



SCOPING REVIEW

Women's experiences of accessing maternal mental health support services: A scoping review

Stephanie Taynton^{A,B} • Nimisha Waller^C • Susan Crowther^C

^A Corresponding author: stephtaynton@gmail.com

^B Te Whatu Ora - Waitaha Canterbury

^C Te Wānanga Aronui o Tāmaki Makau Rau | Auckland University of Technology, Aotearoa New Zealand

ABSTRACT

Background: Maternal mental health (MMH) conditions affect up to one in five women globally during pregnancy and the year following birth. Many of these women need to access MMH services. However, there is a paucity of research focused on the experiences of women accessing MMH services, in a global context.

Aim: The aim of this scoping review was to explore studies that report on women's experiences of accessing mental health support services within a global context.

Method: Six databases were searched in July and August 2022 and May 2023. Only studies focused on the experiences of women with perinatal mental health conditions were included. Key information and findings from published studies were extracted and meta-synthesis was performed using thematic analysis.

Findings: Sixteen studies were included, and three themes emerged: **Barriers to accessing care**, such as fear, stigma and logistical difficulties; **Facilitators to accessing care**, such as trusting relationships, social support and education; and **System-related barriers to accessing support services**, such as difficulty getting referrals, accessibility to services and long waiting times.

Conclusion: The evidence suggests women's experiences of accessing MMH support services are variable and influenced by cultural, psychosocial and system factors. Trusting healthcare provider relationships and continuity of care support women to disclose MMH concerns. Midwives are well placed to screen and refer women for MMH conditions; however, further post-registration education is needed. Further multi-agency and multi-professional research in New Zealand and globally would be beneficial in informing education, policy and practice recommendations, with the aim of specifically addressing the barriers to accessing MMH identified in this review.

Keywords: maternal mental health, perinatal mental health, midwives, experience, access

INTRODUCTION

Maternal mental health (MMH) conditions, an important area of maternity care, affect up to one in five (20%) women globally in the perinatal period (World Health Organization [WHO], 2022). WHO (2022) defines this period as the duration of pregnancy and to one year following birth. The numbers are lower for women from high-income countries, where it is estimated that one in 10 (10%) women experience perinatal anxiety and depression (WHO, 2022). In New Zealand, it is estimated that 12-18% of mothers and 10% of fathers experience perinatal mental health issues (Ministry of Health [MOH], 2021).

MMH conditions include, but are not limited to, anxiety, depression, psychosis, bipolar disorder and post-traumatic stress disorder. Consequences for mothers who have MMH conditions include living with conditions such as anxiety and depression, significant relationship breakdown and a risk of suicide (Perinatal

and Maternal Mortality Review Committee [PMMRC], 2022; Stein et al., 2014). There is also potential that attachment between mother and baby may be impacted, although further research is needed to comprehensively know what this impact is (McNamara et al., 2019; Risi et al., 2021).

However, in the literature there appear to be many factors that negatively influence mothers' experiences of accessing MMH support services. These barriers include negative self-perception of MMH conditions, fragmented services that are under-resourced with long wait lists, language barriers and culturally inappropriate care (Ford et al., 2019; Sambrook Smith et al., 2019). It is evident that there is literature available to inform a scoping review of qualitative studies about the experiences of women with mild to moderate mood disorders and their experiences of accessing support services.

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Rationale

This article reports on the findings of a systematic scoping review that sought to gain an understanding of the extent and type of evidence available in relation to women who have mild to moderate mood disorders and who have or have not accessed MMH services. A global perspective was adopted to understand the breadth of experiences of accessing MMH support services and to identify any potential gaps within the literature. This review focuses on women in the perinatal period.

METHOD

Research question

What is known about women's experiences of accessing MMH support services when they have mild to moderate mood disorders?

Search strategy

The scoping review was completed with guidance from the Joanne Briggs Institute (JBI) protocol for scoping reviews (Peters et al., 2020). The JBI protocol has nine steps in the framework that was developed by Arksey and O'Malley (2005) and then reviewed by Peters et al. (2020). The nine steps followed were: defining the research questions and objectives; developing the inclusion criteria; describing the approach to searching for literature; searching for the literature; selecting the published articles; extracting the data; analysing the data; presenting the results; and summarising the evidence in relation to the review, including implications of the findings.

