Report 4

Reducing Inequalities in Perinatal Mental Health Care

Inequalities in identification and management of perinatal mental health problems: views and experiences; what 'good' looks like

Zoe Darwin[2], Sarah Blower[1], Chandani Nekitsing[1], Sarah Masefield[1], Kathryn Willan[3] and Josie Dickerson[3]

[1]University of York, [2]University of Huddersfield [3]Born in Bradford.

Approved by:

Name	Version no.	Date
Josie Dickerson	1.0	22.04.22

The research presented in this report formed part of a wider research project examining inequalities in perinatal mental health care in West Yorkshire, to provide recommendations for local regional services and learning that is transferable more widely. The report is intended for service commissioners, service managers and those working in services.

Contents

Executive summary

Aim

The aim of the research presented in this report was to understand the key factors that enable and hinder access to perinatal mental health (PMH) care across the pathway, that is, disclosure and identification in universal services, and access, referral, and uptake of specialist (targeted) PMH services.

Method

Views and experiences were gathered from various stakeholders across West Yorkshire, including: i) semi-structured interviews with: women (n=19) from ethnic minority and/or socio-economically deprived backgrounds; ii) semi-structured interviews with voluntary sector workers (n=12); and iii) an online survey with NHS healthcare professionals (n=145).

Findings

Barriers and facilitators were mapped to a sociotechnical framework to understand the role of processes, people, technology, and the system. It was found that the barriers within each level have the potential to deepen inequalities.

Processes: the process-level includes availability/provision of interpreters, modality of contact, digital exclusion, access to transport and childcare. For example, we found that women from a low-socioeconomic background or those who were seeking asylum were likely to face many of the barriers under processes.

People; women: people-related influences include those concerning women themselves (e.g., stigma, knowledge of PMH and available support, fear of consequences, lack of empowerment and distrust of practitioners/services). For example, women from South Asian backgrounds spoke about mental health being taboo in their culture and this may inhibit some women from seeking professional help. We also heard about heightened distrust of practitioners/services amongst people from certain backgrounds, linked to experienced or anticipated negative interactions which reflected wider attitudes experienced by individuals and communities.

People; practitioners: barriers/facilitators regarding practitioners include: knowledge and confidence with discussing PMH; knowledge and confidence with asking about PMH; knowledge of pathways and available services; knowledge and confidence with cultural competency (specifically in the context of PMH); time to cover all needs (especially where complex/interpreter needed); struggle to build relationship and trust (time, continuity, interpreter); ethnicity and cultural background of practitioners; and, attitudes and at times discriminatory approaches. For example, practitioners have told us of their lack of confidence in asking about PMH, especially where women come from different cultures, or where women have other family members present. Some women shared their experiences of negative attitudes, which they connected with their ethnic or cultural background. Practitioners in the NHS identified time pressures and the impact for fully addressing mental health, including that this may be heightened in the context of additional communication needs.

People; others: influence of others (i.e., partners, other family, peers, interpreters) could facilitate or inhibit women's PMH support, both in relation to being physically present (or absent) at an appointment but also the anticipated reaction of others (for example, in relation to mental health being taboo). It was noted that presence of others was also relevant for appointments that took place remotely; for example, with some women living in multi-generational households being unable to have private telephone conversation with mental health services.

Technology: technological barriers were indicated regarding instances of poor information sharing with women and between services. For example, women were not always kept informed about the outcome of their referrals.

System: the system-level includes the extent to which PMH is viewed as a core business, partnership working between services, representation in workforce, high turnover of staff, high caseloads and fixed short appointment times, staff capacity for training, narrow rules on engagement and culturally insensitive services. For example, perinatal appointments in maternity or health visiting are often focused on assessing physical wellbeing rather than mental wellbeing. Also, voluntary sector workers voiced that narrow rules in the NHS (for example, concerning non-attendance at appointments) can limit women's access and engagement within the NHS, particularly for individuals from ethnic minority groups and those living with trauma. This stringent approach was also noted to have implications for other aspects such as building emotional safety.

All stakeholders expressed that several of these influences have been further compounded by the covid-19 pandemic.

Recommendations

To reduce inequalities in PMH care, multiple actions are needed at the system-level to enable changes in processes, people and technology. This includes:

1. Building emotional safety for individuals and communities, and this links to trauma-informed care and extends to consider the ways in which communities have been marginalised. Without addressing emotional safety, barriers remain in all steps of the pathway (from disclosure through to uptake of treatment). Building emotional safety requires: additional time in appointments, tackling distrust in services and ensuring that communication needs are met.
2. Making PMH core business for all services involved in caring for new and expectant parents. This includes: enhanced information and knowledge of PMH, having staff capacity for longer appointment times and for additional training, and improved data capture.
3. Demonstrating cultural competency in PMH care, which includes: representation in the workforce (paid and voluntary), tackling discrimination (including racial), improved access/engagement (tackling narrow rules of engagement), use of interpreters (and widening to consider spoken language, disability, neurodiversity), and consideration for mode of contact (e.g., digital inclusion, literacy, and flexibility).
4. Facilitating closer partnership working by recognising and valuing the expertise of all organisations involved in caring for new and expectant parents.

Report 4 – views and experiences; what 'good' looks like

1. What we set out to achieve

The overall aim of the research presented in this report was to understand the key factors that enable and hinder: disclosure and identification of perinatal mental health (PMH) difficulties in universal services, and access, referral and take-up of targeted/specialist PMH services; with an emphasis on inequalities. Two studies explored these factors from the perspectives of: women (4a); Healthcare Professionals (HCP) and staff working in the Voluntary and Community Sector (VCS) (4b). They were carried out in multiple sites across West Yorkshire: Bradford District and Craven, Calderdale, Kirklees, Leeds and Wakefield. Specific objectives for both studies are provided below.

4a objectives:

To understand the perspectives of women (parents) from seldom heard and ethnic minority groups concerning the key factors that enable and hinder: disclosure/identification of PMH in universal services; and access/referral/take-up of targeted PMH services. This included consideration of challenges and opportunities relating to service access presented by the Covid-19 pandemic.

4b objectives:

To identify specific inequalities observed by frontline HCPs working in both universal and specialist services, and staff working in the VCS. This included their perspectives on health inequalities identified in previous research (ethnicity; specific communication needs; low socio-economic status; multiparous; not partnered/a lone woman and low literacy; and learning difficulties) and included an opportunity to self-identify any other inequalities. The survey also explored how these inequalities have been affected by the COVID-19 pandemic.

2. Who we heard from or spoke with?

We heard from people in the following ways: interviews with 19 women (parents), survey with 145 practitioners (96 working in universal services and 49 working in specialist PMH services - Improving Access to Psychological Therapies (IAPT) practitioners varied in the type of service they self-categorised as), and interviews with key informants (KIs; 12 practitioners from 11 VCS organisations).

2.1 Women interviews

Invitations were sent by specialist PMH community teams to 330 women using last known contact details (see Appendix 1 for further information). The study was also publicised by relevant VCS via social media; therefore, it is unknown how many women in total were made aware of the study. Information about the study was made available in English and the most common languages in the area/ones spoken within the research team: Urdu, Punjabi, Mirpuri, Pahari, Hungarian and Polish.

Women were eligible to take part in the interviews if they met the following criteria (see Appendix 2 for the recruitment flyer):

- had been pregnant in the past 3 years
- gave birth in West Yorkshire
- experienced symptoms of PMH difficulties - even if they did not receive a diagnosis
- and were *offered* a specialist PMH service or they felt that they needed support but did not get it at the time
- we were particularly keen to hear from women who were not White British, and/or had difficulties in speaking, reading, or understanding English, and/or were living in deprived areas.

Women were asked to volunteer to take part only if they felt well enough at the time of the study. Each participant was given a £20 high street voucher to compensate for their time.

Forty women contacted the team expressing an interest in participation and 22 of them met the eligibility criteria (see Figure 1). Three eligible women were not interviewed because they did not respond to further contact or declined to take part. Of the 19 women who were interviewed about their views and experiences of support for PMH difficulties, 6 learned about the research through specialist PMH services and 13 learned about the research from VCS; it is possible that women may have experienced both types of services and we do not link quotations with individuals' contact with specific services. Table 1 summarises the characteristics of the women we interviewed.

Most women were from low to medium socio-economic status, as indicated by the questions asked in assessing eligibility. They were mostly located in Bradford (47%), Leeds (26%) or Kirklees (21%). The majority of the women reported to be from Pakistani (47%) or Bangladeshi (16%) heritage and 5% reported to be White British. Country of birth and nationality were not asked however 10 self-described as British (6 Pakistani, 3 Bangladeshi, 1 White).

Invitation sent / women approached via
- Three specialist PMH services n = 330 (LTYFT = 120, BDCT = 96 , SWYT = 114)
- Five VCS: number approached unknown (research advertised on social media)

Total women contacted research team (n = 40)

Lost to follow-up (n = 11)
- Unable to contact (n = 9)
- Drop-out (n = 2)

Checked for eligibility (n = 29)

Lost to follow-up (n = 7)
- Did not meet criteria PMH (n = 3)
- Did not meet criteria VCS (n= 4)

Eligible (n = 22)
- Specialist PMH services (n = 6)
- VCS (n = 16)

Lost to follow-up (n = 3)
- Unable to contact VCS (n= 1)
- Drop-out VCS (n = 2)

Completed interviews (n = 19)
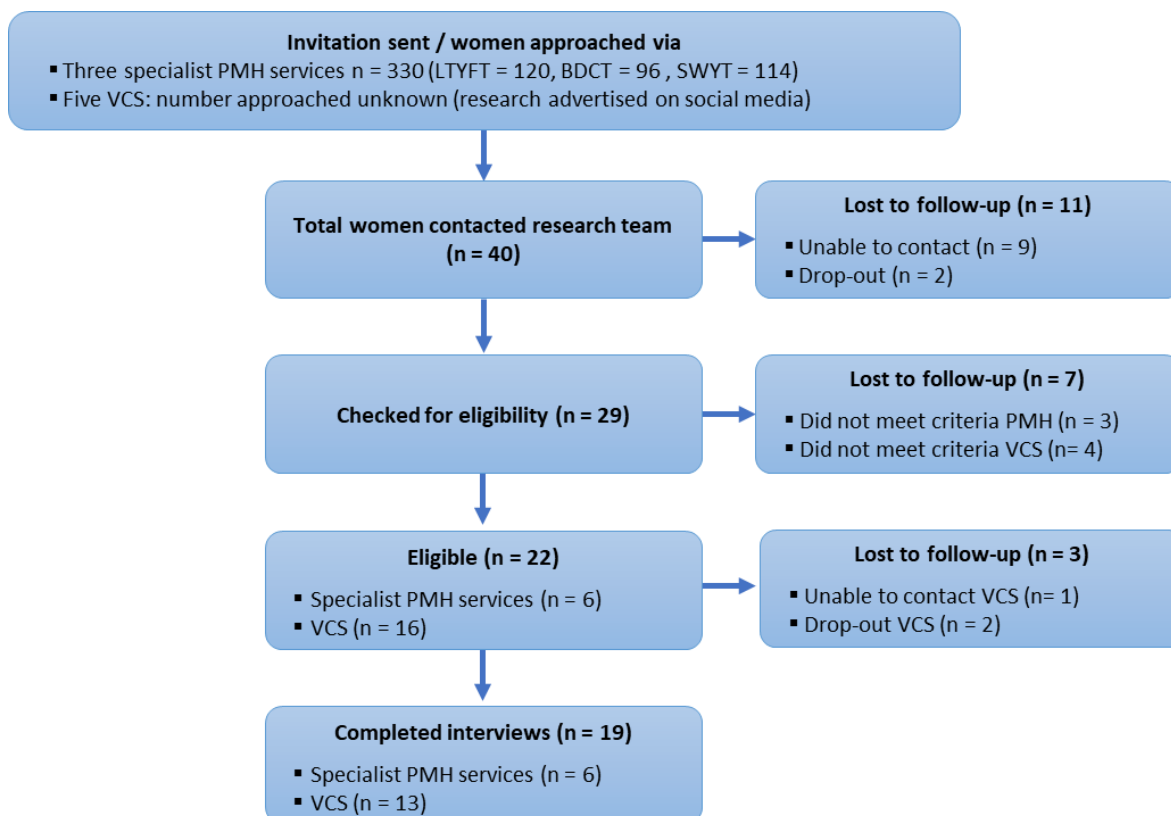- Specialist PMH services (n = 6)
- VCS (n = 13)

Figure 1. Flow of women who were approached and those took part in the interviews

Women had received support through different services for their emotional and mental wellbeing. By virtue of the eligibility criteria, all were either *offered* a specialist PMH service, or felt that they needed support but did not get it at the time. The six women who were recruited through the specialist PMH services had all accessed support within these services, but it appeared that some had not accessed all services that had been offered (for example, one reported being unable to attend on the day indicated and one reported not knowing what the relevant team was or having heard from them). Women reported having been supported by mental health professionals (including psychiatry, clinical psychology and IAPT), Samaritans, social services, domestic violence teams, and primary care (GP).

Women who were recruited through the VCS received a range of support including support from a midwife, health visitor, GP, IAPT, counselling, and one-to-one or group peer support. However, some reported that this support was not enough for their mental health. Furthermore, some did not access any external support for their mental health because they found discussing mental health difficult, declined additional supported that had been offered to them or sought self-help (e.g., through online searching/engaging in prayers).

Table 1. Summary of characteristics of 19 women who were interviewed

Women characteristics	
Location	Bradford = 9, Leeds = 5, Wakefield/Kirklees = 5
Referred to specialist PMH service	6 women were referred to specialist PMH services; all had a mental health diagnosis. Women ranged in support accessed, including crisis team, psychiatrist, perinatal psychologist, intensive support service, PMH services (unspecified) and a 'Diverse Mums group' linked to the PMH service
Onset of difficulties impacting in the index perinatal period, where reported	Antenatal onset = 13 Postnatal onset = 6 (including some following pregnancy loss in index pregnancy)
Previous or ongoing mental health difficulties/emotional concerns (if mentioned)	14
Type of difficulties impacting in the perinatal period, as expressed by the women	Anxiety, feeling really anxious, nervous, trauma, having panic attacks, flashback, episodes of psychosis, depression, postnatal depression, depressive mood, low mood, boding problem with children, traumatised by the losses - afraid going to lose child, suicide ideation/ feeling suicidal, tendency to self- harm (e.g. want to take extra medication), being/ feeling angry, don't feel like doing much, feel lonely, thinking too much, feeling numb, felt overwhelmed, low confidence, not smiling in family pictures - happiness was wiped off my face, stopped going out, stressed, struggling to do simple tasks, really struggling, feeling shut down, sleep problems
Mental health diagnosis, where specified	11 including depression, postnatal depression, anxiety, borderline personality disorder, episodes of psychosis
Perinatal loss (pregnancy loss or baby loss, where mentioned)	10 (including 3 in the index pregnancy)
Currently pregnant	2
Parity (number of previous births, i.e. excluding current pregnancy or any previous early loss)	One = 4, two = 6, three or more = 9
Age	Mean age 35 years (range 24 – 43 years)
Ethnicity	Pakistani = 9, Bangladeshi = 3 , Indian = 2, Other mixed = 2, Other Asian = 2, White British = 1 Note: country of birth and nationality not routinely asked
Interview language	All women spoke English. 12 women commonly spoke other languages but opted to be interviewed in English. Languages included: Punjabi = 6, Urdu = 3, Bengali = 2, Gujarati = 2, South East Asian language = 1
SES (socioeconomic status)	Mostly low-medium (based on eligibility questions asked)
Currently in a relationship	18

2.2 Healthcare professionals survey

An electronic survey was distributed to HCPs employed in fourteen organisations across West Yorkshire responsible for providing NHS services to women during the perinatal period. HCPs were eligible to take part if they were involved in the provision of health care (whether universal or specialist) to perinatal families and employed in one of the five study areas (Bradford district and Craven, Calderdale, Kirklees, Leeds and Wakefield). Table 2 provides the names of organisations that were asked to distribute the survey and the number and proportion of survey respondents from each.

