

Measuring the equity of access to psychological therapies for women of the global majority in the Leeds Perinatal Mental Health Service

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Context and Terms

This service evaluation was completed with women of the global majority. It is acknowledged that grouping together all women in this way can falsely suggest that these women belong to a homogenous group and this ambiguity can cause confusion. However, for the purposes of this evaluation, the women are grouped in this way because they will have some similarities in their experience of accessing healthcare due to navigating this as someone who is ethnically minoritised in the UK. As well as using the term ethnically minoritised, in this report I will refer to these women as being of the global majority as I feel that this is the most empowering term. My intentions for this project are to shed light on the difficulties experienced by women of the global majority in the most accurate way, but I am mindful that as I am a White woman I may be limited by my own biases. I have endeavoured to limit these biases through developing my own awareness of issues faced by reflecting on this project with colleagues.

The prevalence of perinatal mental health problems for people of the global majority

Women of the global majority are at increased risk of mental health problems during the perinatal period. Factors that increase this risk include having low social support, low socioeconomic status, lower English language proficiency and being a refugee/asylum seeker (Anderson et al., 2018). Moore et al. (2019) that ethnicity was a stronger predictor of mental health problems than migrant status for a cohort of mothers from an ethnically minoritised background. This highlights that these women are disadvantaged whether they are a first or higher generation migrant. Moore et al. (2019) highlighted that higher social and material deprivation was a predictor of poor mental health, however, socioeconomic status only partly explains this difference and cumulative exposure social marginalisation and racism also plays a role.

Barriers to perinatal mental healthcare

Before discussing the barriers to perinatal mental healthcare for women of the global majority, it is important to acknowledge the challenges to engagement within the service as a whole. Perinatal mental health problems affect up to 27% of new and expectant mothers in the UK (NHS England, 2022). The five year forward plan (2014) stated that 85% of localities did not have a specialist service that met NICE guidelines. Progress in 2017/2018 has exceeded expectations more than three-fold, with 7,000 more women accessing services by March 2018 against a target of 2,000 (All-Party Parliamentary Group on Mental Health, 2018). However, despite increased funding, service provision has struggled to keep up with the increase in demand following the covid-19 pandemic (The Royal College of Psychiatrists, 2021).

Sambrook Smith et al. (2018) synthesised the barriers to perinatal mental health care for all women. They highlighted that at an individual level, women were limited by poor knowledge from healthcare professionals who may miss symptoms. Similarly, mothers and/or their families who are unaware of mental health difficulties may not recognise symptoms or do not act on them due to perceived stigma. At the organisational level, staff shortages and a limited service provision could mean that healthcare practitioners feel rushed and do not have the time to explore mental health within their role. Fragmented services also disrupt communication between health visitors and GPs. This exacerbates confusion between who's role it is to refer for specialist help. At a structural level, healthcare professionals reported that using assessment tools enabled women to feel like their concerns were taken seriously, but sometimes could be perceived as tokenistic. Healthcare professionals were worried about the ethical issue of completing thorough assessments when they were not convinced that the issues that this highlighted could be followed up effectively.

Barriers to perinatal mental healthcare for women of the global majority

The barriers mentioned previously are amplified for women of the global majority. A systematic review conducted by Watson et al. (2019) evaluated the experiences of help seeking and perinatal mental ill health for ethnically minoritised women. First, they found that these women were unable to recognise their experiences as being an illness and described them in alternative ways. Their experiences could be due to financial problems, difficulties in personal relationships, hormonal factors, pregnancy-related physical health problems, racist incidents, living in a different country, stress, lack of community and issues related to being an asylum seeker. Some women who were Black Caribbean or South Asian explained that depression was not culturally acceptable because of the role they are expected to have in society where they need to remain strong and not show signs of poor coping. They highlighted how important it was for them not to talk about problems with people outside of the family home due to stigma. The women shared that they felt emotionally isolated. This was exacerbated when they felt misunderstood by close relations. In contrast, social support from people close to them was valued and sought out by them. In terms of accessing services, some women were fearful of accessing support due to fears of being judged as a bad mother or that it would lead to them losing their children. Women were concerned about being labelled with a mental health diagnosis and having to take medication. There were concerns about being involved with service providers who were not of the same ethnic background or who weren't women, or they anticipated a lack of compassion based on previous experiences. For some women, language difficulties made it difficult for them to explain their symptoms, ask for support or access any support offered. Asian and Black women were less likely to be offered treatment than White women and healthcare providers were perceived to discriminate against the women on account of their ethnicity.

