

Fair Care from the Start.

A Framework for Equitable
Perinatal Mental Health Care.

Co-designed with women
with lived experience of
perinatal mental health
difficulties and professionals
across South Yorkshire



PRAMS: Perinatal Redesign for Accessing Mental Health Services

Glossary.

Underserved women

Women from ethnic minority backgrounds, those living in areas of deprivation, women facing language barriers, insecure immigration status, trauma, or multiple disadvantages.

Equitable care

Focusing on removing barriers and tailoring support to meet individual needs rather than treating everyone identically.

Perinatal

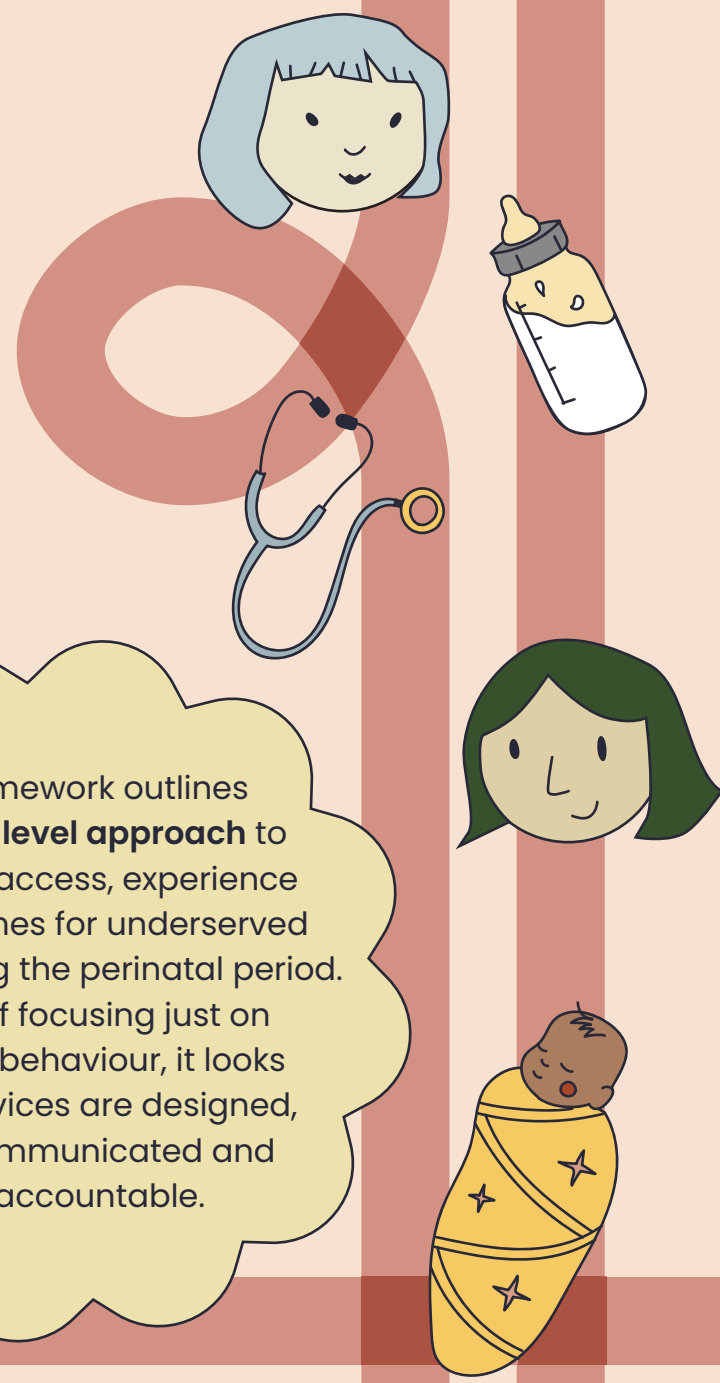
The time period "around birth," generally spanning from the beginning of pregnancy up to one or two years after childbirth.

What, Why, Who?

Mental health difficulties during pregnancy and the early months of parenthood are common, yet access to timely, appropriate support is unequal. Women from underserved communities across South Yorkshire are less likely to receive the mental health care they need.

The PRAMS project used Experience-Based Co-Design to understand why these inequalities persist from the perspectives of women with lived experience and the professionals who support them. As a result of that collaboration this framework is organised around six connected domains. Together, they describe what equitable perinatal mental health care should feel like in practice—and what local systems can do differently to make that a reality.

