersonal way MC • Health professionals focusing on the infant LC	• Health professionals' poor knowledge about services and referral pathways HC • Health professionals dismissing women's symptoms HC • Health professionals having low confidence in making referrals MC • Health professionals not recognising helpseeking or symptoms MC	• Health professionals being unhelpful or disinterested in women HC • Health professionals being dismissive or normalising women's symptoms HC • Health professionals' poor knowledge about services and referral pathways HC, and perinatal mental health MC • Health professionals appearing too busy MC • Health professionals not being sensitive to the needs of women from non-western cultures LC	• Health professionals with poor knowledge about perinatal mental health MC • Health professionals having low confidence about providing treatment MC • Health professionals focusing on the infant LC • Health professionals appearing too busy MC • Health professionals with insufficient knowledge of cross-cultural issues VLC	• Health professionals being dismissive or normalising women's symptoms HC • Health professionals' poor knowledge about other services and perinatal mental health MC
INTER-PERSONAL	• Language barriers HC • A previous lack of open and honest communication between women and health professionals MC	• Language barriers HC	• Language barriers HC • Health professionals not openly communicating about assessment MC	• Lack of trusting relationship between health professionals and women HC • Language barriers HC • Lack of open and honest communication MC	• Lack of shared decision making between women and health professionals LC	• Lack of trusting relationship between health professionals and women HC • Language barriers HC • Lack of shared decision making between women and health professionals LC	• Lack of trusting relationship between health professionals and women HC • Language barriers HC • Lack of shared decision making between women and health professionals LC	• Lack of trusting relationship between health professionals and women HC • Language barriers HC • Lack of open and honest communication MC • Lack of shared decision making between women and health professionals LC
SERVICE MANAGERS	• Lack of culturally sensitive care HC • Lack of collaboration between services MC • Lack of logistical support MC • Insufficient information provided to health professionals and women about services MC 	• Lack of culturally sensitive care HC • Inadequate provision of perinatal mental health training for health professionals HC	• Inadequate workforce therefore health professional's workload is too heavy HC • Inadequate provision of perinatal mental health training for health professionals HC • Lack of continuity of carer HC • Lack of culturally sensitive care HC • Poor linkage in technology systems HC • Women and health professionals believing assessment or screening to not be acceptable MC • Lack of collaboration within services MC • Unclear or confusing assessment processes MC • Lack of privacy LC, and assessment being carried out in a busy medical setting LC • Confusing wording of assessment tools LC	• Lack of continuity of carer HC • Lack of culturally sensitive care HC • Lack of collaboration between services MC 	• Inadequate workforce therefore health professional's workload is too heavy HC • Inadequate provision of perinatal mental health training for health professionals HC • Lack of culturally sensitive care HC • Lack of collaboration between services MC • Lack of collaboration within services MC • Unclear or confusing referral processes MC • Insufficient information provided to health professionals and women about services MC • Lack of confidentiality LC	• Inadequate workforce provision therefore health professional's workload is too heavy HC • Lack of continuity of carer HC • Lack of collaboration between services MC • Lack of collaboration within services MC • Lack of logistical support offered by service MC • Restrictive eligibility criteria LC	• Inadequate workforce therefore health professionals' workload is too heavy HC • Inadequate provision of perinatal mental health training for health professionals HC • Lack of continuity of carer HC • Lack of culturally sensitive care HC • Lack of collaboration between services MC • Lack of collaboration within services MC • Lack of logistical support offered by service MC • Insufficient information provided to health professionals and women about perinatal mental health MC • Inflexible care MC • Women not finding group or peer support acceptable MC • Care provided in difficult to access location LC • Lack of privacy & confidentiality LC	• Difficulties with technology related to care HC • Lack of continuity of carer HC • Lack of collaboration between services MC • Insufficient information provided to women about perinatal mental health MC • Inflexible care MC • Women not finding group or peer support acceptable MC • Care that is not appropriate to women's needs MC • Provision of care in a medical setting LC
COMMISSION-ERS	• Lack of appropriate or timely services HC		• Lack of appropriate or timely services HC • Confusing referral pathways MC • Complexities of funding, resources & financial reimbursement MC	• Lack of appropriate or timely services HC	• Lack of appropriate or timely services HC • Confusing referral pathways MC	• Lack of appropriate or timely services MC • Complexities of funding, resources & financial reimbursement MC	• Lack of appropriate or timely services HC • Complexities of funding, resources & financial reimbursement MC	
GOVERNMENT	• Women who have moved to a new country, or women who are refugees HC • Women having low financial means and the cost of healthcare MC					• Women who have moved to a new country, or women who are refugees HC • Women having low financial means and the cost of healthcare MC	• Women who have moved to a new country, or women who are refugees HC • Women having low financial means and the cost of healthcare MC	• Women who have moved to a new country, or women who are refugees HC • Women having low financial means and the cost of healthcare MC
SOCIETY	• Stigma HC • Cultural beliefs about perinatal mental health HC • Maternal norms to be a 'good mother' and a 'strong woman' HC	• Cultural beliefs about perinatal mental	• Stigma HC • Cultural beliefs about perinatal mental health HC • Maternal norms to be a 'good mother' and a 'strong woman' HC	• Stigma HC • Cultural beliefs about perinatal mental health HC • Maternal norms to be a 'good mother' and a 'strong woman' HC	• Stigma HC	• Stigma HC • Cultural beliefs about perinatal mental health HC • Maternal norms to be a 'good mother' and a 'strong woman' HC	• Stigma HC • Cultural beliefs about perinatal mental health HC	• Stigma HC • Cultural beliefs about perinatal mental health HC • Maternal norms to be a 'good mother' and a 'strong woman' HC