The scoping review protocol was then submitted to Open Science Framework (ref b4yq5). The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines were used to create a PRISMA flow diagram to visually summarise the screening process (Figure 1). Four academic databases were searched: Scopus, Medline (via National Library of Medicine), Pub Med-advanced (via National Library of Medicine) and British Medical Journal (BMJ) Journals. Auckland University of Technology

(AUT) Google Scholar and AUT Library were searched to ensure no additional literature was missed and the reference list of each eligible paper was searched. Grey literature, such as government documents and conference papers, was also considered. The search was conducted with keywords such as “maternal mental health”, “perinatal mental health”, “women's experiences mental health”, “access maternal mental health”, “mood disorders”, “postnatal depression” and “maternal mental health diagnoses”. These keywords were revised with a librarian and were narrowed down to “perinatal mental health” AND “experiences” AND “women”, as the initial search indicated over 700 articles.

Eligibility criteria

This scoping review included qualitative studies to explore women's experiences of accessing services. The studies selected were published within a 10-year timeframe (2012-2022) and were accessed in July and August 2022. An additional search was conducted in May 2023 to ensure no additional literature had been published since August 2022. The literature included had to be published in the English language. Articles where only abstracts were available, without the full text, were excluded from the scoping review. This is because it cannot be assumed that the abstract is an accurate representation of the article in its entirety.

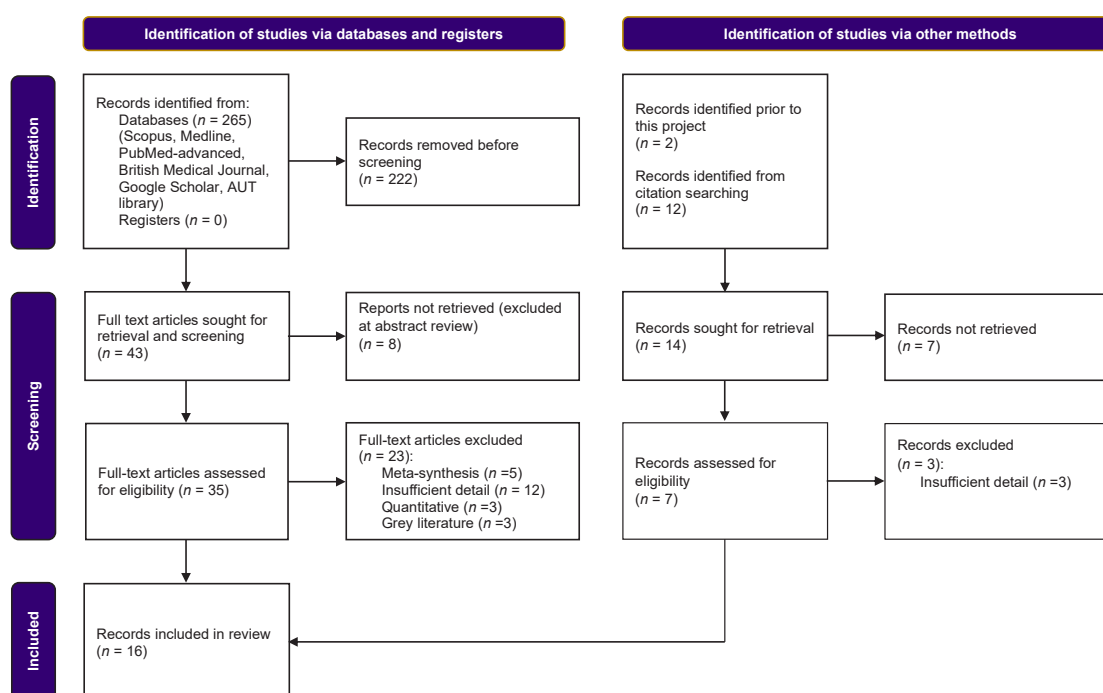
Study selection

EndNote was used to assist with the reference list and storing relevant research, ensuring duplicates were removed. The titles and abstracts were searched for relevance, and the eligibility criteria were applied to the full-text articles.

Quality appraisal and data extraction

The quality and relevance of the selected articles were examined using a checklist in a data extraction form, first by the lead author and then by the co-authors. The data extraction form covered a range of information, including general information about the articles such as date accessed, keywords and the database used to access the literature, and other information such as the title,

Figure 1. PRISMA flow diagram



publication date, methods, sample, intervention and key findings and outcomes (JBI, 2015). Key findings that related to the scoping review objective and question were commented on. A section on the experiences of participants was also added following a discussion and consensus with the research team.

Data synthesis

The selected articles were read carefully, and themes were identified within the data presented in the included articles. The data were extracted and then organised thematically and reported according to Sally Thorne's interpretive description methodology (Thorne, 2016). Interpretive description methodology allows for deep reflection and for the researcher to see beyond the obvious and search for meaning within the literature (Thorne, 2016). Once themes had been identified they were written down and grouped together. The themes and subthemes were then reviewed and critically analysed by all the authors, ensuring that they were accurate and reflected the most plausible meaning.