The framework is intentionally practical. Each domain describes what equitable care requires and what commissioners should expect to see in practice.



This framework outlines a **system-level approach** to improving access, experience and outcomes for underserved women during the perinatal period. Instead of focusing just on individual behaviour, it looks at how services are designed, linked, communicated and held accountable.

Why Change is Needed.

The Problem

Women experiencing perinatal mental health difficulties do not all have the same chance of receiving help. Underserved women are more likely to experience:

- ▶ Barriers to accessing services (unclear pathways, exclusionary systems)
- ▶ Care that feels unsafe, judgmental, or culturally disconnected
- ▶ Inconsistent support – birth trauma frequently goes undetected
- ▶ Poorer mental health outcomes for themselves and their babies

These experiences affect bonding, confidence, relationships, and long-term wellbeing—and they compound existing social and structural inequalities.

Real change requires redesigning services around women's real lives, not idealised pathways. It means shifting power, improving connections, and building trust—especially with communities who have previously been excluded or harmed.

Why System-Level Change Matters

Lived experience voices were clear: inequalities are not caused by a lack of goodwill or compassion among staff. They are created and sustained by how systems are designed, which was echoed by professionals.

- ▶ Services that are hard to find or understand unless you already know how systems work
- ▶ Reliance on digital access, English literacy, or confidence in professional spaces
- ▶ Fragmented pathways where women must repeat their story multiple times
- ▶ Poor communication between maternity, mental health, and community services
- ▶ Lack of transparency about data sharing and decision-making

Capable

A supported, skilled, and compassionate workforce

Ready

Services that are visible, inclusive, and embedded in communities

The Six Domains.

Equitable perinatal mental health care systems.

Accessible

Continuous care across pregnancy, birth, and beyond

Trustworthy

Culturally safe, transparent, and relationship-based

Supportive

Strong networks around women and families

Accountable

Learning systems that act on feedback

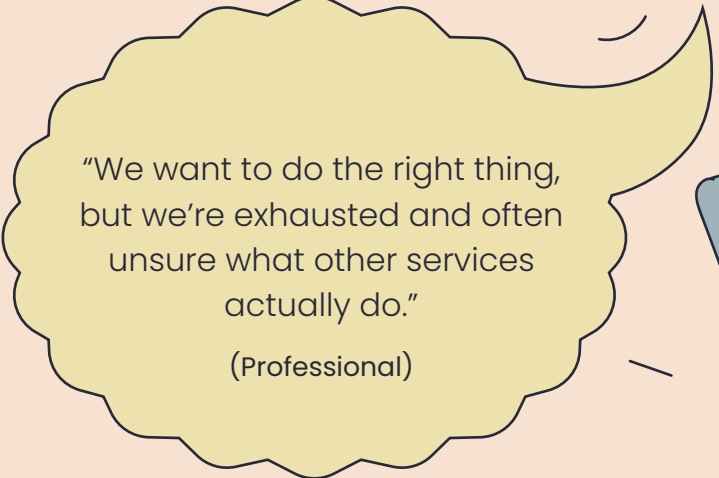


A Capable & Compassionate Workforce.

A workforce across maternity, mental health, primary care, and the voluntary sector that is trained, supported, and enabled to provide consistent, person-centred care.

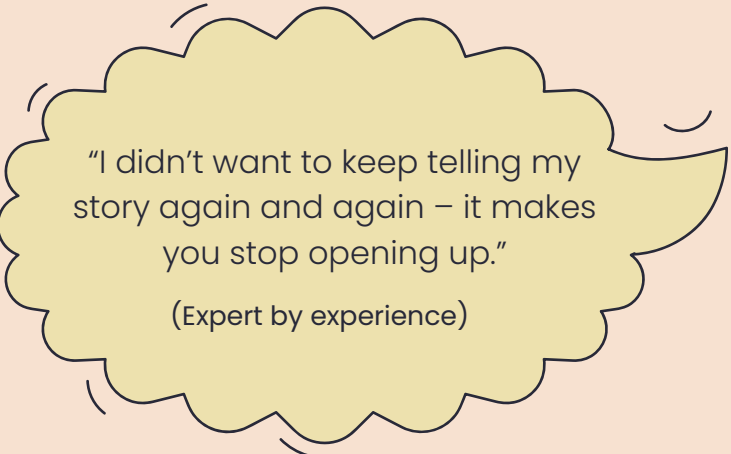
Key commissioning considerations

- ▶ Training must be protected, ongoing, and co-delivered with communities
- ▶ Workforce wellbeing and psychological support are essential for quality care
- ▶ Clear but flexible role boundaries reduce fragmentation and repetition
- ▶ Workforce diversity and community knowledge improve engagement and trust



"We want to do the right thing, but we're exhausted and often unsure what other services actually do."