MATRIx

KEY

HC high confidence with evidence MC moderate confidence with evidence LC low confidence with evidence VLC very low confidence with evidence

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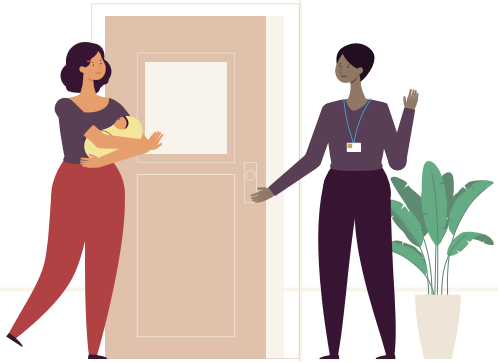
	DECIDING TO CONSULT	HEALTH PROFESSIONAL CONTACT	ASSESSMENT	DECIDING TO DISCLOSE	REFERRAL	ACCESS TO TREATMENT	PROVISION OF OPTIMAL TREATMENT	WOMEN'S EXPERIENCE REFERRAL OF TREATMENT
INDIVIDUAL	• Recognising that something is wrong **HC** • Supportive family and friends **MC** • Previous positive experiences of mental health services **MC** • Previous mental health diagnoses/symptoms **VLC**		• Supportive family and friends **MC**	• Supportive family and friends **MC**		 		• Women's social support network **MC** • Supportive family and friends **MC** • Previous positive experiences of mental health services **MC**
HEALTH PROFESSIONAL	• Previous experiences with health professionals who have valued characteristics (trustworthy, empathetic, kind and caring, with a genuine interest in women) **HC** • Health professionals having similar demographic characteristics to women **MC**	• Health professionals with valued characteristics (trustworthy, empathetic, kind and caring, with a genuine interest in women) **HC** • Health professionals having good knowledge and understanding of perinatal mental health **MC** • Health professionals making time to address perinatal mental health **MC** 	• Health professionals with valued characteristics (trustworthy, empathetic, kind and caring, with a genuine interest in women) **HC** • Health professionals having a good knowledge and understanding of perinatal mental health services, referral pathways **HC**, and perinatal mental health symptoms in women **MC** • Health professionals feeling confident in carrying out assessment **MC** • Health professionals carrying out assessment in an individualised way **MC**, and making the time to carry this out **MC** • Health professionals having similar demographic characteristics to women **MC**	• Health professionals with valued characteristics (trustworthy, empathetic, kind and caring, with a genuine interest in women) **HC** • Health professionals making time to address perinatal mental health **MC** • Health professionals having similar demographic characteristics to women **MC**	• Health professionals having good knowledge and understanding of perinatal mental health services and referral pathway **HC**, and perinatal mental health **MC** • Health professionals feeling confident in making a referral **MC** • Health professionals who take the time to advocate for women during referral process **MC**	• Health professionals having good knowledge and understanding of perinatal mental health services **HC** 	• Health professionals with valued characteristics (trustworthy, empathetic, kind and caring, with a genuine interest in women) **HC** • Health professionals having good knowledge and understanding of perinatal mental health **MC** • Health professionals feeling confident in providing intervention **MC** • Health professionals making time to address perinatal mental health **MC** • Health professionals having similar demographic characteristics to women **MC**	• Health professionals with valued characteristics (trustworthy, empathetic, kind and caring, with a genuine interest in women) **HC** • Health professionals making time to address perinatal mental health **MC** 
INTER-PERSONAL	• Previous development of a trusting relationship and rapport between health professionals and women **HC** • Women being able to communicate openly and honestly with health professionals **MC**		• Development of a trusting relationship and rapport between health professionals and women **HC** • Women being able to communicate openly and honestly with health professionals **MC**	• Development of a trusting relationship and rapport between health professionals and women **HC** • Women being able to communicate openly and honestly with health professionals **MC**	• Shared decision making between women and health professionals **LC**	• Development of a trusting relationship and rapport between health professionals and women **HC** • Shared decision making between women and health professionals **LC**	• Development of a trusting relationship and rapport between health professionals and women **HC** • Shared decision making between women and health professionals **LC**	