Leeds Perinatal Mental Health Service

The Leeds Perinatal Mental Health Service offers support to women during pregnancy and up to a year after childbirth. The service has been undergoing a period of rapid expansion since 2019, which has included the establishment of a psychological therapies service offer which includes Cognitive Behavioural Therapy (CBT), Eye-Movement Desensitisation Reprocessing (EMDR), parent-infant work, couple and family therapy and group work. The service has been actively working to overcome known barriers to perinatal mental health treatment for women of the global majority by raising awareness of the service within relevant communities in Leeds to challenge stigma and improve accessibility.

Project Aims

The evaluation aims to answer the following questions:

- Are women of the global majority suitably represented in the referrals for psychological therapy within Leeds Perinatal Mental Health Service?
- How do women of the global majority experience the accessibility of psychological therapy within Leeds Perinatal Mental Health Service?

Method

Accessibility refers to attendance in the service as well as how well an individual's needs are being met. Therefore, a mixed methods approach was selected to establish observable differences in service involvement, while also providing opportunity to gather rich data about how service users experience the service. The design of the two arms of the project will be discussed below.

Quantitative Method

We thought it was most appropriate to utilise existing service level data to identify how well represented women of the global majority were within the service. The perinatal mental health service collects data that includes:

- The ethnicity of all cases open to the perinatal service as a whole
- All of the clinical contact that has occurred in the last year, what the contacts were for (e.g. nursing, psychology), and the ethnicity of the individual having that contact.

This data could be used to determine whether there are differences between the women of the global majority accessing psychological therapies and those accessing the service as a whole. This data could also be compared with demographic information about the city of Leeds (Office for National Statistics, 2021).

The data from the ONS is grouped by the major categories of Black, Asian, White or Other. Although the service level data does have more detailed categories of ethnicity, we grouped our data in accordance with those major categories used by the ONS for ease of comparison. This meant that when we wanted to account for those who are of mixed ethnicity, we needed to carefully consider the most appropriate category. We reasoned that they were more likely to be exposed to issues relating to women of colour than not (such as racism), and so included them within the most relevant racialised category (e.g. mixed Asian was included in the Asian category). We were mindful of the risks of creating broad categories in this way as it perpetuates the idea that these ethnicities are homogenous groups. However, we planned to only use this grouping to give a broad indication of whether, in the context of these categories, the service is equally accessible as this would be useful information for identifying development needs for the service. The data was not to be used to draw any more specific interpretations based on ethnicity as this would not be valid or appropriate.

The data was analysed using descriptive statistics to observe any notable differences between the population figures and those at the service level. Statistical differences could not be calculated due to the limited details within the published data from the ONS. Statistical differences were also not of great importance in this project; if the data had an observable difference that would give an indication that the service was not representative and needs to develop in this area, regardless of statistical significance.

Qualitative Method

To understand how accessible the service is from the service user perspective, the second part of the evaluation involves semi-structured interviews (see Appendix A for Interview Schedule). Participants were identified using the following criteria:

- Their ethnicity was listed as ethnically minoritised background (this is self-disclosed when they first join the service)
- They had completed psychological therapy in the last 6 months

There was limited uptake and so the criteria was extended to include participants who were still attending therapy.

When designing the project, it was acknowledged that only contacting those individuals who had attended therapy would not reflect the perspectives of the individuals who had not progressed to psychological therapy, and so would only partially reflect the accessibility of the service. However, recruiting individuals who were in the perinatal mental health service but had not attended psychological therapy presented some ethical issues. It was considered unfair to ask those women about a service that they had not attended if the therapy arm of the service was unavailable to them due to them not being offered therapy by the professionals involved in their care. This would cause distress if they were then made aware of a service that they were unable to access due to barriers outside of their control (i.e. professional decisions, service related issues). Referrals to the therapy arm of the service are discussed informally and so there is no documented evidence that may show the processes within the service that might hinder equity of access for service users from a minority background. It also seemed unlikely that individuals who had not attended therapy when it was offered would opt-in to a service evaluation project, the barriers that had prevented them from attending therapy were likely still present. Therefore, this project focussed on the experiences of those individuals who were successful in attending for therapy. This could help reveal strengths within the service and potential ways the service helps women of the global majority to overcome known barriers to accessing support for their mental health.

Participants were invited to take part in a semi-structured interview using Microsoft Teams. The interviews focussed on how they experienced the referral to psychological therapy as well as their experiences during therapy, including the cultural sensitivity of the support they received (see Appendix 1 for the interview Schedule). The interview schedule was designed in collaboration with the Access and Inclusion Co-ordinator and individuals from the service's Diverse Mums group.

The target sample was 6-8 service users but unfortunately only five suitable candidates were approached and three of these agreed to participate.