(Professional)



"I didn't want to keep telling my story again and again – it makes you stop opening up."

(Expert by experience)



What good looks like in practice

- ♥ Joint training for NHS, voluntary sector, and community link workers
- ♥ Use of real lived-experience stories in training (positive and negative)
- ♥ Systems for sharing key information once, with consent
- ♥ Psychological support and reflective space for staff

Ready and Inclusive Services.

Services that are proactively inclusive—designed to be found, understood, and trusted by communities who have historically been excluded.

Key commissioning considerations

- ▶ Inclusion must be demonstrated in design, not assumed
- ▶ Outreach should occur before crisis points
- ▶ Trusted community organisations are critical delivery partners
- ▶ Communication style is as important as language



"We rely too much on leaflets and websites – that's not how people actually find help."

(Professional)

"If you don't already know the system, you don't know where to go."

(Expert by experience)



What good looks like in practice

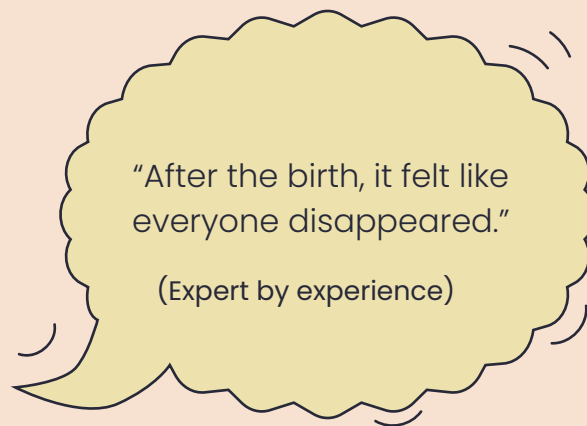
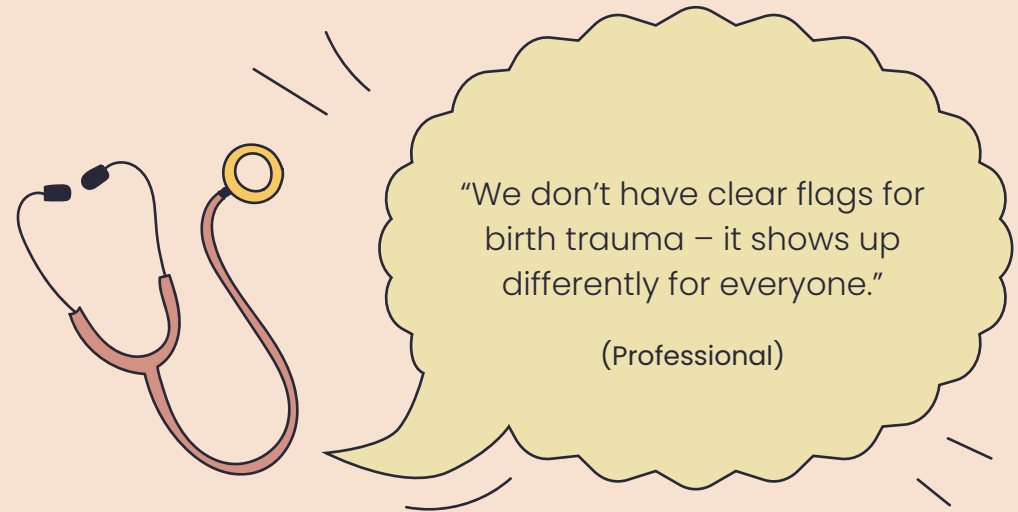
- ♥ Commissioned outreach via mosques, churches, schools, and community centres
- ♥ Community hubs or co-located services using trusted local organisations
- ♥ Information in multiple languages, formats, and culturally relevant styles
- ♥ Link workers acting as bridges between services and communities

Accessible Care Across the Full Journey.