SERVICE MANAGERS	• Continuity of carer **HC** • Culturally sensitive care **HC** • Provision of logistical support **MC** • Care that is delivered at home **MC** • Sufficient information about available services provided to women **MC** • Co-location of services **LC** 		• Adequate workforce provision **HC** • Provision of optimal training in perinatal mental health assessment for health professionals **HC** • Technology that reminds health professionals to complete assessment **HC** • Collaboration between services **MC** • Collaboration within services **MC** • Clear assessment and referral process **MC** • Carrying out assessment in women's own home **MC** • Private setting for assessment **LC** • Care with a dedicated person or perinatal mental health champion **LC** • Clear organisational goals and guidelines **VLC** • Provision of supervision **VLC**	• Continuity of carer **HC** • Culturally sensitive care **HC**	• Adequate workforce provision **HC** • Provision of optimal training for health professionals in perinatal mental health **HC** • Culturally sensitive care **HC** • The use of working technology **HC** • Collaboration between services **MC** • Collaboration within services **MC** • Clear assessment and referral process **MC** • Care that has a dedicated person or perinatal mental health champion **LC**	• Adequate workforce provision **HC** • Continuity of carer **HC** • Culturally sensitive care **HC** • Collaboration between services **MC** • Collaboration within services **MC** • Care that provides information about intervention options **MC** • Individualised and person-centred care **MC** • Care that is appropriate to women's needs **MC** • Care that offers logistical support for women (e.g. childcare, travel) **MC** • Care that has a dedicated person or perinatal mental health champion **LC** • Co-location of services **LC**	• Adequate workforce provision **HC** • Continuity of carer **HC** • Provision of optimal training in perinatal mental health for health professionals **HC** • Provision of culturally sensitive care **HC** • Collaboration between services **MC** • Collaboration within services **MC** • Care that offers logistical support (e.g. childcare, travel) **MC** • Care that is delivered in women's own home **MC** • Individualised and person-centred care **MC**, that is appropriate to women's needs **MC** • Flexible care **MC** • Acceptability of group or peer support **MC** • Care that has a dedicated person or perinatal mental health champion **LC** • Co-location of services **LC** • Provision of supervision for health professionals **VLC** • Clear organisational goals and guidelines **VLC**	• Continuity of carer **HC** • Culturally sensitive care **HC** • Technology that is fit for purpose and enhances the provision of care **HC** • Care that is delivered in women's own home **MC** • Individualised and person-centred care **MC**, that is appropriate to women's needs **MC** • Flexible care **MC** • Acceptability of group or peer support **MC** • Care that is delivered face to face **LC** • Care that provides women with an opportunity to talk **LC** 
COMMISSION-ERS					• Clear referral pathways **MC**			

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Evidence based recommendations

The conceptual frameworks informed the development of evidence-based recommendations on how to address barriers to ensure that all women are able to access the care and support they need. Recommendations were made for health policy, practice and research.