Table 2. Participating organisations and number of staff who responded to the survey from each site

Study sites	Survey respondents n	(%)
Acute Trusts: Airedale NHS Foundation Trust, Bradford Teaching Hospitals NHS Foundation Trust, Calderdale and Huddersfield NHS Foundation Trust[1], Leeds Teaching Hospitals NHS Trust, Mid-Yorkshire Hospitals NHS Trust	45	31%
Clinical Commissioning Groups (CCGs): Bradford Districts and Craven CCG, Calderdale CCG, Kirklees CCG, Leeds CCG, Wakefield CCG	7	5%
Bradford District Care NHS Foundation Trust	23	16%
Leeds Community Healthcare NHS Trust	17	12%
Leeds and York Partnership NHS Foundation Trust	14	10%
South West Yorkshire Partnership NHS Foundation Trust	32	22%
Other/ Unknown[2]: Locala Community Partnerships combined with HCPs with missing study site information	7	5%

The survey was distributed to a minimum of 1900 HCPs. Of those, 201 (11%) HCPs clicked on the survey link and 145 completed the survey giving an estimated response rate of 8% (although not all respondents gave responses to open-ended questions).

The 145 healthcare professionals who completed the survey were from diverse job roles: 66 % (n = 96) reported working in universal services (e.g., midwives, health visitors and GPs); 24% (n = 34) worked in specialist community or inpatient PMH services; and 10% (n = 15) identified themselves as

---

[1] At an organisational level, Calderdale and Huddersfield NHS Foundation Trust were unable to formally participate in the study due to staff capacity, however 3 staff from their trust did attempt the survey. This may be because the survey was also circulated through the West Yorkshire PMH Steering Group.

[2] HCPs have not clearly identified location or have accessed the survey through West Yorkshire PMH Steering Group

specialists working in universal services (e.g., a PMH specialist midwife working in a community team). HCPs working in IAPT self-identified differently: some as working in universal services and others in specialist services. The wording in the survey could have been clearer in directing IAPT colleagues consistently to the universal category. A variety of professions are represented in the respondent group (see Table 3). A quarter of the respondents described themselves as midwives or specialist midwives (27%, n = 39). Respondents also included health visitors (8%, n = 11), mental health nurses (7%, n = 10) and a variety of other professions (see Table 3). Over half of the respondents reported to have been in their role between 1-5 years (53%, n = 75) and just over a third (36%, n = 53) were in their current role for 6 or more years. Relatively fewer respondents reported holding their role for less than 1 year (11%, n = 17).

Table 3. Summary of job roles of healthcare professionals who responded to the online survey (n = 145)

Profession	N	(%)
Midwives	31	21%
Specialist Midwives[3]	8	6%
Health Visitors	11	8%
GPs	7	5%
Mental Health Nurses	11	8%
Community Psychiatric Nurses	10	7%
Senior PMH Practitioners/ Other Senior Practitioners	10	7%
Psychiatrists/ Psychologists	9	6%
Mental Health practitioners (liaison/ early intervention psychosis)	5	3%
Wellbeing Practitioners/Counsellors	10	7%
Cognitive Behavioural Therapist	8	6%
Support Workers (peer support, link/ social workers)	7	5%
Clinical Leads	5	3%
Other Nurses	5	3%
Others	5	3%
Unknown	3	2%

The majority of the healthcare professionals who responded were female (89%, n = 129), followed by 8 % (n = 12) who were males and 3% (n = 4) did not wish to disclose their gender. Professionals were mostly White British (85%, n = 124), followed by White Irish (4%, n = 6), and Indian (4%, n = 6).

---

[3] Specialist midwives included: Perinatal Mental Health Midwife, Lead Perinatal Specialist Midwife, Early Intervention Midwife, Specialist Midwife, Continuity of Care Midwife, Senior Midwife

6% (n = 8) were classified as others and one person (1%) preferred not to disclose their ethnicity. Seventeen (12%) respondents spoke languages other than English. These languages included French, Finnish, Spanish, Arabic, Bengali, Gujarati, Hindi, Malayalam, Punjabi, Tamil, Urdu, Shona and Yoruba.

2.3 VCS key informant (KI) interviews

Twenty organisations across different areas in West Yorkshire who provide emotional support to women during the perinatal period were approached. Twelve KIs from 11 organisations (Mind, Doulas, Asha Neighbourhood Project, Hope Bereavement Support Service, Women's Health Matters, Women's Counselling and Therapy Services, Happy Moments, Talkthru, Café Christos, Health Access for Refugees Programme, Maternity Stream - City of Sanctuary) took part in interviews. Four organisations were based in Leeds, two each in Bradford and Kirklees, one in Wakefield and two organisations were more widely spread across Yorkshire. Appendix 3 highlights details of the VCS organisations who were represented by the KIs in this project.

3. What we asked about and how we asked it

Data collection tools and sampling for this research were informed by our first report, "Inequalities in identification and management of PMH problems: A review of academic and local reports" and wider knowledge within the multidisciplinary team of the literature on PMH (predominantly on disclosure and identification). Due to social distancing restrictions arising from the COVID-19 pandemic, information was collected remotely - online, by telephone or using secure NHS approved technology for videocalls (e.g., Microsoft Teams).

3.1 Interviews with women

The interviews gathered women's experiences of barriers and facilitators at the relevant steps of the care pathway; for example, discussion of mental health in universal services (maternity, health visiting, primary care), any referrals made (e.g. to specialist PMH midwives or health visitors) and their outcomes, access of specialist services and other services in relation to their mental health (e.g. community mental health teams, IAPT, counselling). The interviews also explored how this may have been impacted by the COVID-19 pandemic when applicable (e.g. perinatal period overlapped with the pandemic).

3.2 Healthcare professionals survey

The survey comprised a mix of open-ended questions with free text response formats and closed questions with simple yes-no or multiple response formats. Topics included background information on the respondent and perceptions of inequalities in the PMH pathway (the survey also explored

experiences of what works well and service improvement ideas that have been taken forward into Report 5). The questions were tailored according to the respondent's role in the perinatal pathway, for example universal service staff (GP, midwife, HV) were asked questions that focus on identification, disclosure and referral whereas the specialist staff (e.g., IAPT, community mental health team, psychotherapist) in targeted PMH services were asked questions that focus on referral, access and take-up of targeted services. Some questions were tailored to ask specifically about six groups which may experience inequalities in the PMH pathway (1. Women who do not speak English, 2. Ethnic minority women who speak English, 3. Women experiencing individual and area-based socioeconomic deprivation, 4. Multiparous women (having borne more than one child), 5. Not partnered, or a lone parenting woman, 6. Women with learning difficulties and 7. Low literacy). However, due to an error, low literacy was not included in parts of the specialist survey.

3.3 VCS key informant interviews

VCS interviews included general questions about the remit of the organisation, the support they provide to families during the perinatal period, how women access their service and their role within the organisation. The KIs were then asked questions to identify inequalities in the PMH pathway and questions were tailored to ask about the seven groups described previously. Practitioners were given the opportunity to identify any other groups who may experience inequalities. A range of topics were covered in the interviews relating to barriers and facilitators of identification and treatment of PMH difficulties, the role of VCS organisation in the perinatal pathway, and challenges due to the COVID-19 pandemic. Informants were also asked to suggest recommendations for reducing inequalities in PMH services.

4. Findings

4.1 How we generated the findings

Data from the HCP survey were analysed and presented using basic descriptive statistics. Qualitative data arising from the HCP survey and interviews with women and KIs were analysed as follows. Informed by our own previous research and wider literature, we firstly analysed data with a focus on: the level of the 'system' (i.e. individual, family, practitioner, service (including service managers and commissioners), government and society) and the point in the PMH pathway (i.e. disclosure/identification, referral, access/uptake) in which a barrier/facilitator was observed. We then applied a sociotechnical framework which offers a way to understand these barriers/facilitators (see Figure 2, and Appendix 4). The sociotechnical framework enables us to take a systems approach, taking account of the complexity of the interactions and bi/multi-directional relationships between 1) processes, 2) people (including practitioners and women), 3) technology; all situated in

4) the wider system. In applying this framework, we are able to enhance our understanding of how and why inequalities arise and what might be done to alleviate those inequalities. This can be done by identifying possible solutions (areas for action) and how these may help to overcome barriers, with consideration of particular groups/inequalities, together with identifying where these actions need to occur. These solutions are the focus of Report 5. The research presented in Report 4 primarily informed us about people, processes and the system (Report 2: mostly system; whereas Report 3 generated learning predominantly about technology, followed by processes; Report 1 offers learning across all aspects).
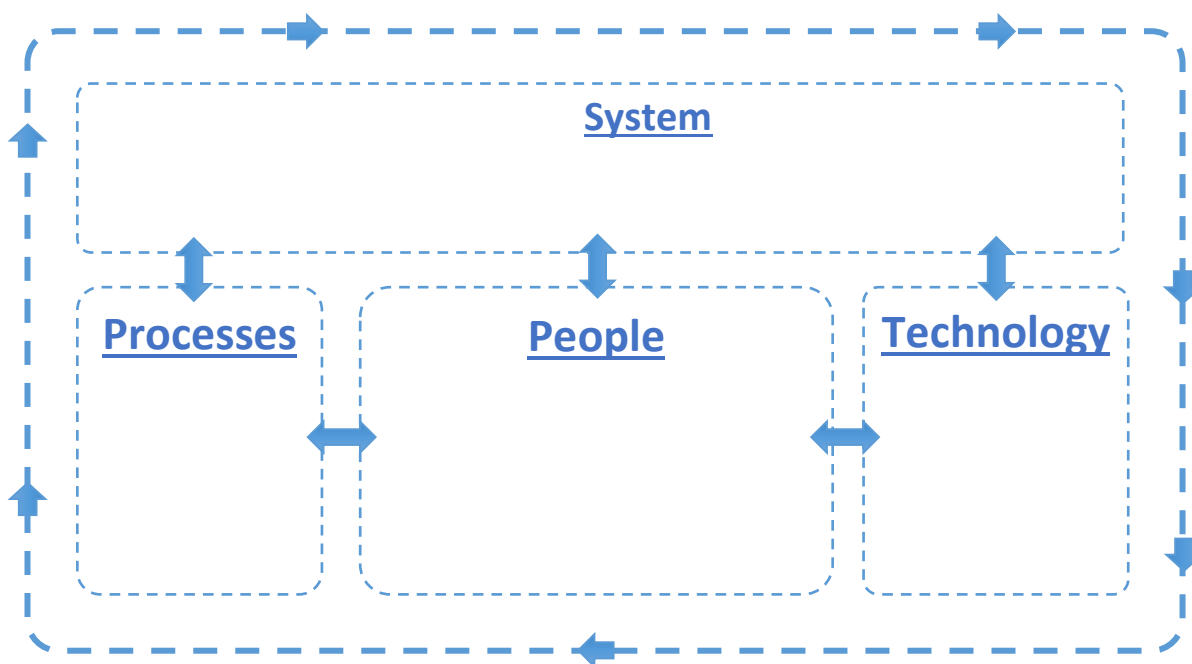

Figure 2. The sociotechnical framework as applied to this project

In interpreting data from interviews with women, we needed to be careful about what could be inferred, e.g. we could not infer why a HCP did not refer a woman (e.g. it may be seen to be appropriate professional judgement, that a person would not meet the threshold for a service). We also needed to be cautious with quotations where women were hypothesising about barriers that may be faced by other women, not their own direct experience or concerns. Quotations that were ambiguous in these ways were therefore not included in the analysis. We recognise too that the study is limited by recall bias: it is evident that some women struggled to recall details accurately (perhaps due to length of time or due to their health/symptoms at the time) and some women themselves expressed this challenge with recall.

4.2 Quantitative findings – Who experiences inequality?

The inequality section of the HCP survey had 83 respondents. These comprised 53 HCPs working in universal services and 30 HCPs working in specialist services. 84% of the HCPs reported they have observed PMH inequalities among at least one of the pre-specified groups (respondents were able to select multiple options). However, 13 HCPs (5 in universal services and 8 in specialist services) reported that they have not observed any inequalities among the pre-specified groups.

Figure 3 shows that all groups which were pre-specified in the survey were identified as those experiencing inequalities in the PMH pathway.
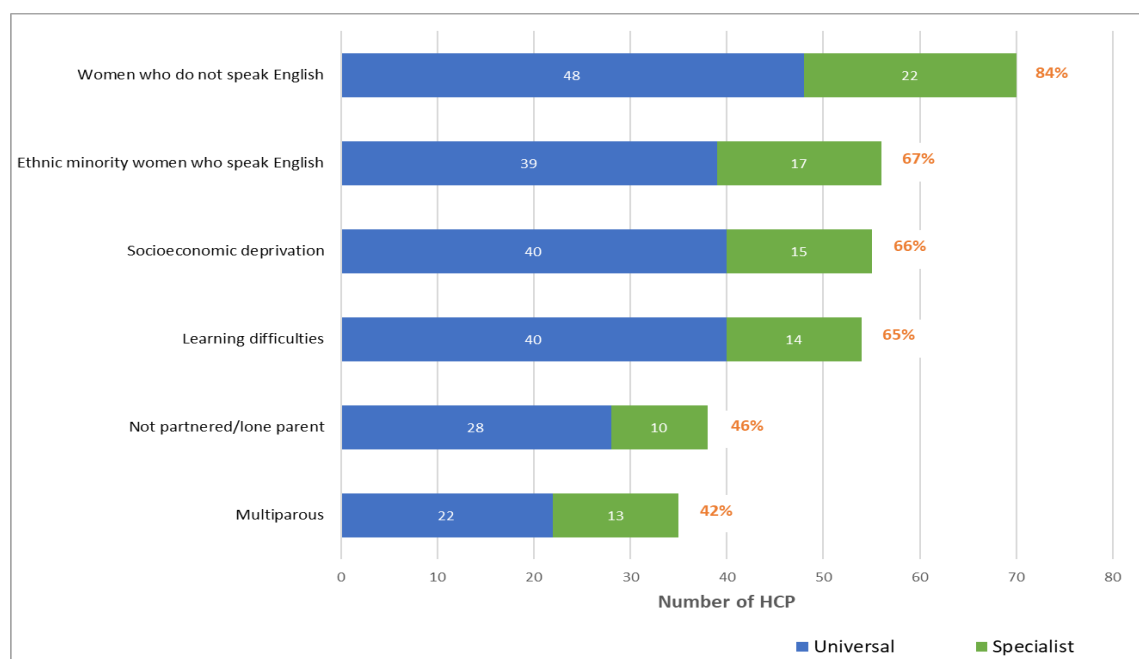

Figure 3. Groups identified by universal and specialist HCPs as experiencing inequalities in PMH care (total n = 83)

Respondents from both universal and specialist services indicated they felt that women who do not speak English were most likely to experience inequalities in the PMH pathway (indicated by 84% of all respondents), this group was followed by ethnic minority women who speak English (67%), those experiencing socioeconomic deprivation (66%) and individuals with learning difficulties (65%). Significant concerns were also noted for multiparous women and lone women. The universal HCP survey also identified low literacy as a pre-specified group[4], with 34 Universal HCP reporting that they have observed inequality for the low literacy group. Respondents were asked whether they had observed inequalities in specific points in the PMH pathway. HCPs working in universal services were

---

[4] Due to an error, the 'low literacy' group was missed from the specialist HCP survey, therefore quantifiable data for this group is only available from universal HCPs.

asked about disclosure, identification and referral and specialists were asked about referral, access and take-up.
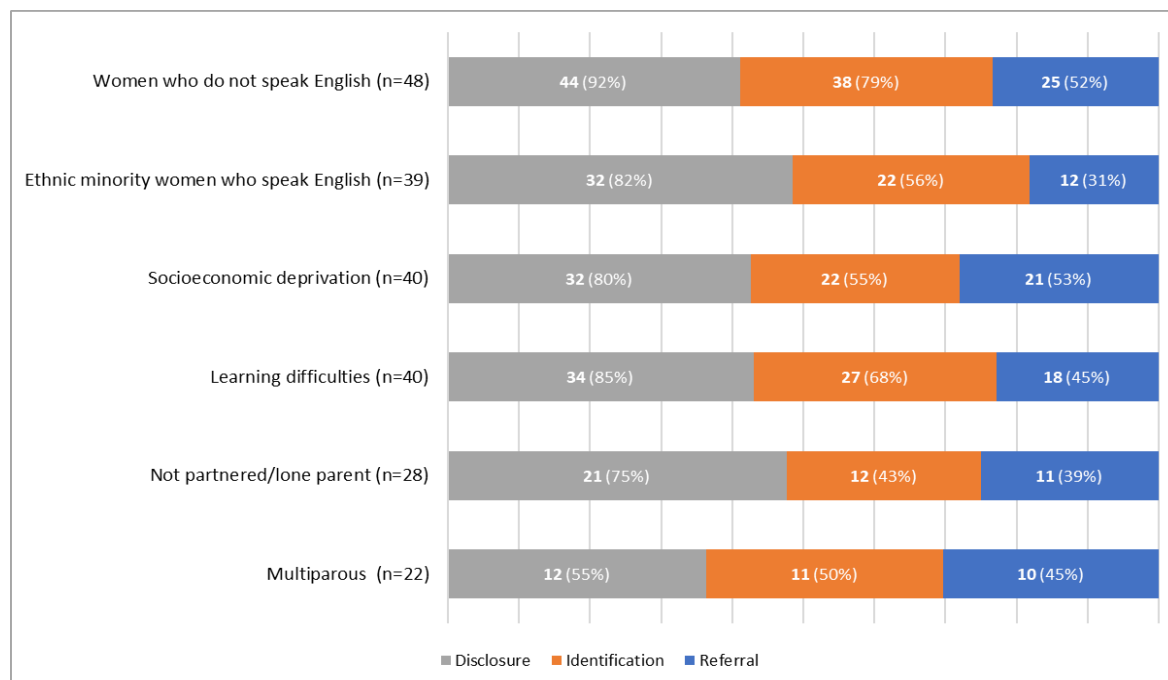

Figure 4. Groups identified as experiencing inequalities in the PMH pathway, identified by universal HCPs (n=53)

Figure 4 shows that universal HCPs most frequently identified inequalities in disclosure for all groups, followed by identification and referral. For example, women who do not speak English were most likely to experience inequality because of disclosure (92%), however these women would also be disadvantaged from being identified (79%) and subsequently referred (52%) for their mental health problems. Similar patterns were also observed for the low literacy group (disclosure: 79%; identification, 62%; referral, 50%).