FINDINGS

Search results

There were 279 records identified: 225 in the initial database search (2012 to August 2022) and 40 in the subsequent search (August 2022 to May 2023), along with two studies identified prior to this project and 12 from citation searches. Of these, 263 records were excluded, which resulted in 16 articles being included in the meta-synthesis (Figure 1).

Study characteristics and assessment

Of the 16 included articles, 14 were qualitative studies, one was quantitative, and one was a mixed methods government report. Although it did not meet the eligibility criteria, the quantitative study was added following review with the co-authors. The study examined women's mental health outcomes and their retrospective experiences of accessing MMH support services, hence, relevant to the research questions (Koire et al., 2022). The mixed methods New Zealand government report was included as it provided an overview of MMH services, cultural appropriateness and the needs of the New Zealand MMH sector (MOH, 2021).

The included articles had a range of study methodologies, including descriptive, thematic analysis, mixed methods, quantitative and interpretative phenomenology. Eight qualitative studies collected data by individual interviews. Three studies used multiple ways of collecting data, such as questionnaires that allowed written responses to share experiences and digital or in-person interviews. Two of the studies included used focus groups. The studies were conducted in seven countries: United Kingdom (UK), Ireland, Canada, Brazil, the United States (US), Australia and New Zealand (NZ; Table 1).

Description of findings

Three themes and seven subthemes were derived from the identified and included literature (Table 2).

BARRIERS TO ACCESSING CARE

The literature reviewed showed that there were many personal and social barriers that women experienced when they identified they needed to access support services for their MMH condition. These included the fear and stigma of not being perceived as a good mother, the fear of children being removed from their care, a limited knowledge culturally about mental ill health, and mental illness not being acknowledged as a health condition. Other barriers were logistical difficulties, such as transport and making it to appointments on time.

Fear and stigma

Fear and stigma was a prominent subtheme across the literature review and was evident in nine of the articles. This was not a generalised anxiety state or mood but specific fears of certain aspects of accessing care. For example, there was a fear of being judged by healthcare professionals (HCPs), such as general practitioners (GPs), nurses, midwives and other community health workers. How the HCP reacted when women voiced their MMH concerns strongly impacted their likelihood of, and comfort when, engaging with HCPs further (Ford et al., 2019; Oh et al., 2020; Pilav et al., 2022). The wider family was also fearful of this judgement and reluctant at times for the mother to be seen by an HCP for MMH concerns, due to a fear of being stigmatised (Pilav et al., 2022; Taylor et al., 2019). Many midwives perceived that the fear of stigma acts as a barrier to women accessing MMH care (Mellor, 2016). This was highlighted by a midwife in Mellor's (2016) New Zealand study.

Showing them that it's OK for them to talk about it, it's OK to have a mental health issue, it's not the end of the world, and just making them feel safe about talking about it, because I've had some women when I've said about mental health services they've said, I'm not mental! It's got so much stigma attached. (p. 100)

Likewise, women were reluctant to share their MMH concerns with friends or family due to fears of being misunderstood and/or unsupported (Higgins et al., 2016). The fear of children being removed from a mother's care was another barrier reported in the literature. This fear prevented some women and families seeking help for MMH conditions (Baldisserotto et al., 2020; Pilav et al., 2022; Taylor et al., 2019).

There was also a fear amongst women that having an MMH condition prevented them from being a "good mother" (Baldisserotto et al., 2020; Law et al., 2021; Pilav et al., 2022; Savory et al., 2022). This belief was shared by a participant in the Baldisserotto et al. study (2020), who stated, "a woman with depression can't be a good mother" (p. 103). The literature identified that motherhood could be a complex time for new mothers as they navigate their changing sense of self and that they could feel challenged about what a good mother is and how motherhood should be experienced (Law et al., 2021; Pilav et al., 2022; Viveiros & Darling, 2018). The societally imposed ideal of being a good mother, along with a personally imposed idea of what being a good mother is, only increased the fear of getting it wrong, adding further stress to women (Hore et al., 2019). Due to this pervasive ideal, it was demonstrated that women who have an MMH condition may feel inadequate and judged by other people, particularly other women. This meant they were unlikely to disclose their MMH concerns to other mothers to maintain a "good mother" identity (Law et al., 2021; Pilav et al., 2022; Oh et al., 2020). Two of the articles inferred that this need to maintain being seen as a good mother by others led to women concealing their MMH condition, and seeking control in other areas of their lives, such as being very organised or presenting themselves well (Oh et al., 2020; Savory et al., 2022).