The interviews were analysed using rapid qualitative analysis (RQA). Other approaches, such as thematic analysis (TA), were considered too resource intensive given the time constraints of this project. The benefits of a more robust analysis such as TA were unlikely to achieve better results due to the small sample size, and so a more rapid approach was sufficient. RQA is a method that is suitable for time-sensitive projects in healthcare. It usually includes 5 core features: 1) used as part of a mixed methods approach 2) a quick timeline, 3) population of interest involved in planning the research, 4) team approach to research process, and 5) iterative cycle of data collection and analysis. To improve validity in this project, themes were reviewed by a peer researcher and there was agreement that these appropriately reflected the service user experiences.

Results

Part 1: Representation within referrals

Within the population of Leeds, 21% of people are reported to be from a the global majority (Figure 1). Within the perinatal mental health service, 20% of referrals were women of the global majority and so they were appropriately represented within this service (Figure 2).

For the service to be considered to have equity of access, the proportion of appointments offered to each of the ethnic groups should be consistent with the proportions that are present within the service.

Figure 1
Leeds population data 2021

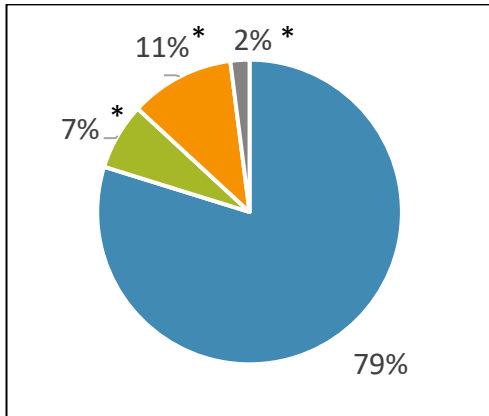
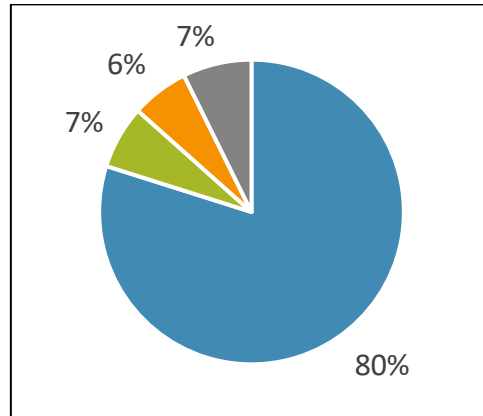


Figure 2
Perinatal mental health service referrals



* Data available was to 2 decimal places, this has been rounded up to 0 decimal places for ease of comparison with service level data.

Figure 3
All non-psychology clinical contacts

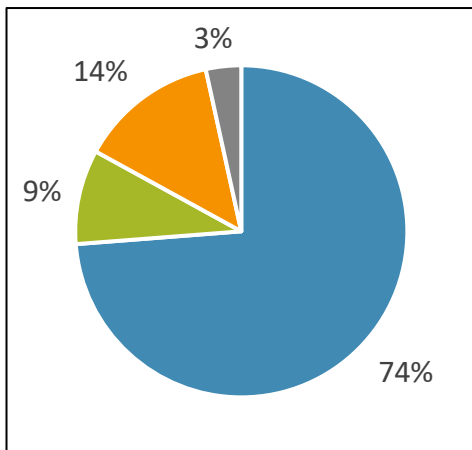
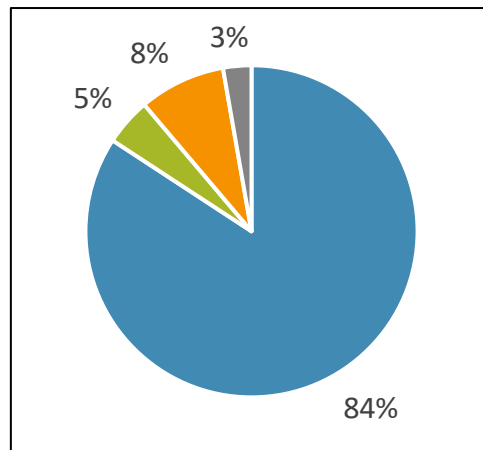


Figure 4
All psychology clinical contacts



Legend: ■ White ■ Black (and mixed) ■ Asian (and mixed) ■ Other

Of all of the medical appointments (non-psychology) within the service, women of the global majority attended a greater proportion of those appointments than expected (Figure 3). 26% of medical appointments were made up of women from the global majority . This over-representation was particularly notable for women from an Asian background. While

these women made up 7% of service users, they accounted for 14% of all medical appointments offered.

This over-representation was not observed for psychology appointments (Figure 4). Women of the global majority had slightly fewer psychology appointments than would be expected; they made up only 16% of all psychology appointments despite making up 20% of the open referrals in the service. The largest discrepancy was observed for women whose ethnicity was labelled “other”. These women made up 7% of all referrals but only 3% of all psychology appointments. This group should include individuals who have an ethnicity that is different to the other three major ethnicity groups, however, there is no clear definition of this category and so it is difficult to ascertain the characteristics of this group.