Figure 5 shows that specialist HCPs most frequently identified inequalities in take-up (in other words engagement in treatment), except for the learning difficulties group. Significant concerns were also indicated for all groups being able to access treatment/services. For example, for women who do not speak English, of the specialist HCPs, 73% reported that these women are likely to be disadvantaged when being referred, 68% indicated these women are likely to experience inequality in access and 86% indicated inequality in women taking-up the treatment. It is also interesting to note contrasting perspectives between universal and specialist practitioners in relation to inequalities experienced at the referral stage experienced by women from low socioeconomic (SES) backgrounds, women who are not partnered and multiparous women.
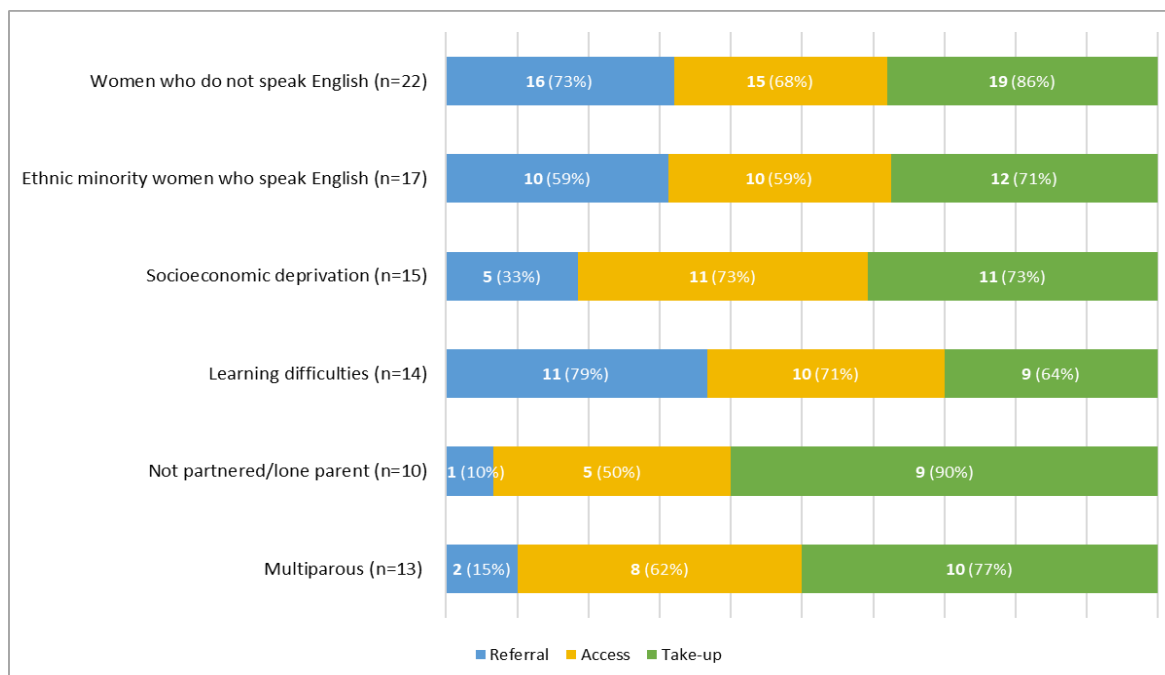
Figure 5. Groups identified by specialist HCP (n=30) as experiencing inequalities in the PMH pathway

In addition to pre-specified groups, HCPs were also given the opportunity to identify up to three other groups who may experience inequalities in PMH. Table 4 summarises other groups which were identified by 28 HCPs. The most common groups identified by HCPs were lesbian, gay, bisexual, or transgender (LGBTQ+) and young people/ teenagers. Concerns were also raised for women who experience abuse, have past trauma/ mental ill health or are substance users.

Table 4. Summary of other groups identified by HCPs (n=28)

Other groups identified	Number/ % of HCP responses	
LGBTQ+	7	25%
Young people/ teenagers	6	21%
Complex needs/ multiple/past traumas/ mental ill health/ (e.g. childhood adversity, domestic abuse, sexual abuse)	6	21%
Refugees, asylum seekers, immigrants	2	7%
Travelling community	2	7%
Social care involvement	1	4%
Women with children removed	1	4%
Substance misusers/ addiction	3	11%
Distanced from specialist services	2	7%
Deaf community	2	7%
High SES/ privileged women	2	7%
Women in custody	2	7%
Autistic women	1	4%
Homeless	1	4%
Roma community	1	4%
Surrogate	1	4%

4.3 Qualitative findings barriers and facilitators

4.3.1 Processes

Using the sociotechnical framework leads to us framing various aspects that are sometimes located at the level of the women, as more accurately locating a barrier/facilitator at the level of process. Two key aspects concerned the **use of interpreters** and the **modality of visit/contact**, both of which have the potential to deepen inequalities.

Appropriate language provision was understood by professionals and KIs as key and that, despite there being funding available in the NHS for interpreters, provision was inconsistent[5].

> *"One thing which I think they could do is always use interpreters, and that is missing so often. Either from GP appointments, you know, midwifery appointments, maybe even in counselling, I don't know, but you know, if they're offering perinatal mental health [support], are they offering interpreters for women who need it? Because everyone has a right to be understood, and there is funding for interpreters in the NHS, but frequently they're not used."* [VCS KI interview 4, language/interpreters]

> *"Deaf people often find it difficult to access services in general. Interpreters can be difficult to access and telephone support is more difficult to arrange. Deaf people's level or written English is often poor as it is not their first language and has different grammar from British Sign Language."* [HCP survey 93, universal services, Mental Health Nurse, language/interpreter for deaf community]

Some indicated that where language barriers impacted on communication, the need for continuity could be even greater.

> *"Language barriers create difficulties when try to communicate the FNP [Family Nurse Partnership] programme and support understanding of the client. During a contact with a Hungarian client recently I was tasked with trying to recruit this client through use of a phone interpreting service which was very difficult and may have been the reason why the client declined. The client reported she had enough support from her family and therefore declined the FNP programme. It is more difficult to establish relationships with clients through an interpreter but it can be achieved if they see you regularly enough as I achieved this in another area where I worked as a Health Visitor."* [HCP survey 78, specialist in universal service, Other Nurse, language/interpreters/ modality of contact]

There were concerns too about information not being communicated effectively, even where interpreters were available, because of interpreters not having specific knowledge or understanding relating to PMH support.

> *[Survey question asked: example of good practice for women who do not speak English] "Having a staff member who speaks fluently in that language as using translator is very varied depending on their knowledge of perinatal mental health."* [HCP survey 36, specialist service, job role: other, language/ interpreter with PMH knowledge]

---

[5] The quotes (italic font) are presented to illustrate themes, they are presented alongside some identifying features such as the type of informant: women, key informant (KI) from VCS or HCP from universal or specialist services. For HCP their job role is also indicated. *Asterisks indicate barriers/facilitators explicitly impacted by covid-19.

> *"Interpreter services having a good understanding of what we offer to pass this onto GPs. Having GPs who speak different languages and having a better understanding of what IAPT therapy involves." [HCP survey 34, universal service, Wellbeing Practitioner/Counsellor, language/interpreter's knowledge of IAPT]*

Modality of visit/contact was emphasised particularly where there are language barriers, and it is acknowledged that this has become a more immediate consideration of the COVID-19 pandemic. While the importance of in-person contact was voiced - both for conversations including mental wellbeing and as part of socialising for women and babies - it was recognised that remote provision could potentially help to overcome some practical barriers with access, concerning process; for example, the **geographical location** when accessed in-person (e.g. being in a different city), **access to transport** and **access to childcare**:

> *"The financial barriers are quite real because when you're not allowed to work and you've got a specific amount of money that is just for your food and clothing because being, when you're an asylum seeker you just get £5 a day per person and that is for your food, that is for all your toiletries including everything and they just forget about your travel and if I had to go over to [name of organisation] or for the mental health face-to-face appointment I had to buy bus tickets or if I was getting late, maybe I had to get to the taxi and it wasn't just possible and yeah, that was a barrier as well." [Women interview 11, access to transport]*

> *"They [PMH service] didn't have any childcare and I couldn't, I wasn't feeling safe leaving my baby with my husband because he gets anxious with his crying, so then we have to leave that and then I discuss with health visitor that this is okay and she said there's not much we can do about it but I can speak to your GP to increase your medications." [Women interview 11, access to childcare]*

> *"So I was offered counselling, well face-to-face it would have been in Leeds, which wouldn't have been, you know, something that I could access easily with like five children and plus I was bedded in for quite a long time because of the amount of blood loss, I was like severely anaemic, so anything would have been done over the phone but because I had never had a loss and I didn't know even how to talk about loss and to talk about grief, you know, I'd never been through it so I found doing it over the phone really out of my comfort zone, so I couldn't take their counselling forward so the only thing I was left to do was to self-refer to MyWellbeing College and that was the only kind of support that I could kind of access." [Women interview 16, modality of contact/ remote provision]*

> *"The limited number of contacts that mums and dads have with professionals is limited and some contact are telephone only. these are missed opportunities to pick up on women mood as it is unlikely that they will state how they are feeling over a phone." [HCP survey 53, universal service, Other Nurse, modality of contact/remote provision]*

It was evident from comments across all participant groups that the potential benefits of remote provision needed to be balanced with recognition that remote services may present **digital exclusion**, both concerning knowledge or confidence with using online/electronic communication and also, for example, the need for an appropriate device with adequate data or requiring appropriate funds.

> *"So many of the, well I'd say all of the groups identified, particularly refugees and asylum seekers where there's no devices to access it. So we were delivering all of our service for a while virtually, we've moved back to face-to-face now, but when we were often we would just find that we'd be working with families, refugees and asylum seekers and they wouldn't have any devices, so there was*

just, there was no way for them to engage with our service, or when I was referring families to other services, so for, for example, like perinatal mental health service, again they were dependent on families having electronic devices so that they could access that and they, they couldn't, so it was just like, just felt, you know, so difficult for them. It also I, you know, in terms of, often we refer to English as a Second Language course, again that was all virtual, so it did feel very, very much like big sort of groups of the community were being excluded from, from that." [VCS KI interview 11, digital exclusion]

"The increased use of video appointments affects the poor the most. They do not have access to enough data for video calls / are on PAYG phone contracts. Intervention should be focussed on identifying community hubs where people could go in order to use "remote consultation booths" with free data allowance." [HCP survey 19, specialist service, Psychiatrist/Psychologist, digital exclusion]

4.3.1 People: women, practitioners, influence of others (significant others including partners and other family members, interpreters, peers)

Turning to the level 'people' offered a way to understand the barriers/facilitators that operated in different groups, including **women**, **practitioners**, and the wider **influence of others**.

4.3.1.1 Women

Here, barriers resonated with the wider literature concerning access to PMH care but seemed likely to be compounded in women from ethnic minority communities, and marginalised communities more widely. Concerns relating to **stigma** were highlighted both with women and with KI interviews. These related to discussion of PMH being seen as 'taboo' and women experiencing challenging emotions, including shame.

> *"Language barriers pose a real obstacle in women feeling confident with engaging with any service, particularly mental health. Furthermore, in some cultures, mental health is simply not spoken about - which proves difficult for some women to disclose their mental health difficulties and the appropriate referrals being made." [HCP Survey 41, specialist in universal service, Early Intervention Midwife, stigma in ethnic minority communities]*

HCPs suggested that the pandemic may be having a positive impact on public awareness of mental health and that this might support the normalising of help-seeking around PMH for both women and partners and contribute towards reducing stigma.

> *[Survey question: Have any of these barriers been compounded or alleviated by the covid-19 pandemic and why?] "I think women and partners are more able to talk about MH. Everyone recognises it has been a tough time [in the pandemic]." [HCP survey 44, universal service, Midwife, stigma]**

The **fear of consequences** of disclosing PMH needs was repeatedly identified as a barrier, resonating with existing evidence. These fears were linked to stigma and included aspects such as judgement/abandonment in communities, fear of being judged by practitioners, fear of unwanted involvement with services (including social care) and for those who were forced migrants with unsettled status, fears of dispersal.

> *"I was feeling a bit anxious as well because I don't open up to many people so I was like oh I have to tell, so I wasn't quite comfortable… you know, if I tell them my fears then I was thinking oh if I tell them that I'm suffering mental health and dad is too there could be Social Services involved… and you*

just think oh, they're going to take my children away, so there was so many fears before accessing these services and I was thinking like oh, if they think we're not good enough for parenting like my husband has got you know, the anger problems and temper then he's suffering from depression and I was going through a difficult time so I was just, I just needed reassurance from the health visitor that nothing is going to be, she said everything was going to be in a positive way and it's just to help you, we're not going to take your children away from you, it's just to help you with you know, managing them better, so yeah, there was lots of fears before accessing the services." [Women interview 11, fear of consequences - social service]

"I think many of the women that I work… if they'd got perinatal mental health could drop out, yes, because again fear to trust, fear they're not being understood, I think it's problems they may be sent to a detention centre and so then the support would stop, or they've been dispersed, this is all, the impact of the, the seeking asylum that has on it, and they want the help but they don't know, they're fearful to trust, it's huge." [VCS KI interview 4, fear of consequences]

"Feeling inadequate as a mother and failing to fulfil role. Fear of speaking out and concerns of questioning of capabilities and baby safety and wellbeing." [HCP survey 48, specialist service, Community Psychiatric Nurse, fear of consequences]

For some, these fears were compounded by **distrust of practitioners and services**. Here, it was evident that women in marginalised communities were particularly alert to previous negative interactions, experienced either directly or within their communities, i.e. they were both experienced and anticipated negative interactions (including with health services more broadly and not necessarily specific to mental health) which could deter people from confiding in practitioners or using services. Here, VCS voiced this distrust and the work done by their organisations in building safety.