The influence of culture and knowing

It was evident from the literature that, although MMH education and screening were provided by some HCPs, Pasifika and Māori women had variable experiences. The women in the Holden et al. (2019) study felt that not enough culturally appropriate education was provided for them, while the midwives in their study reported a lack of understanding about MMH conditions from women and their families. Pilav et al. (2022) highlighted the importance of HCPs having an awareness about how MMH is understood and

Table 1. Summary of the literature

Author/country/year	Aim	Methods and participants	Relevant findings or results/themes
Baldisserotto, M. L., Miranda Theme, M., Gomez, L. Y., & dos Reis, T. B. Q. Brazil, 2020	To investigate the factors influencing the decision not to seek or to refuse treatment for perinatal depression in a low-income country	Focus group discussions, content analysis 26 pregnant and postpartum women	<ul style="list-style-type: none"> - Lack of knowledge - Lack of MMH services - Fear of children being removed - Self-denial of MMH condition
Blackmore, R., Boyle, J. A., Gray, K. M., Willey, S., Highet, N., & Gibson-Helm, M. Australia, 2022	To evaluate a perinatal depression and anxiety screening programme	Semi-structured interviews, the Standards for Reporting Implementation Studies (StaRI) checklist 28 healthcare professionals and 9 women in the perinatal period, including women of refugee background	<ul style="list-style-type: none"> - Stigma is a barrier to receiving care - HCPs need more education about MMH screening and referral - More bicultural MMH HCPs - Continuity of care is important for ongoing engagement
DeRoche, C., Hooykaas, A., Ou, C., Charlebois, J., & King, K. Canada, 2023	To understand HCPs' perception of women's experiences of the MMH system	Survey, qualitative analysis 435 perinatal mental health HCPs	<ul style="list-style-type: none"> - Services do not serve the LGBTQI+ or ethnic communities well - Wait lists for services - A need for more community support services - Lack of national MMH guidelines
Ford, E., Roomi, H., Hugh, H., & van Marwijk, H. UK, 2019	To develop a questionnaire to measure quantitatively barriers and facilitators to women's disclosure of perinatal mental health problems in primary care To pilot and evaluate the questionnaire for content validity and internal consistency	Study 1: Cognitive debriefing interview 5 women who had given birth in the last three years, whether or not they had experienced anxiety or depression Study 2: Questionnaire 71 women who had given birth in the past two years and had symptoms of distress or feeling unable to cope	<ul style="list-style-type: none"> - Fear and stigma of having an MMH condition - Logistics of travelling to and attending an appointment - Trusting relationship with an HCP
Higgins, A., Tuohy, T., Murphy, R., & Begley, C. Ireland, 2016	To explore the views and experiences of women with mental health difficulties, who received care from publicly funded maternity care services during pregnancy, childbirth and immediate postnatal period in hospital	Qualitative descriptive design, face-to-face interviews 20 women with an MMH condition, who had birthed within the last 2 years	<ul style="list-style-type: none"> - Lack of MMH services - Feeling misunderstood by others - Shame about having an MMH condition - A need for specialist MMH services - Lack of antenatal education about MMH conditions
Holden, G., Corter, A. L., Hatters-Friedman, S., & Soosay, I. NZ, 2019	To explore current MMH screening practices and support services for Māori and Pacific mothers and midwives	Thematic analysis, semi-structured interviews 9 midwives interviewed by phone, 13 women interviewed in person in a focus group	<ul style="list-style-type: none"> - MMH services are variable and inconsistent - Cultural understanding is a barrier to accessing MMH support services. - Lack of family support to seek MMH treatment - Cost, transport and time are barriers to accessing services
Hore, B., Smith, D. M., & Wittkowski, A. UK, 2019	To explore women's experiences of anxiety during pregnancy	Interpretative phenomenological analysis, semi-structured interviews 7 English-speaking, pregnant women who reported having anxiety in pregnancy	<ul style="list-style-type: none"> - Unrealistic expectations of pregnancy/motherhood. Trusting relationships enable disclosure - Continuity of care with an HCP supports disclosure
Koire, A., Nong, Y. H., Cain, C. M., Greeley, C. S., Puryear, L. J., & van Horne, B. S. US, 2022	To assess the influence that time accessing reproductive psychiatry services has on the mental health of peripartum women	Retrospective observational study, reviewing data from obstetric, paediatric and reproductive psychiatry practices, screening for postnatal depression using the Edinburgh Postnatal Depression Score 490 women	<ul style="list-style-type: none"> - Increasing MMH funding - Investigating other care options such as home visits and digital psychotherapy - Delays in care result in worsening MMH and an increase in self-harm
Law, S., Ormel, I., Babinski, S., Plett, D., Dionne, E., Schwartz, H., & Rozmovits, L. Canada, 2021	To understand how individual and cultural narratives of motherhood and perinatal mental health can be sources of shame, guilt and suffering but also spaces for healing and recovery	Descriptive study, semi-structured interviews 21 women with perinatal mental health conditions	<ul style="list-style-type: none"> - Unachievable expectations of motherhood - Feeling like a failure for having an MMH condition - Unlikely to disclose to other mothers due to the fear of judgement - MMH support groups were helpful - More resources and support that encourages disclosing MMH concerns - Fear of children being removed