Recommendations for women and families

DECIDING TO SEEK HELP

During pregnancy or after birth you may experience feelings and thoughts which aren't usual for you.

These may include:

1. Feeling hopeless
2. Not being able to stop crying
3. Feeling you can't cope
4. Poor concentration or memory
5. Feeling on edge or worrying about many different things
6. Intrusive thoughts about your baby
7. Irritability or anger
8. Flashbacks or nightmares related to your birth
9. General aches and pains
10. Extreme tiredness
11. Sweating, breathlessness, feeling sick, trembling

If you experience any of these, or have any thoughts or feelings that don't feel right, seek help. You can contact your midwife, health visitor or GP about any concerns you might have.

WHO CAN I CONTACT AND WHAT ARE THEIR ROLES?

A midwife

Midwives provide care and support whilst you are pregnant, throughout labour and during the early period after your baby is born.

A health visitor

Health visitors are trained nurses. They specialise in working with families with a child aged 0 to 5 to identify health needs as early as possible and improve you and your baby's health and wellbeing. You should be referred to the health visitor by your midwife.

A General Practitioner (GP)

GPs are doctors who are trained to treat all common medical conditions and refer patients to hospitals and other services, including mental health services.

All health professionals working with women during pregnancy and after birth should be aware of perinatal mental health difficulties, and will know, or be able to find out, how best to help you.

CONTACT WITH HEALTH PROFESSIONALS

The MATRIx study found that sometimes when women contact health professionals about their mental health difficulties or symptoms, they may be dismissed. If this response doesn't feel right to you, it is important to go back again, either to the same health professional or a different one.

Partners and family. It is important to encourage your partner/family member to continue to seek help until the right care is accessed. Sometimes this can be difficult, but it could make all the difference.

ASSESSMENT

After making contact with a health professional about your symptoms or difficulties, they may ask you to complete some questionnaires. These enable the health professional to work out what you are experiencing and how this is impacting you, in a standardised way. This is called assessment. During pregnancy and after birth, your midwife or health visitor may ask you about your mood. NHS guidelines say every woman should be asked about their mood during pregnancy and after birth. You can find out more about possible assessment tools **here**.

DECIDING TO DISCLOSE

The MATRIx study found that during assessment and screening women may be worried about telling the truth because they are concerned about the consequences. The most frequently mentioned fear is that of social services involvement, or being seen to be a bad mum. It is important to remember that mental health difficulties during pregnancy and after birth are common, affecting around 1 in 5 women. They do not make you a bad mum.

In terms of social services involvement, the main reasons for social services referrals are concerns about child abuse or neglect, family dysfunction such as domestic abuse, and child illness or disability. If a referral is made, the aim of social services is to help you.

REFERRAL

This step is where health professionals will, with your permission, pass your details on to services that will be able to help you with your symptoms.

ACCESS TO TREATMENT

Partners and family. It is important to offer as much support as possible to ensure your partner/family member is able to access the treatment they are offered. Findings from the MATRIx study suggest the biggest barriers to women accessing treatment are practical barriers such as lack of transport, or lack of childcare, so where possible, offer this support.

PROVISION OF OPTIMAL TREATMENT

This refers to health professionals and treatment to meet your needs. If you feel something is not working for you, it is important to voice this with the health professional you are seeing, and discuss other options.

WOMEN'S EXPERIENCES

Partners and family. One barrier to women not being able to make the most of the treatment offered was social isolation and having no one to talk to. It is important to be supportive and offer a listening ear if this is what your partner/family member wants.