"I was taking on the anger and emotions of like the busy staff. I get that they're swamped in the NHS, I understand that, but so having pregnant women come through your doors with so many different needs, we do not need to react that way to someone who has just fainted in a shop. I mean, it's not something I was choosing to do. So I had that, which made me very, very reluctant to want to use the NHS services, to the point where I was going to switch from BRI to Airedale." [Women interview 13, negative interaction]

"Disclosure - people are afraid that they will be seen as a "bad mother". "Worse in deprived areas, worse for people with learning difficulties or low literacy, as they often don't trust services due to bad previous experiences and fear children will be removed (often from past experience)" [HCP Survey 9, universal service, GP, distrust of services/previous negative interactions]

"We try and address the kind of barriers as much as possible but I think in terms of NHS services it's almost, it's difficult because it seems really formal and there's nothing you can do about that. There's nothing the NHS can do about that because it has to be a formal situation that can sometimes scare people off, but I think the more the NHS or, you know, [specialist PMH service] or whichever department, perinatal mental health or wherever, the more they work with community organisations like us who build up that trust and they see that yeah, we're working with the NHS on this particular research project because we do lots of maternity research involvement too or on this particular, I don't know, initiative or whatever, we're working with Locala on a Starting Well initiative at the moment, the more they see that the more that will build up confidence [in NHS services], and quite a lot of these things stem from a lack of confidence." [VCS KI interview 9, building trust/emotional safety]

"All of these particular issues are things that can stop women from feeling safe or confident enough to try and access services. For example, you know, so much stuff is done online and on telephone and it's, you know, I do a session in quite a few of my groups on accessing support and why asking for help and asking for support is really important and we look at all of the barriers that stop people from, stop women from accessing those supports and what we can do to kind of overcome those barriers. Yeah,

yeah, undoubtedly, undoubtedly, picking up the telephone, … Going onto websites and finding information in community languages, having credit on your phone to be able to pick up the telephone and, you know, make an appointment, you know, if they've had negative experiences of using services in the past, you know, and they haven't got anybody around them to support them to overcome those opinions based on those previous bad experiences, yeah, they're all barriers to women accessing services." [VCS KI interview 7, building trust/emotional safety]

"But the barriers that the people I work with face are many, I would divide it into three different groups, one because of their previous experience, secondly because of the seeking asylum and third because of the NHS. And considering the personal experiences it… one of the biggest barriers that the people we work with face is fear to trust and they've been let down in their own countries, they don't know if they're going to be allowed to stay here and they're fearful to trust people. So they, you know, they may not be open or they may not seek care, and secondly their personal experience… everywhere, everyone who groups in a country thinks that's normal what happens, and yet it can be very different in other countries than in the UK. For example, in many countries people come from they don't have GPs. Everyone tells them to register with a GP and they haven't got a clue what they're talking about, because they don't have GPs. If they're ill they go to hospital and then they pay for their care, so they don't access care unless they need to." [VCS KI interview 4, fear of negative consequences/distrust of services]

The Covid-19 pandemic added new dimensions to both fear of consequences and distrust of practitioners and services. HCPs and VCS KIs reported anxiety amongst women about contact with health practitioners and services due to risk of transmission of the virus. The VCS in particular highlighted beliefs in some communities that the virus and/or vaccine was designed to 'kill them off' and there was a perceived reduction in help-seeking behaviours and contacts as a result.

[Survey question: Have any of these barriers been compounded or alleviated by the covid-19 pandemic and why?] "My experience is that during the pandemic people were less likely to contact services as there was anxiety about meeting professionals/attending services" [HCP survey 17, universal service, Psychiatrists/Psychologist, fear of consequences]*

"Women out there, especially in the south Asian or Black communities have been avoiding going into hospital, getting any support from a perinatal perspective because they're scare that it's going to be used, that this pandemic is an opportunity to be used to kill us off. This is the feeling that we've been hearing" [VCS KI interview 3, fear of consequences/distrust of services]*

Some women felt they had limited influence on their own care or the decision made about them; expressed here in relation to care more widely.

"Look at the end of the day, I'm the patient, this is my decision. Whether or not you agree, I still have to consent. And you're not supposed to be coerced, that's another important thing in medicine, you're not supposed to be coerced into decisions, and I feel a lot the times I was actually coerced. I was made to feel like if I don't do this, then this will happen. Something negative will happen" [Women interview 1, lack of empowerment]

"I would say the younger end get a really rough deal. The younger end do get a really rough deal and there's still an element of well what do you know, the first time mums can be kind of shrugged off when they do voice concerns so I add a young first time mum into the mix and they're trying to tell a health visitor or another medical professional that they think that there's something wrong, it does seem to take an awful lot longer for them to be heard and for any form of treatment to start, whether it's their own or for their child, than somebody I don't know, that's maybe in their 30s, maybe a little bit more articulate with what they're saying, so yeah, I'd say they could be shrugged off quite a lot." [VCS KI interview 12, younger mothers' lack of empowerment]

This **lack of empowerment** was something that VCS spoke of actively trying to tackle.

> "Creating spaces where people can have their voices heard, where they can say what they need and what they want and not necessarily what professionals think are best for them, but what are the best interventions for those women, and it maybe that women in certain communities that therapy isn't the right intervention for them, isn't what would be most effective, it may be that they need more community groups or they need more peer support, or they need more crisis lines, or they need more, you know they need more help connecting with other women that are experiencing similar things you know, I don't know, I don't know, it's like there are two, there seems to be you know, two different sort of mental health services available which is IAPT or services like us that offer therapies around mental health, and then there's support work, crisis lines, but that is a very specific way of working with mental health and it may be that those people need something different or they want something different. Or they might want shorter waiting lists, or they might want more clarity around knowing what's going to happen next, or they might want more, to feel more empowered in their care and their treatment, yes I think that would be really important." [VCS interview 10, empowering women and able to influence their care decisions]

Together, all of the above can be understood as the need for **emotional safety**, as summed up by this KI:

> "All of these particular issues are things that can stop women from feeling safe or confident enough to try and access services." [VCS KI interview 7, emotional safety]

Information, education and knowledge were raised in relation to **current symptoms** (including the extent to which these were interpreted by women as related to PMH), **knowledge both of PMH and support, awareness of symptoms,** and having **the words to express symptoms**. Such barriers could impact most early in the pathway, concerning disclosure and identification, but also be felt further along in relation, for example, to what may be considered appropriate and accessible support. Some participants highlighted the negative impact of the pandemic on awareness of and experience of symptoms.

> "Cultural differences in views and beliefs about health and mental health. Stigma surrounding struggles with mental health. Being able to attend confidential appointments on their own through lack of childcare. Not having the words to describe how they are feeling in a way which our culture or someone who does not struggle with a learning disability, is able to express. For example, they may focus more on the physical aspect of a problem rather than how they are feeling and therefore a mental health difficulty is missed it is harder work for people who do not speak English, are deaf, do not have childcare to attend appointments and communicate their needs in a way that someone from white background with support can." [HCP survey 74, specialist service, Cognitive Behavioural Therapist, stigma/current symptoms/words to express symptoms]

> "I think [women from South Asian backgrounds] do suffer from it, but they don't know what it is either. So then, like, obviously when I went to the GP and because you know when you're speaking you think about 'you're tired' more than yourself. That's why I went to the GP… and then when they were like saying anxiety and stuff and like I've never heard about the word in my life. And then they were like oh this and they're having to explain it. I'm like 'oh my God! Like I've been going through this all my life then.' It's not just now. It just got worse now because I have to stay home." [Women interview 5, knowledge of PMH/words to express symptoms]

> "When I was pregnant with my first child I was struggling when I was having the suicidal thoughts, but at that time I put it down to the breakdown of my marriage, my marriage broke down whilst I was heavily pregnant, and then having the baby I just thought with the whole breakdown of the relationship that I'm just more stressed than normal, but it wasn't until my son, he was around three months old I had a few episodes of psychosis, at the time I didn't believe it was psychosis, I believed it

was actually happening, it wasn't until much later on I looked back and realised that it wasn't what I'd thought it was at the time, it was just an episode, a few episodes of psychosis. I did contact the doctor when my son was around one years old, about the psychosis, because of… although it wasn't as prominent as when my son was first born it did linger a little bit." [Women interview 4, awareness of symptoms]

"I felt as though it was just, because it was the first time after all this stuff had happened, my miscarriage happened just a month after my mum had passed away so I had all that emotion and nerves and everything else, the first six weeks I was really dreading to go to the scan and stuff, and the 15 week scan where you find out you're pregnant and stuff, because that all made me quite nervous and anxious and I didn't want to go back to that scan where somebody said there's not a heartbeat and stuff, and that feeling of your heart sinking and then yeah they were there to say okay we've got support and stuff available, but at the time you just want to kind of plod on and get on with stuff and you want to go for your transvaginal scan and then you want to make sure that there's no heartbeat and stuff. So I didn't want to, I felt really like, I felt as though like I could have had a bit more support at that point" [Women interview 19, current symptoms]

[Survey question: Have any of these barriers been compounded or alleviated by the covid-19 pandemic and why?] "Isolation and lack of socialising has meant that women are more isolated so unable to judge their mental health objectively" [HCP survey 47, universal service, Midwife, knowledge of PMH/*awareness of symptoms]**

4.3.1.2 Practitioners

Turning to practitioners, concerns were identified regarding their knowledge and confidence. These are repeatedly identified as barriers in the wider literature but through focusing here on marginalised groups, it appeared that these aspects may be heightened here and contribute to inequalities.

Aspects included lacking knowledge and confidence in relation to **discussing PMH** in general and **asking about PMH** (using assessment tools). Moreover, participants indicated that these were compounded by practitioners lacking **cultural competency**, including specifically in relation to PMH and varied experiences and manifestations/presentations.

"Perinatal mental health and mental health in many communities is a taboo subject, even in the 21st century, and is hidden away and not encouraged to be spoken about. the word depression is not used in many different languages, and it may present itself with somatisation which many professionals are not aware of and go down the route of investigating the physical symptoms rather than being aware that the underlying problem is mental health." [HCP survey 53, universal service, Other Nurse, cultural competency/discussing PMH]

Practitioners sometimes lacked **knowledge of pathways and available services**, both generally and including those that may be most appropriate for people from diverse ethnic, faith and cultural backgrounds. In some cases, this was exacerbated by the pandemic, with HCPs and VCS both reporting a lack of information about whether and how services could be accessed remotely or if they were still running at all.

"I personally don't feel like I needed to be on the sedatives, I feel like I needed an alternative therapy, especially with the support of having two young children and especially with the psychosis, and I just think an SSRI getting me to, you know, try and sleep and things like that, it was, it didn't help, I needed a little bit more support. And then things that had led up to me feeling that way, I talked about

childhood trauma [to the intensive support team], about sexual abuse, I was never referred to any service specialising in childhood trauma, or any type of sexual abuse helplines or services that might specialise in that sort of thing." [Women interview 4, knowledge of pathways and available services]

"Still seems to be issues with midwifes and health visitors not always signposting/referring in and watch and wait is adopted." [HCP survey 16, universal service, Cognitive Behavioural Therapist, practitioners: knowledge of pathways and available services]

Women identified contrasting perspectives on whether having a shared **ethnic/cultural background with a practitioner** could enable/deter disclosure:

"It's a bit weird because I feel as though an Asian person should be able to relate more to an Asian person but I feel as though an Asian person will be like "oh that's normal in Asian households" or "yeah, this is how it is in every household" and I feel as though like with the Asians it's like what if there's this relationship that all of a sudden I find out she's related to so-and-so? And I'm a bit reluctant in that sense that what if she's my sister's friend or she's my sister-in-law's cousin and then she knows my business and it's going to be spreading everywhere, even though there's that confidentiality aspect, I don't know, I'm not able to open up to an Asian because of these barriers that I have within myself thinking that I might end up finding out she's a relative or she'll be just like - oh it's absolutely normal what you're going through, it's normal in every Asian household." [Women interview 14, ethnic/cultural background of practitioner]

"I've a little problem with this, because the psychiatrist I spoke to was same ethnic background as me, and the same religious background as me, and he came out to the home and he said to me that, he said, "I had full intentions of coming out to the home today and starting you on some antipsychotics, just to see how you would get on with the episodes of psychosis, but I see how young you are, and I see, you know, where you're living and everything and I just feel like we should probably try to keep you away from the medication if you can, you know, get yourself together that would be a better idea." And he then said to me that, you know, "You're a Muslim at the end of the day and any thoughts of suicide or self-harm, you know, it's not permissible in our religion, in Islam," and I felt a little torn, and a little bit on the fence, because I completely agreed with what he was saying, that if I did commit suicide it's completely against our religion, and my beliefs. But I was also trying to explain to him that I'm a practising Muslim, and I'm very in touch with my faith, and my background, but these feelings I just could not help them, that they weren't voluntary, yeah, that it was just so deep rooted and I just could not help feeling the way I was feeling. And then he advised me to you know, read Quran and to pray more, and although I appreciated from a religious perspective his advice, just from a medical point of view I was a bit disappointed in that as well, because I almost felt guilty asking for the help, or wanting the help, or even feeling suicidal. So sort of like that was because... he was lovely, and he was you know, had my best interests at heart, but I just feel like possibly he shouldn't have maybe like mixed the two, you know, at that time I was really vulnerable and I just needed some intervention…." [Women interview 4, ethnic/cultural background of practitioners].

"If there was a Pakistani and Asian, it would have made me a lot more better and satisfied during those times, even more moral support."[6] [Women interview 11, ethnic/cultural background of practitioners]

"I definitely think it would make a difference because we called for the chaplaincy knowing that it would be a Muslim chaplain, which would make a difference because they automatically understand your family dynamics, your priorities, your background but unfortunately she just didn't help. But yeah, you want that kind of familiarity, especially in a... We were in like a situation of crisis and you wanted some kind of familiarity rather than people that are not your own culture or your own religion dealing with you." [Women interview 16, ethnic/cultural background of practitioners]

---

[6] Although in the context of baby loss, this example has been included because the woman framed this as being about potential barriers and facilitators in a crisis situation.

There was also awareness amongst some professionals that there could be potential for contrasting perspectives here.

> *[Survey question: Example of good practice for ethnic minority women who speak English]*
> *"It is not as might be expected - I have had some BAME women decline contact with BAME staff- simply because they think that their confidence may be broken due to community links- however contact was made with white staff. Nevertheless, BAME staff have quickly made links where white staff failed previously" [HCP survey 19, specialist survey, Psychiatrists/ Psychologist, ethnic/cultural background of practitioners]*

All groups of participants named challenges concerning having the **time to cover all needs**. This was raised in relation to (perinatal) mental health in general but identified as particularly challenging where needs/circumstances were complex (e.g. housing) or an interpreter was needed.

> *"I have, another problem I have is I did think about calling the GP, but I feel once I, actually I can't go to sleep, I have thoughts running in my head, you call GP and you never can get an appointment and it's really, frustrating, yeah. If you call GP and they'll, call back tomorrow, call at eight o'clock and then you'll get an appointment, and this is only a telephone consultation, literally five minutes, and that's really frustrating, if someone's need help who's got mental health issues, it needs to be dealt with."* [Women interview 7, time to cover all needs]

> *"Only having 10-minute GP appointments is not enough time to discuss sensitive information about mental health. Someone might want to develop a trusting relationship with someone first, before divulging information about their mental health".* [HCP Survey 74, specialist service, Cognitive Behavioural Psychotherapist, time to cover all needs]

> *[Survey question: Example of good practice for women who do not speak English]*
> *"Allowing as much time as possible with an interpreter. Utilising family members of the patient who may speak better English to help with translation. Using images, or showing objects related to what the conversation is surrounding. Sometimes having a staff member who may speak the same language as patient is very useful. Taking things slowly, reading body language, try to reassure them through own relaxed body language."*[HCP survey 26, specialist survey, Mental Health Nurse, time to cover all needs for women who do not speak English]

> *"I think people who don't speak English do face barriers. I think because, you know, unfortunately even though we're in this day and age a lot of services they don't have language skills within the organisation and I think that's really important because even though services may actually use interpreters it's not quite the same because then you're speaking to two people essentially and the time that it takes for the interpreter to kind of, you know, well act as an interpreter in-between but also for the message to get across, it can be really difficult"* [VCS KI interview 1, time to cover all needs for women who do not speak English]

This was seen as a contributing element in the **struggle to build relationships/trust**, which was impacted by lack of time, lack of continuity and potentially the use (or absence) of an interpreter. There were however examples where people shared positive experiences about relationships with practitioners:

> *"She [midwife] knew what was happening, she knew what she was saying, she was really like empathetic to my needs. There was no rushing, she was really, really good. […] She would just like listen, she would understand, she knew the area, she knew like families and things and, you know, she kept everything confidential. But the fact that she just listened and she didn't judge, that was really, really helpful. And even my anxiety and things, she got it, she understood."* [Women interview 13, struggle to build relationship/trust]

25

KIs emphasised the importance of building such trusting relationships and several felt that the way that there services operated helped to enable them to work in ways that promoted these, which they contrasted with arrangements in the NHS. This was an example of how the system can influence another level; here, practitioners.