Author/country/year	Aim	Methods and participants	Relevant findings or results/themes
Mellor, C. NZ, 2016	To explore midwives' perceptions of mental health and the assessment of MMH during pregnancy	Interpretative, descriptive, focus groups 25 midwives working as lead maternity carers in a NZ context	<ul style="list-style-type: none"> - Lack of appropriate MMH services - Not enough services for midwives to refer women to - Midwives reluctant to screen when there are limited services to refer to - Trusting relationships between women and midwives are important - Potential for dependency on midwife
Ministry of Health NZ, 2021	To undertake a stocktake of MMH services in NZ and understand what services different regions provide	Multiple methods, thematic analysis Online survey asking District Health Boards about what MMH services they provided, eligibility criteria and what they see as gaps and issues; followed up with interviews and site visits	<ul style="list-style-type: none"> - Increasing complexity of MMH needs - Services are inequitable between regions - Minimal primary MMH services - A need for more MMH care workers - Mothers with good support networks adapt to the challenges of parenthood better
Oh, S., Chew-Graham, C. A., Silverwood, V., Shaheen, S. A., Walsh-House, J., Sumathipala, A., & Kingstone, T. UK, 2020	To explore women's experiences of the identification and management of perinatal anxiety and their engagement with healthcare professionals	Qualitative study, semi-structured interviews 17 women (aged 25-42 years) with self-reported anxiety during pregnancy and/or up to 12 months postpartum	<ul style="list-style-type: none"> - Barriers to disclosure: stigma, fear of judgement, shame - Lack of screening and follow-up from HCPs - Maintaining the "good mother" identity - Established and trusting relationships with HCPs support disclosing MMH concerns
Pilav, S., De Backer, K., Easter, A., Silverio, S. A., Sundaresh, S., Roberts, S., & Howard, L. M. UK, 2022	To improve access to perinatal mental health services, by exploring the multi-level barriers Black, Asian, and minority ethnic women experience when accessing services	Thematic analysis, semi-structured phone interviews 18 mothers from minority ethnic groups who have experienced MMH conditions	<ul style="list-style-type: none"> - Loss of identity and shame for struggling with mental health - Being dismissed by an HCP - Lack of family understanding - Fear of children being removed from their care - More cultural understanding from HCPs about MMH - MMH peer support groups are good for removing stigma and providing support
Savory, N. A., Hannigan, B., & Sanders, J. UK, 2022	To explore the experiences of women during pregnancy with mild to moderate mental health problems and describe the barriers to receiving support in relation to their mental health	Thematic analysis, written questionnaire followed up with a semi-structured interview 20 women with MMH condition, viable pregnancy over 18 weeks gestation	<ul style="list-style-type: none"> - Trying to appear as a good mother - Little education on MMH conditions and where to get support - Fear of being misunderstood or unsupported - Long wait times for MMH services - Not being mentally unwell enough to be seen by the MMH team - Continuity of care supports disclosure
Taylor, B. L., Billings, J., Morant, N., Bick, D., & Johnson, S. UK, 2019	To understand women's, their partners' and the wider families' experience of MMH services in supporting women with MMH conditions	Qualitative, semi-structured interviews 52 women who had accessed National Health Service treatment for perinatal mental health difficulties, and 32 of their partners/family members	<ul style="list-style-type: none"> - Family felt marginalised by services and could be included better in care - Family can put pressure on women to not receive treatment due to fear of judgement or children being removed from their care - Women and their families wanted their family involved in their care - Considerations to be made to support the support people for women who have an MMH condition
Viveiros, C. J., & Darling, E. K. Canada, 2018	To explore what factors midwifery care recipients perceive to prevent or facilitate access to mental healthcare in the perinatal period	Qualitative descriptive, semi-structured interviews 16 mothers who had received or were currently receiving midwifery care, self-identifying as having experienced or experiencing perinatal mental health concerns	<ul style="list-style-type: none"> - Lack of MMH specialists and HCPs - Stigma and the fear of the perception of others - What makes a "good mother" and how motherhood should be experienced - Inadequate referral pathway and limited MMH services - Midwifery continuity of care was helpful to disclosing MMH concerns

Table 2. Themes and subthemes identified in the scoping review

Themes	Subthemes
Barriers to accessing care	<ul style="list-style-type: none">- Fear and stigma- The influence of culture and knowing- Logistical difficulties
Facilitators to accessing care	<ul style="list-style-type: none">- Trusting relationships matter- Education is key
System-related barriers to accessing support	<ul style="list-style-type: none">- Accessibility to services- Improving access

perceived within a woman’s cultural context. This cultural awareness thus increased the likelihood of HCPs engaging effectively with a woman from another ethnic group (Holden et al., 2019; Pilav et al., 2022).