Recommendations for Health Professionals

WHAT THE RESEARCH SAYS	HOW YOU CAN ADDRESS THIS
Some women believe their symptoms are a normal part of motherhood. This may mean they minimise symptoms or ignore them.	Attend training on perinatal mental health so you know the cues to look out for.
Some women may not want to disclose symptoms because of fears of being judged to be a "bad mum", and being fearful of social services.	Listen to women's concerns and take them seriously. According to **data published by the department for education** the main reasons for social services involvement include: child abuse or neglect, family dysfunction such as high conflict relationships, and child illness or disability. Provide assessment in a woman-centred way. Explain questions or wording that women are not clear about. Clearly discuss findings of the assessment with women and explain next steps.
Barriers to women disclosing their symptoms or discussing perinatal mental health include previous experiences of being dismissed or seeing health professionals as being too busy.	Validate women's concerns. Take the time to address their concerns and take responsibility for that woman to ensure she is referred to appropriate services.
A facilitator to perinatal mental health care is health professionals having good knowledge about perinatal mental health, services and referral pathways.	Consider participating in continuing professional development activities related to perinatal mental health including participating in high quality training or reading **perinatal mental health good practice guides**.
Another facilitator to perinatal mental health care is working with other health professionals and services.	Communicate clearly and openly with other health professionals. Take part in multidisciplinary team meetings where these are available.

Recommendations for Service Managers

Workforce

1 All staff who come into contact with pregnant and postnatal women should have some training on perinatal mental health. The more contact health professionals have with women during the perinatal period, the more training they should receive.

Training should:

- Be ring fenced/time protected
- Provide accreditation, matched to competencies and appropriate to level of involvement
- Be interactive and provided by a knowledgeable person or network
- Where relevant be face-to-face
- Consider simulation training

Training should cover:

- Symptoms of perinatal mental illnesses – not just depression
- How to talk about perinatal mental health, what questions to ask, language use
- How and where to refer to
- Diverse family structures
- Vulnerable groups
- Health inequalities
- Lived experiences
- Trauma informed care
- Cross cultural presentations of mental illness
- How to engage women from diverse backgrounds

Policy support

Maternal Mental Health Alliance – Make all care count campaign

"Everyone who comes into contact with women before, during or after pregnancy has the opportunity to provide mental health support."

The MMHA calls for:
All women and families across the UK to have equitable access to comprehensive, high-quality perinatal mental health care.

This includes:

- A confident, well-equipped **workforce** delivering excellent, safe perinatal mental health care and support.
- Care for **all** women, including those impacted by **inequalities**.
- Specialist perinatal mental health services that meet **national standards** and act as a catalyst for change within the wider system of care.

Examples of good practice

Brighton and Sussex University Hospitals NHS Trust provide Perinatal Mental Health Simulation Training on the identification and management of common perinatal mental health problems using actors and 'real-life' settings.

Useful resources

- **Perinatal mental health training directory**

Examples of good practice

The Motherhood Group offer training on Understanding Diverse Motherhood. This workshop and training provides information on:

- Awareness and beliefs about mental illness health within the black community
- Better engagement with Black and minority ethnic communities, overcoming barriers to effective engagement
- Language barriers, taking into consideration cultural barriers and traditions
- The importance of diverse focus groups, patient forums, resources and support groups
- The difficulty for Black mothers to express emotional distress: expectations placed on a Black mother and discomfort with the western/eurocentric label of perinatal depression
- Black mothers are less likely to be identified as depressed: assessment for postpartum depression and how depression usually presents in Black mothers
- Ways to increase Black mothers being screened: increasing dialogue around PND before and during pregnancy, advocacy, awareness
- Shame, weakness, stigma and the Strong Black Women myth
- How faith and religion plays a part in accessing support
- Poor communication and dismissiveness as a barrier for Black mothers receiving support

Training can be booked by emailing: sandra@themotherhoodgroup.com

2 The provision of an adequate number of workers to ensure health professionals have enough time to address women's concerns. Consider using a workforce planning tool to ensure there is a sufficient number of people in each of the key roles (psychiatrist, pharmacist, nurse, psychologist, occupational therapist, support staff, admin, peer support). Recruit a diverse workforce.