Of concern, there were also examples where **attitudes and at times discriminatory approaches** where shared. These linked to wider **distrust of practitioners and services** (named above) and had potential to present barriers to PMH access:

> *"You know, whenever you're an ethnic minority, a woman, and a Muslim, you've got three strikes against you. You know, you feel like you have to prove yourself so much more than other people. Like I, to be honest with you, just the figures and statistics show Black and Asian women are more likely to die in childbirth, they're more likely to have miscarriages. Why is that, you know, there has to be a reason for that? They are starting now to suggest that, you know, perhaps there are differences in care. Like perhaps it's the case that, you know, the White medical staff are making assumptions about these women and they're not really taking their concerns seriously, but maybe if she was a different colour of woman, you know, they would take it seriously. And maybe if she said, you know, if a Syrian refugee said oh, I'm having a really hard time with my 5 kids, you know, and they might judge her. But if it was a wealthy woman from Ilkley, they might not, a White woman, they might not think anything of it. They wouldn't judge, you know. She's a scrounger, they wouldn't say that. But unfortunately, there are those kind of […], even within the medical community they do have these ideas, some of the doctors and nurses. And so, I think until we can make it so that I don't know… I could never do that, you can never completely eliminate prejudice. But at the same time, there has to be something that can be done about you know, giving women a fair example, a fair opportunity to represent themselves and not to have staff thinking the worst of them and, you know, the fact that they would maybe treat other women a different way." [Women interview 1, attitudes and at times discriminatory approaches/ negative interaction]*

> *"I think the main aspect of it was my area that I live in, it's a deprived area as in the crime rates are a lot higher, unemployment rates are a lot higher than other areas, there's a lot more antisocial behaviour in this area, and with my background I just feel like the services I used and the care that I received it just wasn't up to scratch as much as I would have liked, and I feel personally that it was maybe down to my background, a little bit, some parts of it, not most. But yeah, it's there were a few instances where I don't know if I, they assumed I wasn't very good with my English, as long as I didn't say anything, some of the things that were said to me were quite questionable, but it's not until I started speaking and telling them that I also work for the NHS and maybe I had a bit about me that their tone would change, or their care would become a little better. So those were my personal experiences." [Women interview 4, attitudes and at times discriminatory approaches/ negative interaction]*

Lastly, a barrier/facilitator expressed in relation to practitioners concerned the extent to which **women were kept informed**; this including in relation to referrals being made and the outcomes of referrals.

> *"No, no, so once I was with the psychiatrist with the Intensive Support Service, once they deemed that I wasn't as suicidal and I wasn't a danger to myself they discharged me from the service to the crisis support team, and that's, it, like it was a service where I would call them if I needed support, or they would check in with me once a week and then once they felt I was okay to be discharged they just discharged me. I think I was only with them for a matter of maybe five to six weeks, and I got discharged a little early, and so thought I was doing okay. But after that there's been no follow-up from my GP, from my midwife, or any of the services, I haven't heard anything really. I got a letter in the post saying that I was under the care of some postnatal team, I have absolutely no idea who that team was, they never introduced themselves to me, I never got any contact or anything at all, so I*

don't even know what that letter was about, they said somebody would contact me shortly just to see how I've found the service, and I never got a call." [Women interview 4, not kept informed]

4.3.1.3 Influence of others (significant others, interpreters, peers)

The **presence of partners and other family members** in mental health assessment is debated, with potential to both facilitate and inhibit conversation. This is found both in existing evidence and in this study. Whilst flexibility with provision in relation to physical presence may help to address this, it is also necessary to be aware that **influence of others** can be felt without physical presence (i.e. anticipated reactions of others). For example, there can be concerns about bringing shame or other negative judgment to a family through sharing what may be considered 'private' or 'family' concerns. This may also extend to the influence of wider communities.

"If he can see if I am down I do go very quiet, and it's like when he's talking I'm in a world of my own. I won't respond to him, and then he'll know there's something wrong. He'll ask me, and then I will tell him this is bugging me and he'll just reassure me, like supporting me. And just, he knows that I can get worked-up quite a bit with the kids and all, because they can be hard work at times, and he will say to me "go for a drive, or if you want to go down to your mum's go. I'll keep an eye on the kids". So, he is quite supportive, and I know if I've got any issues I can speak to him and he will help me." [Women interview 9, influence of others: supportive family]

"Even when a woman has disclosed and the referral is made, due to often living in multi-generational households, it is not always easy for women to have private telephone conversations with mental health services. Because of this, referrals are often declined by women." [HCP survey, 41, specialist in universal service, Specialist Midwife, influence of others: multi-generational family]

"A lot of mental health difficulties are hidden in certain cultural groups because there's a sense of shame in the community that it's not talked about in particular communities. So I think for some people it's hard just acknowledging you've got a difficulty. Some of them, you know, I'm thinking about some of my clients who've talked about, you know, especially if she and her husband live with family, it's, what will other family members think." [VCS KI interview 5, influence of others: family influence]

Flexibility in relation to physical presence of partners and other family members was limited during the pandemic lockdowns. Some practitioners felt this meant they were able to have more open discussions about PMH, whereas others were concerned about partners feeling excluded (with increased risk of their own PMH difficulties not being spotted). Women reported that the absence of significant others in appointments during this time had a detrimental impact on women's mental health.

[Survey question: have any of these barriers been compounded or alleviated by the covid-19 pandemic and why?] "Due to partners/friends and family not being able to attend the wards during the pandemic I believe it has helped us be able to ask the eight questions when the environment feels safe and secure. Women do not feel pressured and are able to speak openly without others knowing" [HCP survey 103, universal service, Midwife, limited influence of others in pandemic]*

"Partners were not allowed into clinic appts, and so had less opportunity to discuss their mental health… they will have felt excluded" [HCP survey 56, universal service, Midwife, missed opportunity during pandemic]*

> *"I think, ever since covid has happened I think it's made people realise that having somebody with you as a family member, either be your husband or your sibling, or your mum, or anybody who you know, is so valuable to your mental health"* [Women interview 17, influence of others- supportive family]*

Interpreters are discussed in relation to **processes** but also apply to **people**, here linking with the extent to which interpreters and women may be known to each other within local communities. In this example, although not specific to interpreters, we see potential concerns about "community links":

> [Survey question: Example of good practice for ethnic minority women who speak English]
> *"It is not as might be expected – I have had some BAME women decline contact with BAME staff- simply because they think that their confidence may be broken due to community links- however contact was made with white staff. Nevertheless, BAME staff have quickly made links where white staff failed previously involvement of BAME staff writing for a community newsletter"* [HCP survey 19, specialist service, Psychiatrists/Psychologist, individual ethnicity/cultural background - community links]

Another influence that repeatedly featured, particularly in KI interviews, was the influence of peers from VCS organisations. This includes the potential for peers to positively enable conversations about PMH, including disclosure and onward help-seeking or taking up the offer of support.

> *"Yeah. So, obviously they referred me and then I got a phone call and then we would like be on, in groups with other mums. No, it was really good honestly. I kind of miss that now. I was basically with them for a year, like we'd just talk about everything and like you just know you're not alone anymore. Like you're not the only one that's going through it. It's really amazing. Like I couldn't have done it without them because I would just like tell them anything and everything. Even talk about, you know our culture, when it's to change because, like, you know, because in our culture everyone just sees it as, like, just brushed off, like no one talks about."* [Women interview 5, influence of others - peers]

> *"We're not embarrassed to have and we are moving in the right direction, you know, and one of the things they talk about in the group is, you know, how great it is, you know, when one person talks about their mental health issues, their mental health struggles, mental health problems, it gives somebody else permission to talk about theirs. So, you know, for the conversation to be really open and to be, you know, to be had and, you know, and for us to understand, you know, that mental health is like a changeable thing, isn't it, it's like, you know, somebody who's never had any mental health issues, you know, may experience issues at some point in their lives so, you know, talk to everybody. Talk to everybody about it. Not just people who you think are at risk"* [VCS KI interview 7, influence of others - peers]

> *"I created a support group co-produced with our service users from ethnic backgrounds to enable them to have a safe space to talk about the issues that matter to them in relation to their health and well-being. The mum's decided on calling the group "Diverse Mum's Group" as they felt this represented their authenticity. The group purposely created to help tackle health inequalities allows mums from different ethnic backgrounds have a voice, talk about mental health, cultural factors such as faith, religion, spirituality, break down barriers of stigma and shame, opportunities to connect with other women who look like them, talk like them and experience similar life challenges. We celebrate our differences, traditions and what makes us authentic in a group that our mum's refer to as a "lifeline" to them."* [HCP Survey 25, specialist in universal, job role: other, influence of others – peers]

4.3.2 System

In all the datasets used in this report the influence at the system-level concerning the **extent to which PMH is core business** was evident. This was identified as impacting directly on aspects at the

people: practitioner level; for example, some expressed that there is a focus on physical health that is connected with there not being adequate time to fully address mental health concerns.

> *"So, if they didn't rush it as much and I could actually, you know, talk to them and tell them how I felt and stuff, if they focused on the mental health as well aspect of that then that would be much better."* [Women interview 15, extent to which PMH core business]

> [Survey question: Example of good practice for multiparous] *"Always discussing mental health at every contact, even if there is no history of previous issues."* [HCP survey 31, universal service, Health Visitor, PMH core business]

> *"One of the issues I think sometimes when people come to us, is that sometimes I get the impression that the midwife or health visitor or doctor didn't pick up on… that they were having problems. So, and I know because I've talked to health visitors and midwives that often they have so much they have to cover in each appointment that it feels like 'ticking of the box' is actually more important than the mum and of course if you're just being asked all these questions, but there isn't the time and space to say "and how are you doing?" you know, "how are you coping with daily life?" you know, unless anybody is sort of being asking her, if that makes sense."* [VCS KI interview 5, PMH core business - tick box activity]

Similarly, PMH not being seen as core business was linked to aspects such as lacking adequate **knowledge and confidence *(people: practitioners)***. This appeared connected to (at times, limited) **partnership working between NHS services and VCS organisations**. For example, partnership working was identified as being a way to facilitate knowledge-sharing in relation to PMH, its assessment or pathways and available services *(people: practitioners)* and addressing **cultural competency *(people: practitioners)***, to in turn build **emotional safety *(people: women (parents)*** and address **distrust of practitioners and services *(people: women (parents))*.**

> *"Training for primary care staff from perinatal mental health team so we have a better understanding of who should be under their care and resources available e.g., is there a specific service for patients with learning difficulties who are pregnant / is there good access to interpreting services for midwives / is there good representation in the team of midwives from a diverse background to help understand individual needs."* [HCP survey 8, Universal service, GP, partnership working]

> *"Using link workers within community to build relationships with women alongside the community midwife and enable them to communicate their thoughts, concerns. This would enable the woman to also understand what services are available and what they can be offered."* [HCP survey 28, specialist in universal, Specialist Midwife, partnership working]

> *"Making links with the Refugee Council and hoping to raise the awareness of Perinatal Mental Health within these communities. Collaborative working with organisations including voluntary sector is key."* [HCP survey 25, specialist in universal, job role: other, partnership working]

> *"Better communication between midwifery services and primary care and vice versa - midwives used to work in the surgeries and we had excellent links but this has been eroded over the years by moving them out of primary care. This means we no longer know our midwife teams and vice versa. In the past we would have had a chat about patients and discussed best way forward and now sometimes feels like passed from pillar to post."* [HCP survey 8, Universal service, GP, partnership working]

> *"But I think generally, within Leeds because there are really amazing organisations like Hamara and Shantona who work within those communities I think that, for example, a midwife who was working with an Asian woman, for example, who was feeling lonely or isolated, I would imagine that a midwife would make a referral to Hamara or Shantona"* [VCS KI interview 7, partnership working with community]

> *"In terms of perinatal mental health specific services we don't provide counselling or anything like that but what we do is we signpost and work with other local organisations. So here in Kirklees it's with organisations like Auntie Pam's, we're a really active member of the local MVP, and obviously signposting to sort of other local counselling services too. So we work really well with SWYPFT….What we've done is we've built up relationships with midwifery and with SWYPFT and with Locala who are our health visiting provider here….if the NHS work with organisations like us they ensure that our staff are trained, they ensure there is some sort of funding in place for that and funding in place to keep organisations like us going then that kind of helps. So if there is that joined-up thinking right from the ground upwards then it means that like I say that kind of filtration system is there."* [VCS KI interview 9, partnership working with statutory services]

> *"Having a diversity inclusion worker. Speaking directly with service users of all backgrounds and asking for their help and feedback in order to develop services. Having training from other specialist services who work with minority groups"* [HCP survey 60, specialist service, Senior PMH Practitioners/ Other Senior Practitioners, partnership working]

Lack of clarity and consistency in referral pathways (e.g. different pathways, practices, tools, services on offer) was described as a barrier. One woman commented:

> *"I even went to A&E one night because I was just having such a manic episode, I felt like I was just at the brink of doing something really silly to hurt my partner, and I needed to just get somewhere, and when I went to A&E again it felt like they just weren't well equipped with the mental health side of things, I was taken into a room [and] the first thing that was said to me was Social Services and you know, instead of getting me the help that I needed right there and then. So I ended up walking out from A&E, I just told them that I'm just going to self-discharge and I'm going to go home, but what I found interesting was that they didn't contact the Crisis Support Team, they didn't contact the Intensive Support Team, nobody knew that I'd gone into A&E, but three weeks later I had a Social Worker call me, so they had enough time to fill out the Social Worker intervention form, but didn't have enough time to put their input in that this person might be a danger to themselves or their family and they should probably get some help. Which I've just, again I found absolutely ridiculous, like if you can sit at your computer and fill out a form because you're concerned about the children in the family, and you know, it takes two seconds to maybe make a phone call to the support service and let them know that I'm struggling, you know, everything, but it wasn't until the next day I had to tell my support worker myself that I'd been to A&E, he had no idea….. Yeah, so I felt like I was really let down with the service in that sense, but I don't know if it was because of Covid, they did say they had a lot more cases than normal, and they just didn't have the staff and the workforce to deal with it all."* [Women interview 4, lack of clarity and consistency in referral pathways]

Lack of clarity and consistency was identified by VCS KIs too. They noted that while they are well placed to build relationships and create safe environments that enable women to disclose their mental health difficulties, lack of clarity about referral pathways and available services acts as a block to those women accessing treatment or specialist support.

> *"We have regular conversations about this, it is so hard to access mental health services for women. It's hard and it's frustrating and it's dispiriting and we are doing it for a living, you know, just... For the women who are experiencing mental health issues, who are trying to get their head round what services are available and how they access them, I've got no idea because we feel like banging our head against a brick wall and we do it all the time and yet I still can't quite figure out where the referral for the Primary Care Mental Health Team comes from because sometimes when I say to a woman, speak to your doctor and your doctor will make the referral, a doctor will make a referral but then in another surgery when I say to a woman, it's fine, if you speak to your doctor your doctor can make a referral, the doctor will say, well if you go and have a look on the MindWell website you'll be able to find some services that help and there's no consistency and that makes it really hard to support women accessing mental health support."* [VCS KI interview 7, lack of clarity and consistency in referral pathways]

Issues of consistency were also noted by HCPs, in making comparisons across eligibility for specialists PMH services in different areas of West Yorkshire:

> *"Referral problems - actually in Bradford the bar is much higher to get into perinatal mental health services - we have had several women referred from secondary care services in other areas who have not been "bad enough" to get into Bradford services and have just been given My Wellbeing College self-referral information." [HCP survey 9, universal service, GP, lack of clarity and consistency in referral pathways]*

Comments about the potential for shared **ethnic/cultural background** of staff *(people: practitioners)* to be a barrier/facilitator were greatly varied but were one of the most frequently discussed aspects. This linked at the system-level to a lack of **representation in workforce** (e.g. bilingual staff, minority HCPs). This lack of diversity could be seen as contributing to aspects such as lacking **cultural competency** *(people: practitioners)* and **distrust of practitioners and services (people: women (parents))**.