An interesting aspect that emerged from a Brazilian article is that MMH conditions were seen to be the prerogative of “rich” women and that “poor” women “just get on with it” (Baldiasserotto et al., 2020, p. 101). However, WHO (2022) reported that one in five women in low-middle income countries experience an MMH condition compared with one in 10 women in high-income countries.

Logistical difficulties

Studies identified multi-level logistical difficulties that created barriers and prevented women from accessing MMH care. These included the challenge of being able to attend appointments in the allocated time slot while managing a small baby. The cost associated with accessing care, such as transport and paying for the appointment with the HCP, was also a factor that created a barrier. Finally, the location of the appointment with the HCP was a factor that impacted whether the women would be able to access care (DeRoche et al., 2023; Ford et al., 2019; Holden et al., 2019; Viveiros & Darling, 2018).

FACILITATORS TO ACCESSING CARE

The scoping review identified several facilitators to women accessing MMH support services, which are explored in two subthemes.

Trusting relationships matter

Several studies identified the significant role played by the midwives in diagnosing and supporting women with mental health concerns in the perinatal period. When women had a trusting relationship with their midwife, they were more likely to disclose their mental health concerns (DeRoche et al., 2023; Higgins et al., 2016; Hore et al., 2019; Mellor, 2016; Savory et al., 2022; Viveiros & Darling, 2018). Moreover, continuity of midwifery care encouraged a trusting relationship where women felt comfortable to discuss their concerns (Savory et al., 2022; Viveiros & Darling, 2018). As evident in Mellor’s study (2016), there was a risk that women with MMH conditions could build a dependency on their midwife. Therefore, professional boundaries and working with other services were important, as demonstrated by a midwife participant who said that working with other HCPs... *lifted the burden you know... it’s not my role. I’m a midwife, I’m not a social worker... I can’t do all of that by myself* (p. 86).

Other HCPs, such as GPs, also had a significant impact on women accessing care, according to some of the studies. Trusting relationships where the woman felt heard and respected were paramount to having a positive experience and encouraged women to continue engaging with the HCP (Ford et al., 2019; Oh et al., 2020; Pilav et al., 2022). Moreover, this relationship with an HCP was so important to women, that some needed to see several HCPs before finding one that they could trust and build rapport with

(Viveiros & Darling, 2018). Women also appreciated an open discussion rather than a tick box exercise, with transparency about how the information was going to be used or passed on (Hore et al., 2019).

The literature showed that the precondition of having trusting relationships within a strong social network was also an important aspect of supporting a mother’s mental health. Women who had strong, established support networks were likely to look to their social networks for support with their mental health and often felt well supported by them (Oh et al., 2020; Savory et al., 2022). Mothers who had trusting relationships with family and friends were also more likely to cope with the challenges of parenthood (MOH, 2021).

Education is key

Across the literature it was identified that there needs to be more education about MMH conditions for women and their families. Several studies reported that women had a lack of education and knowledge about MMH conditions and where to access support among other women in the perinatal period (Baldiasserotto et al., 2020; DeRoche et al., 2023; Higgins et al., 2016; Savory et al., 2022). To address this, new mothers need information about how to access MMH services, encouraging them to ask for help when needed (Koire et al., 2022; Law et al., 2021). Consideration should be given to other ways of information sharing, such as public campaigns, according to Holden et al. (2019).

Increasing education for midwives was found to be a vital consideration as many women look to their midwife first for support (Mellor, 2016). According to Mellor’s study, midwives at the time were not routinely provided with education about providing MMH care and would benefit from additional education (Mellor, 2016). Two studies anticipated that knowledge and confidence when caring for women with MMH conditions would be increased if education for HCPs was provided (Higgins et al., 2016; Mellor, 2016).

SYSTEM-RELATED BARRIERS TO ACCESSING SUPPORT

The women who participated in the included studies had varied experiences of accessing MMH support. Accessibility of services was impacted by system-related factors, such as difficulty getting an MMH referral, few HCPs able to refer directly to MMH services and long waiting lists. Lack of MMH services and culturally inappropriate services were also barriers for women.

Accessibility of services

It was evident in studies from two countries that there are barriers to obtaining an MMH referral so that support can be accessed. In the context of Viveiros and Darling’s (2018) Canadian study, for women to have funded perinatal psychiatric care, the referral had to be from the GP. This was a barrier for some women who did not have a relationship with, or access to, their GP. This was mirrored in the New Zealand context where midwives do not have the ability to refer to specialist MMH services directly and the referral must come from the woman’s GP (Mellor, 2016).