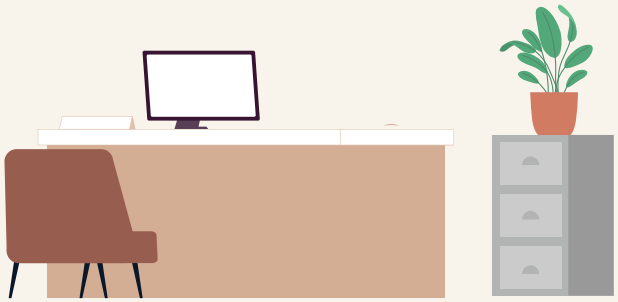
Useful resources

- **NHS Future platform** has a workforce planning tool that can be used by service managers
- National Perinatal Mental Health Workspace –> LTP Commitments –> PMH LTP Planning considerations tool

3 A facilitator to perinatal mental health care is health professionals with a genuine interest in women, who are trustworthy, non-judgemental, empathetic and warm. Therefore, we recommend the recruitment of staff with a positive interest and attitude towards providing high quality physical and mental health care to women. Consider health professionals receiving recognition and accreditation for providing high quality care, team working, and clear communication.

Workplace culture and practices

4 Encourage team working within and across services. Implement multidisciplinary meetings, co-location, joint working, sharing knowledge, and increase approachability.



Examples of good practice

The Greater Manchester Perinatal Parent Infant Mental Health Model of care works within an integrated system to make sure all services work together, and prevent silo style working. The Parent/infant relationship is at the centre of the care, and the system works together across a wide range of NHS services, children's services and partners in the voluntary and community sector. These are supported by integrated Specialist Perinatal Services and Parent Infant Services.

5 Develop clear and easily accessible guidelines on where to refer women to depending on their needs. Development of one referral form that can be uploaded, amended, and discussed at multidisciplinary team meetings.

Examples of good practice

The Perinatal Mental Health Service at South West London and St Georges Mental Health NHS Trust have developed one referral form that can be used by everyone, uploaded and amended. It is then discussed at multidisciplinary team meetings. This process helps standardise and streamline the referral procedures.

6 Employment of a liaison person who has access to all IT systems to bridge the gap between different services and service providers.

Service provision

7 Provision of care that meets women's needs. Care needs to be flexible, easy to access and is child friendly. Involve women in co-production of care services. Collaborate with organisations such as The Motherhood Group and FiveXMore to ensure care is culturally appropriate.

Provide peer support to women who feel it would benefit them. Consider provision of home visits for care and deliver care face-to-face. If home delivery of care is not possible, ensure practical support is available such as childcare.

Examples of good practice

One example of a successful co-produced service is the co-production of perinatal mental health services in Ealing, Hammersmith, Fulham & Hounslow. There was strong engagement with lived experience experts from the start. The approach was shaped around the needs of women and families and helped the team to create a practical service that delivers what families really need.

8 Where possible, provide continuity of care. This increases opportunities for women and health professionals to form trusting relationships which encourages open and honest communication.

This is a facilitator to perinatal mental health assessment and treatment.

Examples of good practice

The Tower Team based in the Tower Hamlets, London is a high-risk caseload midwifery team that works closely with the perinatal mental health team and the consultant obstetrician for mental health at St. Thomas' hospital.

The Tower Team offers continuity of care for women with severe mental illness from their maternity booking appointment, throughout pregnancy, intrapartum and for up to 28 days postpartum.

9 Break down language barriers by recruiting translators or forming partnerships with other agencies that can provide additional support (e.g. translation services, interpreters) to translate infographics/leaflets into local languages and to act as an interpreter at appointments if women feel comfortable.

Examples of good practice

ACACIA Family support provide pre and postnatal depression support services.

They provide multiple resources for Black, Asian and Minority Ethnic Mums/Dads and People of Colour.

Useful resources

The Office for Health Improvement and Disparities provide detailed **guidelines on language interpreting and translation** to ensure the needs of those who don't speak English are met.

10 Ensure that chosen assessment tools are easy to understand. Collaborate with organisations such as The Motherhood Group to ensure cultural appropriateness.

Design or update assessment tools that use pictures alongside words for use with women whose English speaking and understanding is limited.

Examples of good practice

Abi Sobowale (Sheffield South West NHS Trust) developed the "How are you feeling" screening tools to be used by women whose first language is not English.

It asks women about their mental health using translations and pictures. It also asks about physical symptoms associated with mental health difficulties.