> *"Having a diversity inclusion worker speaking directly with service users of all backgrounds and asking for their help and feedback in order to develop services" [HCP survey 60, specialist service, Senior PMH Practitioners/ Other Senior Practitioners, representation in workforce]*

> *"Services should reflect the populations that they serve. we need staff from the same cultural background as the people who need to access our service. too many white staff. it is more likely that the psychiatrist will be BAME than any other professional." [HCP survey 19, specialist service, Psychiatrists/Psychologist, representation in workforce]*

> *"I think as professionals, one I think the professionals providing the help need training on cultural awareness, training about what it's like maybe to be someone seeking asylum and refugees, so that they understand the barriers, and I think they need to go out of their way to form trusting relationships."[VCS KI interview 4, cultural competency]*

The **use of interpreters** was relevant at the *system* level as well in relation to *processes*. This included not only the impact for women but also the need for longer appointment times. In addition, there were concerns about the extent to which interpreters may need specialist knowledge and training to work effectively in PMH.

> *"Interpreting service - takes more time to use and therefore cuts down the time the professionals have to support clients within the session. Meanings may be lost and understanding is difficult to get across as it is unclear if the interpreter fully understands what the [support] is about. Uptake of interpreters means professionals always have a different one for any given session. It would be helpful to have specific interpreters allocated to specific services so that they gain an understanding of the work being carried out and therefore support client understanding better." [HCP survey 78, specialist in universal, Other Nurse, interpreters].*

> *"Yes I don't have huge amounts of experience using interpreters, I do have some and yes I think it's really valuable for women to be able to use a service and to be able to have their story heard, to be able to receive some connection and communication but I'd say therapy is more difficult in those circumstances and yes, it's a really different piece of work. I'm, like I say I don't have huge amounts of experience in it and I know that some therapists do and that there is lots of thoughtfulness and research into using interpreters in therapy, so there will be people who are very skilled at doing that. I wouldn't say I'm highly skilled at doing that, it doesn't form the majority of my work, but I think it does represent a barrier to women, and I think that will just be you know, in I suppose the different models of therapy and maybe some models of therapy might be more smooth with an interpreter, so if somebody's working with like a CBT model that might be more translatable through an interpreter,*

but when you're sort of working with trauma and you're trying to create a containing safe enough relationship that's quite relational it's more challenging to do that." [VCS KI interview 10, interpreters]

"So we have access to interpreters and we've got information that we can provide in different languages and visual aids. We've got doulas from, we try and recruit doulas from different backgrounds, like cultural and ethnicities, and where we can, as much… many different languages as we can, so that we can support a wide range of women." [VCS KI interview 11, language/interpreters]

Concerns about **time to cover all needs** *(people: practitioners)* were linked to wider challenges at the system level, concerning **high caseloads and fixed short appointment times**, and **wait times**.

"Limited Time during appointments or on the ward. Low staffing meaning only basic care can be provided." [HCP survey 46, universal, Midwife, limited appointment time].

"What we know is services like the Mental Health Wellbeing service, you know, it's great that we've got that but the wait is really-really long for women and, you know, what all know, don't we, is that when somebody gets to the point where either they or somebody has acknowledged their kind of mental health needs, what they don't need is somebody then saying, brilliant, we'll put a referral in, somebody will get in contact with you in 3 or 4 months' time." [VCS KI interview 7, wait times]

"The capacity of staff to be able to spend time discussing mood changes when there is so many other things to discuss antenatally." [HCP survey 53, universal, Other Nurse, time to cover all needs]

This was identified as having implications for aspects such as building **emotional safety** *(people: women (parents))*.

"I think for women who have experienced multiple traumas will find it difficult to engage with services because of, I think because of, and I don't just mean trauma you know in that sort of, an event of trauma but more ongoing traumas, traumas from childhood neglect or adverse childhood experiences, sexual trauma, sexual violence, domestic abuse, domestic violence, those experiences really shake people's trust in others, they deeply shake people's trust in others, and any professional if they're not able to be really relational and understand that those women might have a really hard time trusting them, and that extra work needs to go into providing relationships that help them feel trusting, then that will cause those women to disengage because they need to feel safe in a relationship with professionals. So for example if a professional doesn't have enough time for them, if they're really quick, if it's like a ten-minute GP appointment and you've got to go out, if they feel dismissed in any way or if they feel unheard, or like because they've not been taken seriously, like all those things will trigger off an even stronger response in those women that they can't share something or they can't trust in this person." [VCS KI interview 10, emotional safety]

"Having a five-minute appointment and being told you've got postnatal depression and being given some antidepressants and Turning Point's telephone number does not let the mum know that they're doing a good job." [VCS KI interview 12, time to cover all needs/emotional safety]

Women, VCS KIs and HCPs reported that the pandemic placed significant additional pressures on visit times and caseloads (linked to short staffing).

[Survey question: have any of these barriers been compounded or alleviated by the covid-19 pandemic and why?] "There has been a significant reduction in staffing levels, which has caused our service to cease all antenatal contact unless there are known safeguarding concerns. This therefore significantly increases the possibility of mental health issues not being identified, and women not feeling comfortable enough in the therapeutic relationship to do so." [HCP survey 31, universal service, health visitor, High caseloads and fixed short appointment times]*

"It was because of covid…at that time it was all, what's the word…we had to get in and out quickly…it was very quick and it wasn't something that you, you can't just talk about everything, you know, how I'm feeling in those ten minute sessions." [Women interview 15, time to cover all needs]*

Connected to barriers concerning high caseloads and waiting times was the system-level challenge

of **high turnover of staff**:

> *[Survey question: please specify your top 3 recommendations which would help to address inequalities in perinatal mental health identification and management?] "More midwives so workload isn't as high/rushed appointments." [HCP Survey 68, universal, Midwife, high caseloads and fixed short appointment times*]*

> *[Survey question: what difficulties do you see in implementing your suggestions to address inequalities in perinatal mental health identification and management?] "Cost. Availability of midwifery hours to use. Management not seeing it as a priority. Midwives already overworked and stretched to capacity." [HCP survey 57, universal, Midwife, high caseloads and fixed short appointment times*]*

The following comment indicated that this had worsened in the pandemic:

> *"The difficulty occurred because other services changed to telephone and virtual contacts and there have been staff shortages which has contributed to big waiting lists." [HCP survey 78, specialist in universal service, Other Nurse, high turnover of staff]*

> *"The pandemic has placed intense pressure on services. More people have struggled with their mental health and staff shortages have compounded access to support." [HCP survey 58, universal, Psychological Wellbeing Practitioner/Counsellor, high turnover of staff]*

It was noted that **staff capacity for training** is also relevant for addressing PMH. This concerns both

having the time to attend and the time to reflect on and action the learning, for this to be

meaningful and effective at creating change:

> *"I think professionals being given more time, more training, more reflectiveness, I think organisations really deeply looking into these issues rather than them being just tick box exercises you know, like, oh we do your equality and diversity training and then you've done it, and you're somehow able to provide something different, which I don't think we are. You know, for like, for, specifically around ethnicity or skin colour, like we've just got huge, huge things that we need to do you know, like every individual practitioner examining their privilege in the way they use power, and their assumptions and their biases like, it's like a massive piece of work for everybody to do and if institutions are going to say that they're going to do that work then they need to give those practitioners time, support, resources, and it's like real human difficult painful work and it's just, 'oh do a piece of training', and you've worked it out." [VCS KI interview 10, staff capacity for training]*

> *[Survey question: What difficulties do you see in implementing your recommendations to address inequalities in perinatal mental health identification and management?] "Training of staff - again time and resources are often the barriers here." [HCP survey 8, universal staff, GP, staff capacity for training]*

Particularly vocalised by KIs was the ways in which **narrow rules on access/engagement** within the

NHS could present barriers to accessing support, particularly for individuals from ethnic minority

groups and those living with trauma. In having these rules about access it was indicated that this

would also have implications for aspects such as building **emotional safety *(people: women**

(parents)).

> *"I think there has to be more flexibility about appointments, you know, there really is, you know, a 3 strikes and you're out type thing that I see so often in services, you know, that well I've booked you 3 appointments and you've not turned up now so I'm not going to, you know, if that person wants to access these services tell them they're going to have re-refer themselves. But actually, like the person*

who comes the first time is somebody who probably doesn't have as much need as somebody who's going to take 9 times coming to an appointment, you know, the very fact that somebody's not able to come to your appointment when you have said you want them at the place that you have said you want them, kind of suggests that they've got mental health or they may have mental health supports or there may be other things that are going on, there may be domestic violence, you know, there may be caring issues, you know, maybe other access issues and it's really important, you know, for me everything's an access issue, you know, when we look at, you know, doing the trauma informed work, you know, working in a trauma informed way is an accessibility thing, you know, if we don't work in a trauma informed way our services are not accessible." [VCS Interview K7, narrow rules on access/engagement]

The final barrier identified at the system level was **culturally insensitive services**, which includes

some examples indicative of discrimination.

"You know, whenever you're an ethnic minority, a woman, and a Muslim, you've got three strikes against you. You know, you feel like you have to prove yourself so much more than other people." [Women interview 1, culturally insensitive services]

"Stop sending opt-in letters, they are an enormous barrier for marginalised groups. They mean that the most pro-active patients with best literacy and best ability to seek help end up using all the resources and getting a better service, and those who struggle to read, struggle to accept that they have a problem, or don't speak much English, or don't like making phone calls simply don't get any access to secondary care MH services. Instead use a non-clinical engagement team to pro-actively contact all patients who are referred and establish that way whether they would like help or not." [HCP survey 9, universal service , GP, culturally insensitive services]

"Raise the awareness of Perinatal Mental Health within Culturally Diverse Communities. Provide an inclusive, culturally responsive service along with staff whom are culturally competent. Improve access by listening to the local community and implement their suggestions by making it a priority in policy making." [HCP survey 25, specialist in universal service, job role: other, culturally insensitive services]

"Ethnicity- there is no consistency of care. Care of patients from different ethnic backgrounds is below standard. Frequency to detain patients from ethnic background or working-class background as opposed to the less frequent professional working middle class. There is a hold back or lack of social care referrals from middle class patients." [HCP survey 23, specialist, Support Worker, attitudes and at times discriminatory approaches]

"Recently I have been working with someone from a traveller background. She has experienced a lot of prejudice and assumptions about her culture from different services and finds it difficult to build trust with professionals as a result of these experiences. She says that it has helped a lot that we have come to see her at home and have listen to her experiences and shown curiosity about her background and culture rather than making assumptions." [HCP survey 20, specialist service, Psychiatrists/Psychologists, attitudes and at times discriminatory approaches]

"It was only a couple of times, maybe… sometimes, you know, before I spoke, you know, they did sort of act as though I was, I couldn't, maybe they just assumed I couldn't speak English and they were just kind of speaking very loudly. You know what it is, you've probably had that before, you know, just someone speaking very loudly at you as though you don't speak English….It's not like a clear loud voice, you know, I understand when it's a busy room they have to shout [laughter], I get that, you know, I definitely get that. But it's just the way they speak, sometimes it's a bit patronising. And I don't know, I've not really seen them do that with White ladies unless some of them talk… some of them, again not saying all of them, definitely wasn't all of them, but you did get that sometimes." [Women interview 1, attitudes and at times discriminatory approaches]

"I think professionals being given more time, more training, more reflectiveness, I think organisations really deeply looking into these issues rather than them being just tick box exercises you know, like, oh we do your equality and diversity training and then you've done it, and you're somehow able to provide something different, which I don't think we are." [VCS Interview K10, culturally insensitive services]

4.4 Good practice examples

It is important for us to recognise the effort of all staff in delivering the PMH pathway and acknowledge that the experiences uncovered through this work are not universal. Many women in West Yorkshire access and receive high quality PMH services, whether in universal or specialist provision. Nevertheless, our focus in this project has been specifically on identifying and understanding the experience of those who do face barriers and challenges. Examples of good practice were identified by all the groups that we engaged with: HCPs, VCS KIs and women themselves. We have shone a spotlight on two such examples here, with further examples linked to concrete recommendations in "Recommendations on how to reduce inequalities in perinatal mental health care" (Report 5).

BOX 1: Partnership working between VCS and NHS

Happy Moments is a VCS organisation which works closely with other local organisations (e.g. Auntie Pam's, Maternity Voices Partnership, Midwifery and Health Visiting services) to provide support to women during the perinatal period. This includes support groups, stay and play sessions and various classes (mental health course, paediatric first-aid course, fitness classes, English classes). They see themselves as providing a safe space for women, especially for women from Black, Asian and minority ethnic backgrounds to talk about their mental health. The organisation considers itself as a "bridge" to statutory services, supporting women to overcome their fear of talking about their MH to their doctors, midwife or health visitors. Happy Moments volunteers have received training in PMH and safeguarding from specialists provided by their local NHS Trust. This training enables volunteers to recognise symptoms of PMH difficulties and signpost them to appropriate services.

Partnership working and joint training between VCS and statutory services could help to improve practitioners' knowledge of PMH barriers, increase access of PMH services for minority groups (e.g. via signposting from VCS) and support VCS to access funds so that they can continue to provide PMH support to people from minority groups.

BOX 2: Clinical Engagement, Access, and Inclusion Coordinator role and activities

The Clinical Services, Inclusion Team is a new team which has been created in Leeds and York Partnership Foundation Trust. Roles have been specifically developed to address Health Inequalities within different service areas in the Trust. Although based in a specific service, the role is a member of a small network of similar roles which are overseen by the Clinical Services Engagement and Inclusion Lead across our care services.

The Leeds Perinatal Community Team have employed a Clinical Engagement, Access, and Inclusion Coordinator to focus on improving the engagement, access, and inclusion of underrepresented minority groups (including Black, Asian, and other minority groups) and to support the service to meet their needs. The role involves the Inclusion Coordinator raising the awareness of PMH illnesses within diverse communities, improving their access, and supporting the frontline and leadership team to provide a culturally responsive service to meet the needs of our local communities.

The Perinatal Service has been working creatively to share PMH knowledge more extensively to underrepresented groups through various relevant media platforms, for example national and local South Asian radio stations (speaking in Punjabi, Urdu, Hindi to connect with people on a grassroot level), local newspapers and through social media podcasts. Service users from diverse backgrounds have also shared their lived experiences by writing blogs, making videos and presenting at mental health events within the Trust. Links have also been created within the Sikh and Muslim communities with places of worship for future collaboration.

In September 2020 with support of the Inclusion Coordinator, the Diverse Mums' Group was launched, which provides tailored support to meet the cultural needs of service users. Women are usually referred to the group by care coordinators or medics within the specialist PMH service. The group which is described as an informal friendly support group covers various topics through a cultural lens including: breaking the stigma/ myths of mental health, celebrating religious & spiritual events, discussion around health and nutrition (body image, weight, and mental health), and child development and also provides information about support for partners. Within the group discussion there is also opportunity for women to raise topics that reflect their interests and needs. The group sessions allow women from diverse cultural backgrounds to talk about their mental health, share their cultural experiences, break down cultural barriers and build connections with mum's who they can relate to. The purpose of the group is to empower women by boosting their self-esteem/self-confidence and break down cultural norms in order to normalise mental health. If willing, service users also have the opportunity to share their PMH experience more widely to raise awareness and reduce stigma within the society, e.g., through podcasts, blogs, training events for doctors etc.

The Diverse Mums group is facilitated by the Inclusion Coordinator and a volunteer peer support worker and runs on a weekly basis for an hour on Zoom (group usually run for 8 weeks at a time). The Diverse Mums group won the 2021 National Service User Award for Breaking Down Barriers and were finalists for the Health and Well-Being category for the Cygnet Health Care Awards.

A thematic analysis of service user feedback has been conducted by the service, and identified key themes include impact on people's health and wellbeing, providing excellent learning and development for professionals in reducing health inequalities and improving maternal mental health outcomes.