Care pathways that recognise perinatal mental health as a longitudinal need, not a short-term episode.

Key commissioning considerations

- ▶ Postnatal drop-off is a major system failure point
- ▶ Birth trauma requires clearer detection and response pathways
- ▶ Peer and community-based support should be routinely available



What good looks like in practice

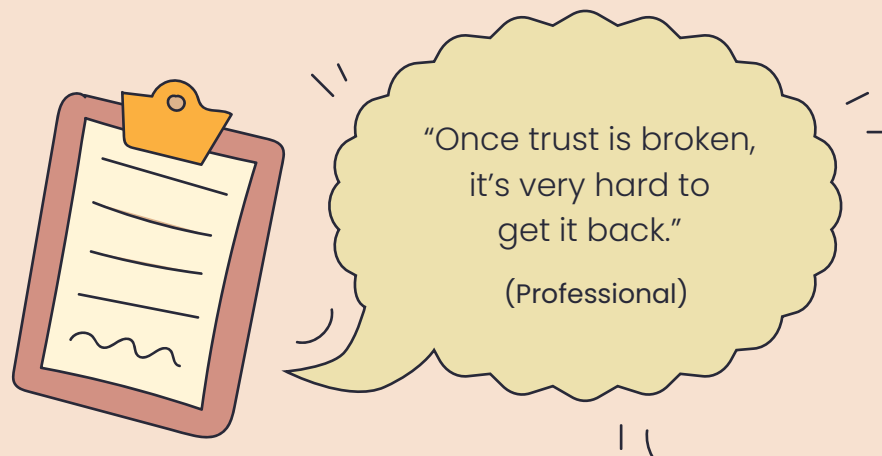
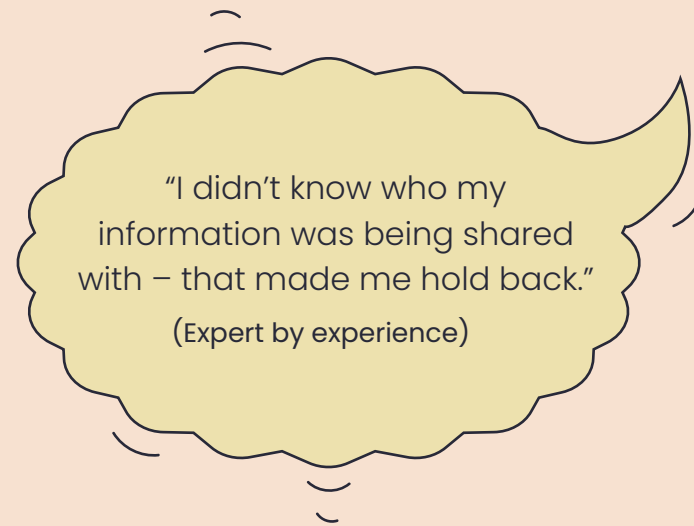
- ♥ Clear follow-up and touchpoints after birth
- ♥ Defined pathways and indicators for birth trauma
- ♥ Face-to-face peer support and local mother-and-baby groups
- ♥ Perinatal-specific crisis or support lines

Trustworthy and Culturally Safe Care.

Care environments where women feel safe, respected, and confident in how decisions are made and information is used.

Key commissioning considerations

- ▶ Trust is built through transparency, continuity, and follow-through
- ▶ Assumptions about literacy, understanding, or culture undermine care
- ▶ Data sharing must be clearly explained and consented



What good looks like in practice

- ♥ Clear, accessible explanations of data sharing and consent
- ♥ Consistency of staff wherever possible
- ♥ Training that values community knowledge alongside clinical expertise
- ♥ Relationship-based, trauma-informed care models

Supportive Networks Around Families.

Commissioning approaches that recognise perinatal mental health as a family and community issue, not an individual one

Key commissioning considerations

- ▶ Partners and families are often overlooked
- ▶ Isolation increases risk and disengagement
- ▶ Community champions and peer supporters are high-impact assets



"When someone goes with a woman to her first appointment, she's far more likely to stay engaged."

(Professional)

"Just meeting other mums who understood made a huge difference."