Services could consider the development of more up to date assessment tools for use with women.

Recommendations for Commissioners

1. Ensure adequate funding is available for service managers to achieve the recommendations provided.

2. MATRIx recommends that commissioners work with health professionals, service managers, third party organisations and those with lived experience to develop clear and concise care pathways.

3. Follow the guidelines provided by **Moreton et al. (2021)** to ensure commissioners are able to provide services that meet the needs of the population. These guidelines suggest commissioners need:
   - A good knowledge of population and the healthcare needs in question. Therefore, training on perinatal mental health should be mandatory for at least one commissioner in each Primary Care Network,
   - Access to reviews or summaries of high quality evidence, such as the MATRIx website
   - Engagement with people with lived experience - services should be co-produced with those who have lived experience

Useful resources

The National Lottery Community Fund have provided guidelines and examples on co-production of care. Co-production of care means that services and activities are a better fit for the people that use them.

Recommendations for England/Scotland/Wales

1. Continued policy support from NHS England, and NHS related to perinatal mental health care, such as the publication of the **Five Year Forward View** and **Long Term Plan** for NHS England, and **Delivering Effective Services** for NHS Scotland.

2. NHS Mental Health Campaign focused on raising awareness of perinatal mental illness and reducing stigma for perinatal mental illness.

Research support

Research suggests public mental health campaigns can increase knowledge about mental illness and improve attitudes about people with mental illness (Dietrich et al., 2010[38]; Jorm et al., 2005[39]; 2006[40]; Makowski et al., 2016[41]). This can therefore reduce stigma, one of the leading barriers to perinatal mental health care.

Recommendations for the Government

1 Free healthcare for all at the point of access.

Research support

Despite the NHS being free for UK residents, there are NHS charging regulations in place for those who are not residents of the United Kingdom. NHS charging regulations have a large negative impact on pregnant and postnatal women, in terms of their mental health (Feldman, 2018[33]) – increasing stress and anxiety, their vulnerability to domestic violence (Harris & Hardwick, 2019[34]) and maternal deaths that may have been prevented through access to antenatal care (Knight et al., 2019; Nullums et al., 2018[35]). Furthermore, Public Health England has identified NHS charging for maternity care as one of the key issues that exacerbates poorer health outcomes for women and babies of colour (Public Health England, 2020[36]).

2 Suspension of NHS charging regulations until a full independent review is carried out of their impact on individual and public health. Simplification of charging criteria and exemptions and safeguards to protect vulnerable patients and ensure they are not denied the care they need.

Policy support

This recommendation is in line with:

a) A **joint statement** set out by the Royal College of Physicians, the Royal College of Paediatrics and Child Health, the Royal College of Obstetricians and Gynaecologists and the Faculty of Public Health in 2018, calling for a suspension of NHS Charging

b) A **statement** from the Academy of Medical Royal Colleges in 2019 calling for the suspension of the NHS charging regulations until a full independent review on individual and public health is carried out

c) A **statement** from the Royal College of Paediatrics and Child Health calling for an end to NHS charging due to its adverse effects on child health and wider public health

d) A **report** from Maternity Action calling for the immediate suspension of charging for NHS maternity care given the deterrent effect on women's access to maternity care.

3 A fair welfare and economic system that ensures no one is living in poverty or in financial hardship, thus reducing health inequalities.

Policy support

The UK government, under **Article 25** of international human rights law, has a legal obligation to ensure "Everyone has the right to a standard of living adequate for the health and well-being of [them]self and of [their] family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond [their] control" and to ensure "Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

4 The provision of a comprehensively researched and adequate budget provided to the Department of Health and Social Care, Health and Social Care Directorates and so all healthcare needs for that financial year can be met and where possible, reduction of in-year funding changes in England so local areas know exactly how much they can spend at the start of the year[37].

SUMMARY AND CONCLUSIONS

- The MATRIx study identified barriers and facilitators to perinatal mental health care.
- These highlight the need for women-centred, flexible care, delivered by well trained, knowledgeable, and empathetic health professionals working within an organisational and political structure that enables them to deliver quality care.
- Results also suggest a need for international efforts to increase awareness and reduce stigma associated with mental health difficulties.



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