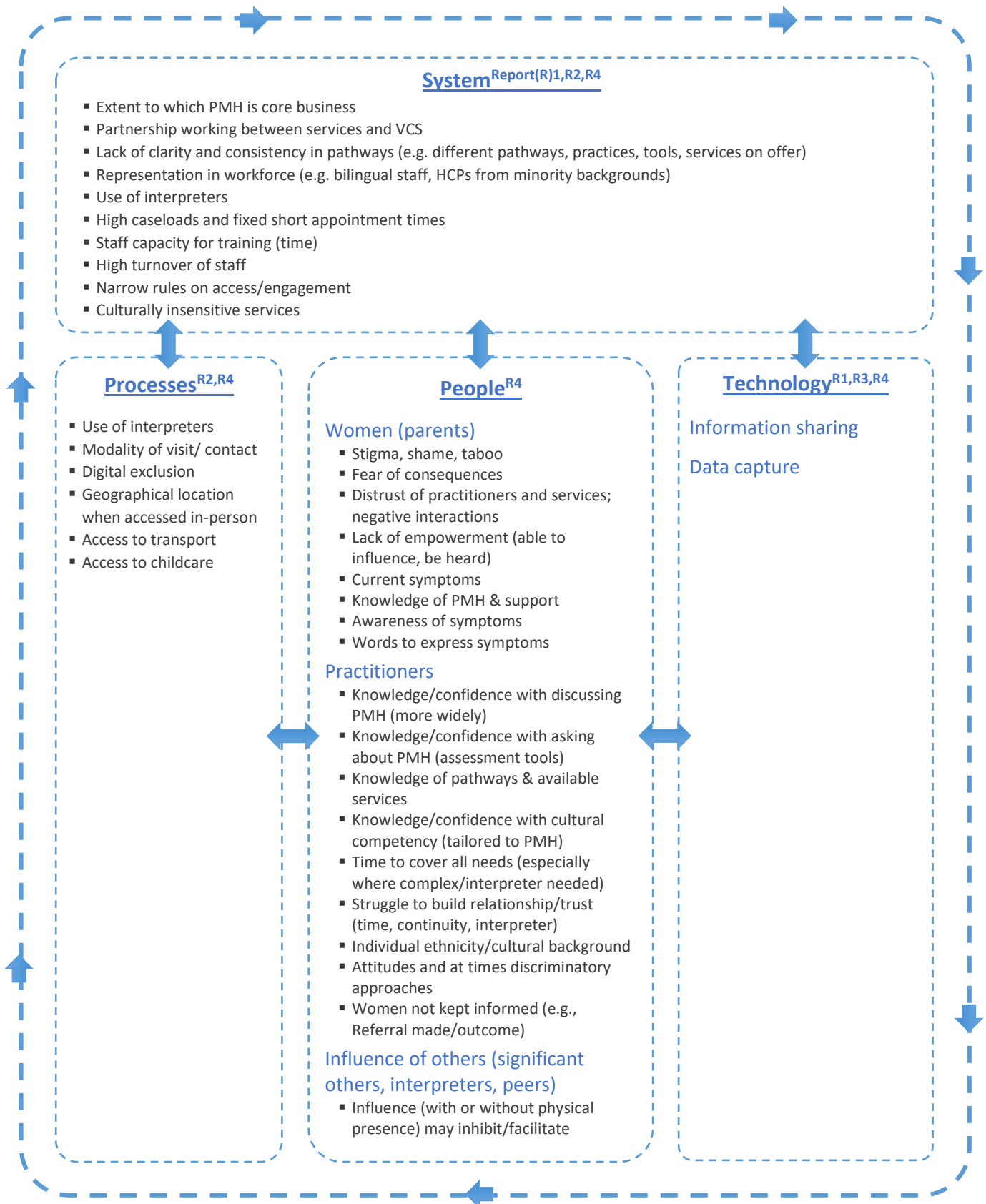## 4.5 Integration of learning from multiple reports within the sociotechnical framework

System[Report(R)1,R2,R4]

- Extent to which PMH is core business
- Partnership working between services and VCS
- Lack of clarity and consistency in pathways (e.g. different pathways, practices, tools, services on offer)
- Representation in workforce (e.g. bilingual staff, HCPs from minority backgrounds)
- Use of interpreters
- High caseloads and fixed short appointment times
- Staff capacity for training (time)
- High turnover of staff
- Narrow rules on access/engagement
- Culturally insensitive services

Processes[R2,R4]

- Use of interpreters
- Modality of visit/ contact
- Digital exclusion
- Geographical location when accessed in-person
- Access to transport
- Access to childcare

People[R4]

Women (parents)
- Stigma, shame, taboo
- Fear of consequences
- Distrust of practitioners and services; negative interactions
- Lack of empowerment (able to influence, be heard)
- Current symptoms
- Knowledge of PMH & support
- Awareness of symptoms
- Words to express symptoms

Practitioners
- Knowledge/confidence with discussing PMH (more widely)
- Knowledge/confidence with asking about PMH (assessment tools)
- Knowledge of pathways & available services
- Knowledge/confidence with cultural competency (tailored to PMH)
- Time to cover all needs (especially where complex/interpreter needed)
- Struggle to build relationship/trust (time, continuity, interpreter)
- Individual ethnicity/cultural background
- Attitudes and at times discriminatory approaches
- Women not kept informed (e.g., Referral made/outcome)

Influence of others (significant others, interpreters, peers)
- Influence (with or without physical presence) may inhibit/facilitate

Technology[R1,R3,R4]

Information sharing

Data capture

Figure 6. The sociotechnical framework as applied to this project, with learning indicated from the research presented in reports 1-4

5. Strengths and limitations, including identified gaps

A key strength of this research is its ability to bring together learning from a range of stakeholders: practitioners in NHS services (specialist and universal/primary care), staff in VCS organisations, and critically, women themselves. Furthermore, we focused on recruiting ethnic minority women and/or those living in materially deprived neighbourhoods for whom there is significant evidence of inequality and whose voices are rarely heard in research. This was made possible through working in collaboration with VCS organisations and the specialist PMH services. We must however also acknowledge those who we did not hear from.

Despite translating the study information into multiple languages and working with VCS to promote access, we did not hear from women with little or no English. We also did not hear from women who had declined all offers of support from specialist PMH services (though they were invited to take part in the research). Within the wider literature, very few studies have sought the views of women from these backgrounds, and research in the context of specialist PMH services and inequalities is even more limited. It is probable that some of the barriers to taking part in research are common with some of the barriers to accessing services and this has implications for our learning; for example, we recognise that it is difficult to fully explore inequalities relating to digital exclusion when our recruitment relies on potential participants making contact by email, telephone or text message. Further research is needed on the perspectives of women in a variety of circumstances that we were unable to capture in this project for practical reasons (including expertise within the team and available resources), such as neurodiverse women and those with learning disabilities.

We invited women via specialist PMH community teams, which would have included a route to hear from women who had received care in Mum and Baby Units (MBUs); however, the study did not involve linking with other inpatient mental health settings. The VCS organisations approached for the KI interviews were prioritised in collaboration with specialist community teams with a focus on those that are directly involved in providing support to women in relation to their PMH. There are many more VCS organisations working across the West Yorkshire region, with wider remits, who may also come into contact with families during the perinatal period. This has implications both for our learning from KIs and onward recruitment of women, where we publicised the research through the selected organisations.

This research concerns the experiences of gestational parents (here, women) and we recognise the need for research with partners (fathers, co-parents and other partners) that addresses their own inequalities in accessing mental health support in the perinatal period.

6. Conclusion and key messages

On the basis of the research presented in this report, we have identified four key messages for those seeking to reduce inequalities in PMH Care (and they are depicted visually in Figure 7). These messages illustrate the need to tackle action at the *system* level in order to enable change in processes, people and technology.

1) We need to **build emotional safety** for individuals and for communities. This links to trauma-informed care and extends to consider the ways in which communities have been marginalised (and even traumatised) [areas of framework: people; system]. Without emotional safety, barriers remain in all steps of the pathway (i.e. disclosure through to uptake). Building emotional safety may require additional time in appointments, to tackle distrust in services and ensure that communication needs are met.

To build emotional safety we need to 2) **position PMH as part of core business for all services involved in caring for new and expectant parents** and 3) **demonstrate cultural competency**. For this to happen, we must recognise and value the expertise of all organisations involved in caring for new and expectant parents by 4) **facilitating closer partnership working**.

In "Recommendations on how to reduce inequalities in perinatal mental health care" (Report 5), we integrate learning across all of the reports and present actionable recommendations for achieving change.

Building emotional safety [people; system] which may require additional appointment time for particular groups

PMH as part of core business [system]
➢ Addressing information/ knowledge [people]
➢ Staff capacity for training
➢ Data capture [technology]

Partnership working (recognising & valuing expertise in all organisations; using shared language) [system]

Cultural competency, including IN PMH care [people: practitioners]
➢ Representation in workforce (paid and voluntary) [system]
➢ Tackle discrimination (including racial) [system]
➢ Cultural competency IN PMH care
➢ What access/engagement looks like (narrow rules) [system]
➢ Use of interpreters (and widening to consider spoken language, disability, neurodiversity) [systems; processes; people]
➢ Digital inclusion/literacy and flexibility (e.g. mode of contact) [processes]

Figure 7. Key messages for addressing inequalities in PMH

Endnotes

Acknowledgements

7. Appendices

Appendix 1: Overview of information packs distributed by three specialist PMH community services

	South West Yorkshire Partnership NHS Foundation Trust	Leeds and York Partnership NHS Foundation Trust	Bradford District Care NHS Foundation Trust
Record search dates	Apr 2019 – Feb 2021	Apr 2019 – Mar 2021	Apr 2019 – Feb 2021
Approached characteristics	Non-White British AND Low IMD (all types of contact, i.e. never attended, attended 1-3, attended >3)	Non-White British (all types of contact, i.e. never attended, attended 1-3, attended >3; only approaching 50% of those with no contact)	Non-White British OR Low IMD attending < 3 appointments, and Non-White British AND Low IMD attending > 3 appointments
N We asked to approach	140	144	132
N approached	114	120	96
Unable to approach	26	24	36

Notes:

We adopted a practical approach here in terms of working with existing service records and recognising that services vary in how data is recorded. This meant that there was variation in who was approached (e.g. both/either characteristics of interest, i.e. non-White British and/or low Index of Multiple Deprivation (IMD), or solely based on ethnicity data).

Throughput varies across the three services. We aimed to have a similar number of packs distributed by each site, rather than to send to a consistent proportion of people referred to the service. We also worked with data that was available in the project's timelines and therefore, at one site, approach was based solely on ethnicity (not IMD).

There are certain limitations with the recording, and this includes that some points of contact did not refer to clinically meaningful contact. We also recognise that for some women, it will have been clinically appropriate for them to have had 3 or fewer points of contact and that this is not necessarily indicative of concerns around attendance/uptake. We recognise that there may be errors in ethnicity data; this is sometimes based on information recorded on the GP data system rather than obtained from the woman directly and we know from women who made contact with the research team that not all identified as the category indicated in their record. There are limits around IMD classification, but this was nonetheless agreed to be the best available metric concerning deprivation. Women were eligible to be contacted by the research team if their home postcode was within the most deprived 20% of areas on the national scale.

Appendix 2: Women recruitment flyer

Make perinatal mental health care easy to access for everyone

Pregnant in the last 3 years?

- We are researchers looking for volunteers across West Yorkshire who have been pregnant anytime between 2018 and 2021.
- We want to talk to people about their experiences of emotional health and wellbeing support during and after pregnancy
- We would like to hear from women who were offered a specialist mental health service, including if they did not continue to use the service. We would also like to hear from women who felt they needed support but did not get it at the time, for whatever reason
- Services have been asked to share this flyer
- If you are interested, please read the enclosed booklet, and get in touch with the research team directly. Taking part is confidential.

- Recording of this information is available in
  - English
  - Ez az információ magyarul is elérhető
  - Ta informacja jest dostepna w jezyku polskim
  - Yeh mahlumaat Urdu/Punjabi/Mirpuri aur Pahaari main bi maujood hai

https://borninbradford.nhs.uk/what-we-do/pregnancy-early-years/perinatal-mental-health/

- You will be thanked for your time with a £20 voucher
- This study may help to improve the way women are cared for in the future

Phone: **01274 364474**
Text: **07940 470294**
Email: **bibresearch@bthft.nhs.uk**

West Yorkshire and Harrogate Health and Care Partnership • bib We are Family • UNIVERSITY of York • University of HUDDERSFIELD Inspiring tomorrow's professionals

HRA & HCRW reference: 21/NW/0158, approved on 16 June 2021   IRAS ID: 293657

Appendix 3 Overview of VCS organisations we spoke to

Voluntary Organisation	Location	Remit and services offered	Mode of support
Mind in Bradford	Bradford, Airedale, Wharfedale and Craven	- Independent charity, with trained staff and volunteers - Mental health and wellbeing support for adult, young people, and children. - Sanctuary crisis service for adult requiring urgent help (accessed through referral from first response). - Provide serious mental illness and physical health training (including inequality focus) to all staff across the VCS who support clients with their mental health. - For perinatal support networking with other services e.g., Little Minds Matter, Family Action and the Specialist Mum and Baby Service (SMABS)	1 to 1 support, group support, befriending, online chat, telephone helpline
Bradford Doula	Bradford	- Trained volunteers - Offering practical and emotional support to pregnant mums six weeks before the birth, during labour and six weeks after the birth - Emotional support, looking for signs of baby blues and postnatal depression - For perinatal support networking with other support services, e.g., baby banks, Refugee Action, baby groups, family hub	1 to 1 support in the home/ via telephone, accompany women to appointments, antenatal classes and hospitals for birth.
Asha Neighbourhood Project	Leeds (South)	- Trained staff and volunteers - Improve life of women and children in South Leeds – an area of multi deprivation and multi ethnicity - Offer a wide range of services: advance education, employment, and health of women (mental and physical), particularly those whose first language is not English (have members of staff who speak Bengali (Sylheti dialect), Urdu, Arabic, Kurdish, Punjabi and English) - Advice, Advocacy (welfare benefits, housing, education, utilities, domestic issues and signposting to other services for e.g., for immigration assistance), Preschool, Play-schemes, Creche, Courses and Classes, Health and well-being projects, Volunteering, and placement opportunities. - Help women to improve and maintain good standards of health and wellbeing by enabling access to mainstream services - For perinatal support networking with other services e.g., Leeds Mind, Touchstone	1-to-1 support, focus groups, forums, drop-ins, face to face, telephone or online support, information sessions, open days and events, stay and play, walking groups, exercise groups

Voluntary Organisation	Location	Remit and services offered	Mode of support
Hope Bereavement Support Service	Leeds (plus)	• Trained staff and volunteers provide mental health and emotional support to women who have experienced bereavement (pregnancy/ baby loss), and support female genital mutilation survivors • Counselling, coaching, bereavement support groups, mental health and emotional wellbeing resilience workshops, trauma healing programme, educational and awareness building workshops, training and consultancy • In house PMH support group (Rainbow Mama) with independent midwife and bereavement counsellors • Networking with other organisations • For perinatal support networking with other services, e.g., Women Health Matters, Linking Leeds, Touchstone, community mental health team	1 to 1 counselling, group support, befriending, educational and awareness workshop
Women's Health Matters	Leeds	• A wide range of support for women and girls who are most at risk, including those experiencing domestic violence, sexual and emotional abuse, those with children in care or at risk of being removed, young mums, women seeking asylum, women with learning difficulties, and women with complex needs or mental health and wellbeing needs. • Not mental health organisation but work with women with mental health issues and follow trauma informed practice • Parenting programme, social wellbeing programme (e.g., isolation, self-esteem, relationship) • For perinatal support networking with other services, e.g., Linking Leeds, GPs, social prescribing service	1-to-1 support, group work and peer support
Women's Counselling and Therapy Services	Leeds	• Trained staff • Provide therapeutic service to the hardest-to-reach (disadvantaged or marginalised) women and girls in Leeds facing complex health and social situations. Support them to recover from experiences of abuse, violence, neglect, trauma, and mental ill health. • Specialised counselling for pregnancy and new mums • Work with wide range of local groups and organisations	Individual counselling and therapy
Happy Moments	Kirklees	• Trained staff and volunteers • Support groups for mum to be and mums, particularly aimed at Ethnic minority community • Women only fitness (including childcare), stay and play, creative journal to boost wellbeing in pregnancy, birth and parenthood, baby massage • For perinatal support networking with other services, e.g., Locala, Kirklees Council, Maternity Mouthpieces, Thriving Kirklees, Auntie Pam's, IAPT, NHS (Southwest Yorkshire Foundation trust), Maternity Voice Partnership	Peer support, workshops, drop-ins, stay and play sessions, WhatsApp groups, exercise sessions