(Expert by experience)



What good looks like in practice

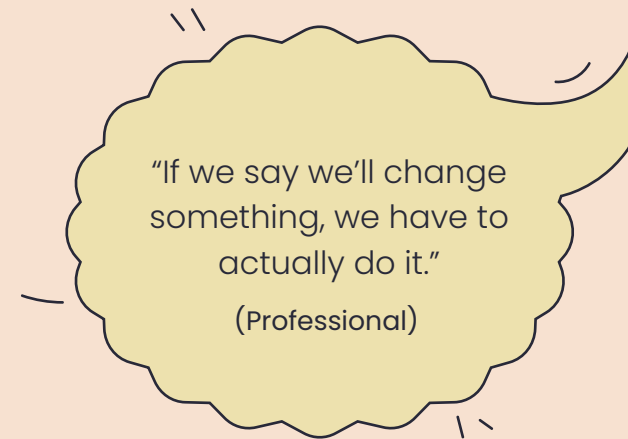
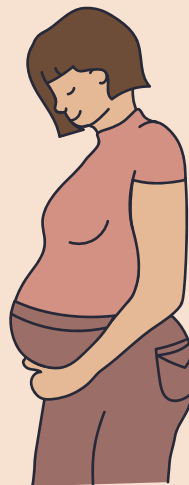
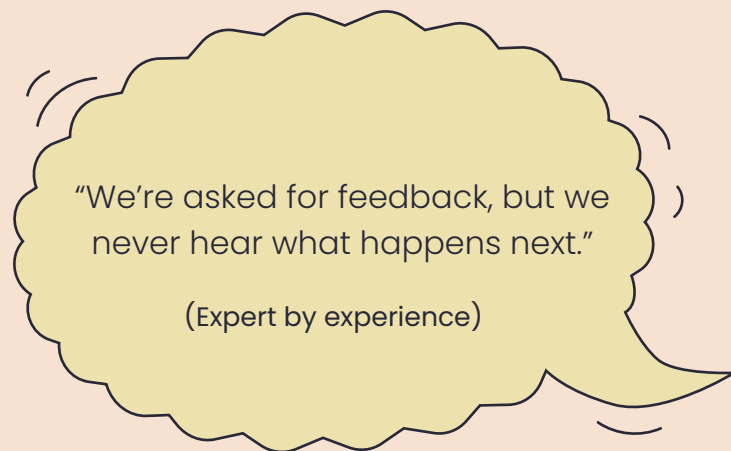
- ♥ Inclusion of partners and families as standard
- ♥ Commissioned peer support and community champions
- ♥ Chaperones or support workers for first appointments
- ♥ Cross-service working to provide continuity

Accountability, Learning and Improvement.

Learning systems that act on feedback and demonstrate change to communities.

Key commissioning considerations

- ▶ Feedback without action damages trust
- ▶ Communities remember negative experiences
- ▶ Compassionate responses matter as much as structural change