Many HCPs were reluctant to screen as they felt there was a lack of guidance and were unsure who and/or where to refer to (Blackmore et al., 2022; DeRoche et al., 2023). This was echoed in three studies which identified a perceived reluctance among midwives to screen for MMH conditions in case the midwifery partnership was jeopardised. In these three studies midwives were concerned that, if the women were not “severe” enough to qualify for MMH services, the midwives would be left carrying the burden of the women’s condition (Holden et al., 2019; Mellor, 2016; Savory et

al., 2022). In the New Zealand context, eligibility for access to MMH services includes having a live baby. Therefore, women who have had a stillborn baby or a termination of pregnancy are not eligible for publicly funded treatment (MOH, 2021).

Long waiting lists for MMH services were identified as a barrier in four studies. The long waiting lists meant that either the services were irrelevant by the time the woman was reviewed or, by the time she was seen, her MMH condition had deteriorated significantly (DeRoche et al., 2023; Koire et al., 2022; Savory et al., 2022; Viveiros & Darling, 2018). One study, based in Texas in the US (Koire et al., 2022), found that the average time between being diagnosed and being seen by services was five weeks. Each week that care was delayed resulted in postnatal depression (PND) scores increasing by 13% and self-harm increasing by 9% (Koire et al., 2022). A Canadian study found there was a one-year MMH service waiting list in some regions (DeRoche et al., 2023). Additional challenges, such as the COVID-19 pandemic and increasing social needs, also put pressure on MMH services (MOH, 2021). Several studies suggested that increasing the number of primary services, such as community MMH organisations, counselling and GP availability, would hugely benefit women, as would an increase in psychiatric MMH care availability (Holden et al., 2019; Koire et al., 2022; Mellor, 2016).

In its stocktake of MMH services in New Zealand, the MOH (2021) acknowledged the need for an increase of MMH service workers. This includes psychiatrists, psychologists and other specialist workers, such as midwives, GPs, Well Child Tamariki Ora providers and community support workers. The MOH also identified a need to increase the number of services that provide specialist MMH care. This finding was echoed in several international studies (Baldisserotto et al., 2020; DeRoche et al., 2023; Higgins et al., 2016; Holden et al., 2019; Viveiros & Darling, 2018). In the New Zealand context, accessibility varied between regions and MMH services were mostly in the main cities (MOH, 2021). There was also a lack of culturally appropriate services, with only 50% of District Health Boards (which were replaced by Health New Zealand | Te Whatu Ora in 2022) offering a Māori service and very few offering an Asian or Pasifika service (MOH, 2021). MMH care for the LGBTQI+ (lesbian, gay, bisexual, transgender, queer, intersex and others) community was considered by DeRoche et al. (2023), who reported that in Canada: *there are not enough options for the gender diverse community* (p. 3). This study found that many people felt that the current MMH services were not appropriate for the LGBTQI+ community due to their heteronormative nature and, therefore, people from this community may be less likely to engage with services.

Improving access

The scoping review identified that, to improve access to MMH services, different strategies of providing care must be considered. In Canada it was found that women who live rurally were often unable to receive support from an MMH service due to their geographical location (DeRoche et al., 2023). Koire et al. (2022) suggested that providing care via digital psychotherapy (phone or video) could be one way to improve access. It was recommended by Viveiros and Darling (2018) that a drop-in service or providing home visits could be a way to improve access to MMH support in the UK. Taylor et al. (2019) identified that the wider family is an important part of MMH care for women. Women liked to have their families involved in their care, but it needed to be on their terms. Many family members of the participants in Taylor et al.'s (2019) study felt marginalised by MMH services and wanted to be included in treatment as they were a part of ongoing support

for women once they were home. It was found that some women preferred a support group rather than one-on-one MMH care, so that experiences could be shared with other women (Law et al., 2021; Pilav et al., 2022). Blackmore et al. (2022) identified that women were also more likely to disclose their condition when they had continuity of care from an HCP. The MOH (2021) identified that lead maternity carer (LMC) midwives, who provide community-based continuity of care, are in an advantageous position to refer women to community agencies and have a good knowledge of these services.

DISCUSSION

This discussion summarises the evidence and themes found in the scoping review of the literature. The question posed of the published literature was “What is known about women's experiences of accessing MMH support services when they have mild to moderate mood disorders?” The scoping review addressed this question comprehensively, as evidenced by the systematic approach to searching and inclusion, and the extent of sources discussed in the findings.