Voluntary Organisation	Location	Remit and services offered	Mode of support
Talkthru	Kirklees	- Trained staff - Pregnancy Crisis Centre - offers a counselling service for women and men facing pregnancy related issue, e.g., unplanned pregnancy, pregnancy/ baby loss, birth trauma, anxiety, depression and people whose baby removed into care - Work with range of organisations including GP's, Young People's Services, Housing Associations, Colleges, Universities, Schools, HCPs	1 to 1 counselling service face to face, online or via telephone
Cafe Christos	Wakefield	- Trained volunteers - Baby weighing service - Help prevent postnatal depression by providing space for new mums to build friendship, reduce isolation, speak to volunteers.	Group support, stay and play, drop-ins,
Health Access for Refugees Programme (HARP)	West and South Yorkshire (Sheffield, Barnsley, Wakefield Rotherham)	- Trained staff and volunteers - Empowers asylum seekers and refugees to access the UK health system - Specialised health workshops and groups covering topics such as: Men's Health, Women's Health, Mental Health, and Maternal Health - Support and advocacy to access different health services, such as registering and liaising with GPs, midwives, hospitals, dentists, and other health care providers - Support to access appropriate mental health, emotional support, and social care services - Volunteer befrienders who accompany refugees and asylum seekers to medical appointments and advocate on their behalf where necessary - Facilitation of 'ESOL for Health', encouraging participants to learn the English words that can help them to communicate their health issues and needs to health professionals. - Opportunity to become volunteers - For perinatal support networking with midwifery service in Leeds and Maternity Stream of Sanctuary	Group support, befrienders, WhatsApp groups,
Maternity Stream - City of Sanctuary	Yorkshire and Humberside (Bradford, Leeds, Hull)	- Trained staff and volunteers - Network of refugee charities, people with lived experience of the asylum system, midwives, health workers, educators and researchers - Raising awareness within maternity services of the issues facing refugee families, ensuring more people get the support they need in the journey from pregnancy to parenthood. - Help asylum seeking and refugee women overcome the barriers they experience when accessing maternity services - Volunteering opportunities - For perinatal support networking with GPs and doulas.	Peer group support, befriending,

Appendix 4 Barriers/facilitators within the framework and where it is demonstrated in the datasets used in the Report 4 research

Findings translated into sociotechnical framework		Level of system and point in PMH pathway in our original analysis	Report 4 Data set		
Level	Section*[7]		Women	HCP	VCS
Processes	Use of interpreters	● **1a Individual (characteristics)** b) Language – need for interpreter ● **3 Practitioner (HCP and VCS staff** i) Language barriers	✓	✓	✓
	Modality of visit/contact*	● **1a Individual (characteristics)** e) Digital exclusion/literacy m) Homelessness/unsafe housing/unstable housing ● **1b Individual** e) Lack of autonomy for own time ● **3 Practitioner (HCP and VCS staff)** k) Digital exclusion/remote working ● **6 Service (service managers and commissioners)** i) Pandemic-specific	✓	✓	✓
	Digital exclusion*	● **1a Individual (characteristics)** e) Digital exclusion/literacy l) Low income/limited financial independence ● **6 Service (service managers and commissioners)** i) Pandemic-specific		✓	✓
	Geographical location when accessed in-person	● **1a Individual (characteristics)** l) Low income/limited financial independence m) Children with additional needs (health/developmental) n) Transportation p) Childcare r) Parity	✓	✓	✓

---

[7] * Asterisk to indicate barriers/facilitators explicitly impacted by covid-19

Findings translated into sociotechnical framework		Level of system and point in PMH pathway in our original analysis	Report 4 Data set		
Level	**Section*[7]**		**Women**	**HCP**	**VCS**
	Access to transport*	● **1a Individual (characteristics)** l) Low income/limited financial independence n) Transportation	✓	✓	✓
	Access to childcare*	● **1a Individual (characteristics)** p) Childcare	✓	✓	✓
People: women (parents)	Stigma, shame, taboo*	● **1a Individual (characteristics)** i) Domestic violence and abuse/gender-based violence o) Children with additional needs (health/developmental) q) Age ● **1b Individual** b) Visibility of services/ knowledge of services c) Knowledge of PMH e) Denial / symptom minimisation l) Fear of negative consequences – fear of being judged/stigma ● **2 Family / significant others (which may include partner, extended family, close friends)** d) PMH difficulties as taboo/stigmatised e) Knowledge of PMH ● **4 Peers working in services (either in a voluntary or paid capacity)** a) Normalising/validating b) Stigma ● **5 Peers accessing services** a) Normalising/validating b) Stigma ● **8 Society** a) Stigma concerning PMH b) Stigma concerning ethnic minority groups c) Narratives around motherhood/parenthood – including womanhood	✓	✓	✓

Findings translated into sociotechnical framework		Level of system and point in PMH pathway in our original analysis	Report 4 Data set		
Level	Section*[7]		Women	HCP	VCS
	Fear of consequences*	● **1b Individual** k) Legal status ● **1b Individual** e) Denial / symptom minimisation h) Fear of negative consequences - social services involvement i) Fear of negative consequences - impact on employment j) Fear of negative consequences – legal implication k) Fear of negative consequences – beliefs about medication/harm to developing baby l) Fear of negative consequences – fear of being judged/stigma (this is particularly in relation to PMH but may be heightened for ethnic minority groups)	✓	✓	✓
	Distrust of practitioners & services; negative interactions*	● **1b Individual (characteristics)** b) Visibility of services/ knowledge of services f) Woman's ability to lead/direct appointment g) Being kept informed about referrals/appointments i) Domestic violence and abuse/gender-based violence m) Previous/anticipated experiences of poor care / distrust of professionals/services n) Trauma ● **1b Individual (characteristics)** c) Knowledge of PMH d) Impact of current symptoms ● **2 Family / significant others (which may include partner, extended family, close friends)** a) Domestic violence and abuse (including coercive control) b) Family presence (inhibit vs. facilitate disclosure) ● **3 Practitioner (HCP and VCS staff** f) Interpersonal skills h) Keeping women informed about referrals/appointments	✓	✓	✓

Findings translated into sociotechnical framework		Level of system and point in PMH pathway in our original analysis	Report 4 Data set		
Level	Section*[7]		Women	HCP	VCS
	Lack of empowerment (able to influence, be heard)	● **1a Individual (characteristics)** c) Language – specific to mental health f) Learning disabilities/difficulties g) Neuordiversity h) Social complexity q) Age ● **1b Individual (characteristics)** b) Visibility of services/ knowledge of services c) Knowledge of PMH f) Woman's ability to lead/direct appointment; power to challenge/negotiate; shared decision-making with practitioner ● **2 Family / significant others (which may include partner, extended family, close friends)** a) Domestic violence and abuse (including coercive control) b) Family presence (inhibit vs. facilitate disclosure) c) Supportive family ● **3 Practitioner (HCP and VCS staff)** a) Extent to which MH is viewed as part of core business f) interpersonal skills g) Woman's ability to lead/direct appointment; power to challenge/negotiate; shared decision-making with practitioner ● **6 Service (service managers and commissioners)** a) Workload/time pressures b) Extent to which MH is viewed as part of core business ● **8 Society** a) Stigma concerning PMH b) Stigma concerning ethnic minority groups c) Narratives around motherhood/parenthood – including womanhood	✓	✓	✓
	Current symptoms*	● **1b Individual (characteristics)** d) Impact of current symptoms n) Trauma (historical/ongoing impact)	✓		✓

Findings translated into sociotechnical framework		Level of system and point in PMH pathway in our original analysis	Report 4 Data set		
Level	Section*[7]		Women	HCP	VCS
	Knowledge of PMH and support*	● **1b Individual (characteristics)** b) Visibility of services/ knowledge of services c) Knowledge of PMH ● **3 Practitioner (HCP and VCS staff)** c) Supportive family	✓	✓	✓
	Awareness of symptoms	● **1b Individual (characteristics)** c) Knowledge of PMH d) Impact of current symptoms e) Denial / symptom minimisation n) Trauma (historical/ongoing impact)	✓	✓	✓
	Words to express symptoms	● **1a Individual (characteristics)** c) Language – specific to mental health ● **1b Individual (characteristics)** c) Knowledge of PMH	✓	✓	✓
People: practitioners	Knowledge/confidence with discussing PMH (more widely)	● **3 Practitioner (HCP and VCS staff)** b) Knowledge of PMH c) Knowledge of cultural difference/culture competence/cultural assumptions d) Fear of causing offense/distress (links to confidence, knowledge, skills) l) Culturally diverse measures	✓	✓	✓

Findings translated into sociotechnical framework		Level of system and point in PMH pathway in our original analysis	Report 4 Data set		
Level	Section*[7]		Women	HCP	VCS
	Knowledge/confidence with asking about PMH (assessment tools)	• **3 Practitioner (HCP and VCS staff)** a) Extent to which MH is viewed as part of core business b) Knowledge of PMH c) Knowledge of cultural difference/culture competence/cultural assumptions d) Fear of causing offense/distress (links to confidence, knowledge, skills) f) Interpersonal skills m) Workload/time pressures • **6 Service (service managers and commissioners)** a) Workload/time pressures	✓	✓	✓
	Knowledge of pathways and available services*	• **3 Practitioner (HCP and VCS staff)** o) Onward referral routes • **6 Service (service managers and commissioners)** f) Onward referral routes g) Visibility of services h) Partnership working	✓	✓	✓
	Knowledge/confidence with cultural competency (tailored to PMH)	• **3 Practitioner (HCP and VCS staff)** c) Knowledge of cultural difference/culture competence/cultural assumptions d) Fear of causing offense/distress l) Culturally diverse measures • **6 Service (service managers and commissioners)** l) Culturally diverse measures j) Training • **7 Government** e) Screening policy/guidelines (NICE)	✓	✓	✓

Findings translated into sociotechnical framework		Level of system and point in PMH pathway in our original analysis	Report 4 Data set		
Level	Section*[7]		Women	HCP	VCS
	Time to cover all needs, esp. where complex/interpreter needed	● **3 Practitioner (HCP and VCS staff)** a) Extent to which MH is viewed as part of core business f) interpersonal skills i) Language barriers j) Literacy barriers m) Workload/time pressures ● **6 Service (service managers and commissioners)** a) Workload/time pressures b) Extent to which MH is viewed as part of core business c) Culturally diverse measures	✓	✓	✓
	Struggle to build relationship/trust (time, continuity, interpreter)	● **1a Individual (characteristics)** b) Language – need for interpreter h) Social complexity ● **1b Individual (characteristics)** d) Impact of current symptoms n) Trauma (historical/ongoing impact) ● **3 Practitioner (HCP and VCS staff)** a) Extent to which MH is viewed as part of core business f) interpersonal skills j) Language barriers m) Workload/time pressures n) Lack of continuity ● **6 Service (service managers and commissioners)** a) Workload/time pressures b) Extent to which MH is viewed as part of core business d) Lack of continuity	✓	✓	✓

Findings translated into sociotechnical framework		Level of system and point in PMH pathway in our original analysis	Report 4 Data set		
Level	Section*[7]		Women	HCP	VCS
	Individual ethnicity/cultural background	● **3 Practitioner (HCP and VCS staff)** c) Knowledge of cultural difference/culture competence/cultural assumptions l) Culturally diverse measures ● **6 Service (service managers and commissioners)** c) Culturally diverse measures ● **7 Government** e) Screening policy/guidelines (NICE)	✓	✓	✓
	Attitudes and at times discriminatory approaches	● **3 Practitioner (HCP and VCS staff)** c) Knowledge of cultural difference/culture competence/cultural assumptions f) interpersonal skills l) Culturally diverse measures ● **6 Service (service managers and commissioners)** c) Culturally diverse measures e) Need for better documentation	✓	✓	✓
	Women not kept informed (e.g. referral made/outcome)	● **3 Practitioner (HCP and VCS staff)** h) Keeping women informed about referrals/appointments j) Literacy barriers n) lack of continuity ● **6 Service (service managers and commissioners)** e) Need for better documentation ● d) lack of continuity	✓	✓	✓

Findings translated into sociotechnical framework		Level of system and point in PMH pathway in our original analysis	Report 4 Data set		
Level	**Section*[7]**		**Women**	**HCP**	**VCS**
People: influence of others (significant others, interpreters, peers)	Influence (with or without physical presence) may inhibit/facilitate; can also influence without being physically present (including anticipated reactions of others)*	• **2 Family / significant others (which may include partner, extended family, close friends)** a) Domestic violence and abuse (including coercive control) b) Family presence (inhibit vs. facilitate disclosure c) Supportive family d) PMH difficulties as taboo/stigmatised • **3 Practitioner (HCP and VCS staff)** f) Interpersonal skills i) Language barriers • **4 Peers working in services (either in a voluntary or paid capacity)** a) Normalising/validating b) Stigma • **5 Peers accessing services** a) Normalising/validating b) Stigma • **8 Society** a) Stigma concerning PMH b) Stigma concerning ethnic minority groups c) Narratives around motherhood/parenthood – including womanhood	✓	✓	✓
Technology: data capture	Lack of feedback from organisations means data incomplete/not followed up	• **3 Practitioner (HCP and VCS staff)** h) Lack of continuity o) Onward referral routes p) Clinical supervision • **6 Service (service managers and commissioners)** d) Lack of continuity f) Onward referral routes k) Clinical supervision j) Training	✓		✓

Findings translated into sociotechnical framework		Level of system and point in PMH pathway in our original analysis	Report 4 Data set		
Level	**Section***[7]		**Women**	**HCP**	**VCS**
System	Extent to which PMH is core business	● **3 Practitioner (HCP and VCS staff)** a) Extent to which MH is viewed as part of core business m) Workload/time pressures ● **6 Service (service managers and commissioners)** a) Workload/time pressures b) Extent to which MH is viewed as part of core business	✓	✓	✓
	Partnership working between services and VCS	● **6 Service (service managers and commissioners)** h) Partnership working ● **7 Government** c) Underinvestment in VCS		✓	✓
	Lack of clarity and consistency in pathways (e.g. different pathways, practices, tools, services on offer) *	● **3 Practitioner (HCP and VCS staff)** o) Onward referral routes ● **6 Service (service managers and commissioners)** f) Onward referral routes g) Visibility of services	✓	✓	✓
	Representation in workforce (e.g. bilingual staff, minority HCPs)	● **3 Practitioner (HCP and VCS staff)** c) Knowledge of cultural difference/culture competence/cultural assumptions l) Culturally diverse measures ● **6 Service (service managers and commissioners)** c) Culturally diverse measures	✓	✓	✓
	Use of interpreters	● **1a Individual (characteristics)** b) Language – need for interpreter ● **3 Practitioner (HCP and VCS staff** i) Language barriers	✓	✓	✓

Findings translated into sociotechnical framework		Level of system and point in PMH pathway in our original analysis	Report 4 Data set		
Level	Section*[7]		Women	HCP	VCS
	High caseloads and fixed short appointment times*	**3 Practitioner (HCP and VCS staff)** m) Workload/time pressures **6 Service (service managers and commissioners)** a) Workload/time pressures **7 Government** a) Cuts to universal support/services, underinvestment etc b) Waiting times	✓	✓	✓
	High turnover of staff*	**3 Practitioner (HCP and VCS staff)** m) Workload/time pressures **6 Service (service managers and commissioners)** a) Workload/time pressures i) Pandemic-specific **7 Government** a) Cuts to universal support/services, underinvestment etc	✓	✓	✓
	Staff capacity for training	**3 Practitioner (HCP and VCS staff)** m) Workload/time pressures **6 Service (service managers and commissioners)** a) Workload/time pressures i) Pandemic-specific **7 Government** a) Cuts to universal support/services, underinvestment etc		✓	✓

Findings translated into sociotechnical framework		Level of system and point in PMH pathway in our original analysis	Report 4 Data set		
Level	**Section*[7]**		**Women**	**HCP**	**VCS**
	Narrow rules on access/engagement	• **1a Individual (characteristics)** e) Digital exclusion/literacy m) Homelessness/unsafe housing/unstable housing • **1b Individual** e) Lack of autonomy for own time • **3 Practitioner (HCP and VCS staff)** k) Digital exclusion/remote working • **3 Practitioner (HCP and VCS staff)** m) Workload/time pressures • **6 Service (service managers and commissioners)** a) Workload/time pressures i) Pandemic-specific • **7 Government** a) Cuts to universal support/services, underinvestment etc b) Waiting times d) Asylum and immigration policy			✓
	Culturally insensitive services	• **3 Practitioner (HCP and VCS staff)** c) Knowledge of cultural difference/culture competence/cultural assumptions f) interpersonal skills l) Culturally diverse measures • **6 Service (service managers and commissioners)** c) Culturally diverse measures e) Need for better documentation	✓	✓	✓