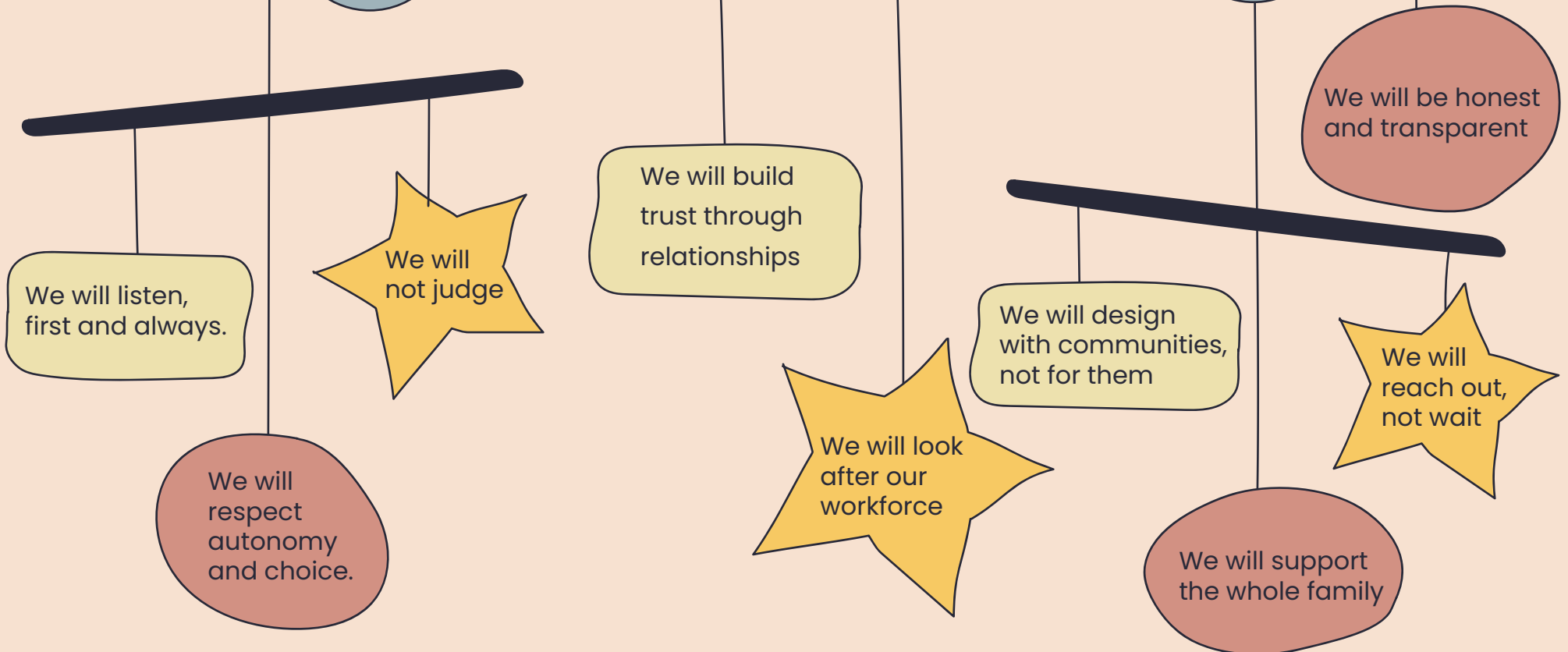
What good looks like in practice

- ♥ Feedback mechanisms co-designed with communities
- ♥ Clear reporting on what has changed as a result of feedback
- ♥ Measures of success that reflect lived experience
- ♥ Visible accountability at system and place level

These are commitments to how care is delivered, not tick-box standards. They reflect what women and professionals told us matters most.

Our Shared Pledges.

Prams Charter of Values.





We will listen, first and always

We will listen without interruption, assumption, or judgement. We recognise that every woman's experience is unique, and we will take her account seriously, even when it does not fit existing pathways or expectations.



We will respect autonomy and choice

We will recognise women as experts in their own lives. We will support informed decision-making, respect consent, and adapt our approach to the level of guidance or support each person wants.



We will not judge

We will provide care that is compassionate, trauma-informed, and free from stigma. We understand that fear of judgement prevents people from seeking help, and we actively work to remove this barrier.



We will be honest and transparent

We will clearly explain what support is available, what will happen next, and how information is shared. We will be realistic about what we can offer and keep the promises we make.



We will build trust through relationships

We recognise that trust takes time. Wherever possible, we will prioritise continuity, human connection, and consistency, and we will value relational work as core—not optional—care.



We will design with communities, not for them

We will value lived experience and community knowledge alongside professional expertise. We will learn and act on community feedback.



We will reach out, not wait

We will not assume people know how to access services or feel confident approaching them. We will proactively engage with communities, using trusted spaces, organisations, and people.



We will support the whole family

We will involve women, families, and communities as partners in shaping services.



We will look after our workforce

We will provide high quality training and supervision so that staff feel culturally informed and emotionally supported at work.

Rebecca's Story.

A note from the co-design process

Participants shared that being part of PRAMS helped build confidence, connection, and a belief that real change is possible. Co-design was not just a method, but an intervention in itself— demonstrating the value of sharing power and listening deeply.



“During pregnancy I struggled with my mental health and quite quickly came under the care of the perinatal mental health team. I was fortunate to have great support during this journey and also since, where I have been treated for postnatal depression. Initially when I raised concerns about my mental health I felt dismissed by my own community midwife. Eventually I was able to navigate services to reach the perinatal team, however I'm almost certain my own background as a health care worker made this much easier than it would have been. I wanted to get involved in PRAMS to share the wonderful care I have received, but also to help reduce the barriers for mothers in this difficult and stressful time.

Being part of the co-design workshops has been really wonderful, I was able to talk openly about my experience in a safe space. It was an amazing opportunity to hear other mums sharing their experiences too; I actually found this quite therapeutic, it made me feel less alone. It was also lovely that my little one was welcome in this space, reminding me that although I am now a mother there are so many new opportunities open to me. I also loved the sense of community that really came from the group, mothers caring so deeply about other mothers.