The first theme, **Barriers to accessing care**, highlights how the opinions of others impact women when they experience an MMH condition. Women were less likely to access a support service for their MMH condition when they feared being judged by the HCP, and the HCP's reaction to a woman's MMH disclosure affected the likelihood of ongoing engagement. Women also feared judgement from their family and friends and of not being perceived as a “good mother”. The literature highlights women's lack of knowledge about MMH conditions and where to access support.

There needs to be consideration of the best way to educate women, their families/whānau and the public about MMH conditions to minimise the potential stigma felt. HCPs have an opportunity to de-stigmatise MMH by encouraging open discussions and educating women about MMH conditions. The literature was clear that continuity of care was the optimal relationship to enable this to occur over successive appointments with the same HCP, and this was acknowledged as a strength of the New Zealand LMC midwifery model. Māori and Pasifika women appear to have different experiences of MMH education and screening; however, further research with these and other ethnic groups needs to be considered to better understand links between their cultural norms and awareness of MMH conditions. This would enable culturally appropriate education and care to be provided for all women and their whānau.

Women faced logistical difficulties such as the location of services, cost of appointments and transport when having to access MMH support services. Maternity services and HCPs should evaluate the accessibility of their MMH service to women in the perinatal period.

Facilitators to accessing care was identified as another main theme, with trusting relationships as the first subtheme. Women who have trusting relationships within a strong support network are likely to look to them for support. This suggests that understanding how women can be supported to create and maintain strong social support networks during the perinatal period is a key area for further investigation.

Education for women about MMH conditions and how to access support services was identified as a second subtheme. To support this, HCPs need more education about MMH screening and referral. Although MMH education in New Zealand undergraduate midwifery programmes is provided by universities and polytechnics,

this fact is not documented in the literature and the effectiveness of this education has not been evaluated. It was identified that HCPs such as midwives are less likely to screen for MMH conditions when they lack knowledge about MMH conditions, screening and where to refer women for these services. Within a New Zealand context there is a need for further investigations and evaluations of screening methods, antenatal MMH education and the standardising of MMH support services in different regions.

System-related barriers to accessing support exist for women. The obstacles identified throughout this scoping review were numerous, negatively impacting many women who needed significant MMH support. These barriers included not having accessible services due to not being able to get a referral to an MMH service, not having a relationship with a GP or other HCP, or the HCP not screening or referring. To lower these barriers, investigations into, and consideration of, other ways of working, such as home visits, drop-in clinics or digital consultations, may help.

Inequities were evident across the findings, pointing to the variable availability of culturally acceptable, financially and geographically accessible services, and to restrictive eligibility criteria. In New Zealand, funding needs to be prioritised to educate more MMH HCPs and widen the eligibility for access to MMH services to include women who have experienced perinatal loss. By educating HCPs from a variety of backgrounds it could be anticipated that all women would benefit, particularly those in rural communities, ethnic groups – particularly Māori and Pasifika – and minority groups such as the LGBTQI+ community.

STRENGTHS AND LIMITATIONS

The scoping review provided many insights into what women encounter when needing to access MMH support services in New Zealand and internationally. The limitations were that only sources published in English were included. By excluding non-English sources, findings may have imposed a regional bias. It is possible non-published and non-accessible relevant information exists yet was not included in our literature search and that contributions from low-resourced regions were also potentially excluded. External validity is limited because some sources had small sample sizes and therefore lacked generalisability. This scoping review did not define mild to moderate mental health conditions and whether this included a formal diagnosis or not. This was due to this information not being available in the included scoping review literature. Notwithstanding these limitations, the scoping review provides a broad overview of the relevant literature in relation to women who have had mild to moderate mood disorders and who have or have not accessed MMH support services within the global maternity setting.

CONCLUSION

The evidence emerging from the scoping review suggests women's experiences of accessing MMH support services are varied. Women may be more likely to disclose MMH concerns if they have a trusting relationship with an HCP, which is enhanced in the context of continuity of care. Antenatal education for women about MMH, and continuing education for midwives to support their knowledge and comfort with screening women are also likely to be of benefit, enabling appropriate referrals to MMH services. However, increased resourcing for more MMH services, an increase in and diversification of the MMH workforce, and remote service delivery innovations will be necessary to ensure accessible and acceptable services are available. Further multi-agency and multi-professional

KEY POINTS

- Internationally, women's experiences of accessing maternal mental health (MMH) support services are varied.
- There are many barriers that reduce the likelihood of accessing support services, including psychosocial, cultural and logistical factors, and a lack of knowledge.
- Midwives are well placed to screen and refer women for MMH conditions; however, further post-registration education is needed.

research in New Zealand and globally would be beneficial in informing education, policy and practice recommendations, with the aim of specifically addressing the barriers to accessing MMH support services that were identified in this review.

DECLARATION OF INTEREST

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