Seeing our ideas incorporated into the framework felt great. At a time where my identity feels so challenged, to be able to contribute to something so important made me feel a big sense of validation and achievement.

I really hope that the work we have done together will make a difference. In a time where maternity services are so stretched it feels so important that new and expectant mothers do not suffer.”

Fatima's Story.

"I am just in such a mess, I rang the doctors like screaming, crying because I was like they're not listening, nobodies listening. The doctors didn't know anything, but I was like nobodies listening to me. Everybody's kissing my baby. I didn't want them to kiss my baby. And he's like, okay, you are the mother, you can set these boundaries. I was like, well tell them then. I wanted the doctor to ring my in-laws for me. Like it was awful. When I think back now, I probably was like super emotional, because I'd just had a baby. But at the same time, I felt like I was being rational, because it's my boundary and you're not meeting it.

So then, that's when I went up for the assessment for the postnatal depression. She was asleep at the time, when I first got to the appointment. I can just remember feeling shame, like that I was sat in the centre, because I thought, I've tried for two years and then obviously when I've got her and I'm in this really bad emotional state, I thought, how ungrateful am I? Why do I feel like this? That's all I wanted and now I'm just sat. Even sometimes when visitors would leave, I would just sit there screaming and crying. I was just like looking at her thinking why are you not making me happy?

It was never, I never had that feeling of, I wasn't connected to her if that makes sense, but I had a feeling of like, why aren't you enough? Why can't I just get over this issue?

Why, what's happening? But then when I went for that assessment, I was sat there like feeling really ashamed. I just kept crying and crying and I was like I don't know why I'm here. I felt like I'd done something wrong. I felt like I'd been a bad mum. And then she woke up while I was there and the lady who was assessing me, said, I just want to tell you that this is not a bonding link. I think she said this isn't linked to the bond with her. She said I've just seen your bond as soon as she opened her eyes and then I instantly cried happy tears. I was like oh my, thank you. It just makes you feel that bit better."





Maryam's Story.

"I'd gone to this specific consultant when I was saying to him I really can't manage with this condition, I've never had it before, it's out of my control, I'm really really really in pain here, and it felt like it was, the baby was just gonna burst out of me this way and I just couldn't manage this real pull and push and tightness and my skin felt like it was just going to break, it was awful, never felt anything like it, and of course, the, it's typical that this, the consultant I got was like not hearing what I was saying about I can't manage, I am in pain, these simple sentences I was saying, and do you know what his response was? It was just be grateful that you have a roof over your head, be grateful that you can see the sun shining in the morning, just be grateful, spend a few minutes every morning just being so grateful that you know, you can see the blue sky and I just felt like punching him, and I'm not a violent person, but I just thought you don't even know if I've got a roof over my head, well obviously I've written an address on paper, but you don't know if I'm safe there, you didn't ask me, you didn't actually ask me, are you ok? What's going on? He just assumed I was being ungrateful, that's the worst thing you can say to somebody who is struggling, making a big assumption."

How We Can Use This Framework.

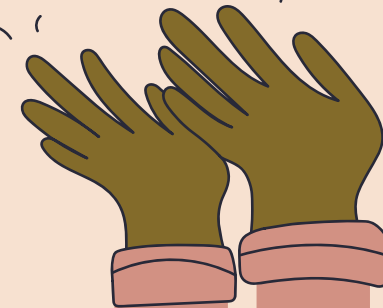
The framework should be used as a whole-system lens, not a checklist.

Assess current pathways against the six domains

Inform service specifications, outcomes and quality improvement work

Support place-based, integrated commissioning

Strengthen accountability to underserved communities



Acknowledgements.

Research Participants and Experts by Experience

We would like to extend our deepest gratitude to the women and families across South Yorkshire who shared their stories, time, and expertise with us. This framework is built upon your lived experience, and your bravery in speaking about perinatal mental health difficulties is the foundation of this work. We thank you for your commitment to ensuring that care is more equitable for those who follow in your footsteps.

PRAMS Team

The co-design process was made possible through the collaboration of several key organisations across South Yorkshire.

Authorship

This framework was authored by the PRAMS research team and stakeholders.

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