Part 2: Experience of accessing psychological therapy

After analysing the interviews, four broad themes were generated. The themes, subthemes and relevant qualitative data are indicated in Table 1.

Table 1. Themes and subthemes from qualitative data.

Theme	Subtheme	Illustrative Quotation
Lack of Knowledge	About the service	<p>"I didn't know that there was a team just focussing on mothers". P3</p> <p>"Let the people know that there is a perinatal team that is available for everyone". P3</p> <p>"I didn't realise it was like a whole different service" P1</p> <p>"I didn't know that the service existed. This was my first point of coming to know this kind of stuff. And it's been brilliant" P2</p>
	About mental health	<p>"I didn't know I had a problem or illness or whatever, I thought it was normal.. like what it means to be a mother".P3</p> <p>"I didn't know [anger] was a sign. I thought if you were depressed, just gonna be crying in a corner. I chose to get help because I found a symptom that I didn't know was a symptom". P2</p> <p>"They thought I probably had personality disorder or depression, which in hindsight I realise I did, but at that time I didn't know" P1</p>
Barriers to accessing	Patience and waiting	<p>"I was strong enough to hold on and wait that long, but other people might not". P2</p> <p>"luckily we get help quicker than other people [in London] do". P2</p> <p>"if I was comfortable with having someone who was training to be my therapist, then I could access it quickly. And I said, well, that's fine by me."P1</p> <p>"the first thing they offered was the medication. I asked for therapy too, because that's what will help me the most, but the only thing that came like a month later"P3</p>
	Fear of judgement	<p>"scared to have a label like being 'the crazy one' or something"P3</p> <p>"if they know how I am, how bad I mom I am, they're gonna take my kids" P3.</p> <p>"I know other mums don't have this, they have a fear of speaking up about it."P1</p> <p>"In our cultures, if you say you have mental health issues, you're crazy. Kids are not safe" P2.</p> <p>"People of diverse backgrounds, it's been like drilled into their heads that you need to be strong no matter what" P2.</p>
	Therapy location	<p>"[without remote access] I probably wouldn't have done the service. I probably would have turned down the whole therapy thing and just not worry about it, but it's the fact that it's available online. You know that I can do, you know, teams." P1</p> <p>"[attending therapy] in another room. I'm not in my house. I'm somewhere else I've safespace I guess."P3</p>

Transparency and collaboration	Being kept in mind	<p>“I never felt like I was forgotten or anything like that at all. I never had to follow up or anything” P1</p> <p>“it was always the kind of thing where all you’d get is ‘someone’s gonna talk to you in two weeks time’ and it was never the case. It just dragged on for a few months”. P2</p> <p>“Everytime I wanted an appointment or anything I have everything arranged. I didn’t know who to call and I called and she listened to me while I was venting”.P3</p> <p>“ I still felt supported through the whole through that whole time as well when it could have easily have fallen through the gaps you know like the normal the non perinatal service”P1</p> <p>“They were really helpful and it helped that my notes were already there and that there was a smooth transition between practitioners. I didn’t have to explain my whole life story again”.P1</p> <p>“there was one point where I was really suicidal and you know, I was already in the service and you know, I didn't know that could actually just call the service”P1 .</p>
	Being involved in decision making	<p>“It’s my first time. I’m not sure if it’s for me or not because I’m lost here”P3</p> <p>“She did tell me that there is talking therapy available, couples therapy and some groups” P2.</p> <p>“Not really in the loop about when and how” P2</p> <p>“Then let me know, but other services they provided at the time and if I wanted help with any. If I wanted to access any of them. So I have, you know, since then access other parts of the service as well. P1</p>
Experience of therapy	Finding connection and feeling understood	<p>“I like that too, because it’s my own space and I’m the only one talking. Sometimes I don’t want to say things in front of the [diverse mums] group, are they gonna judge me for this?” P3</p> <p>“She always respects everything about me. I just felt her. I got lucky” P3</p> <p>“It’s personalised, but structured” P1</p> <p>“I never felt like she had any sort of like bias or discriminated against me. I never felt like she ignored that either, there was that acknowledgment there around it”. P2</p> <p>“[people] don’t understand the cultural side of it. Even my husband doesn’t get it. Like, he’s like a white British male.” P1</p> <p>“I don’t think anyone understands it fully unless theyre in it”. P1</p> <p>“I felt really comfortable. I didn’t feel judged. It was just a relief to talk about these things. Even if she didn’t understand our culture, she was very understanding with what we were saying, and respectful of it as well”. P2</p>

		<p>"I was really worried that I'm not gonna connect, but I was able to and she was amazing".P2</p> <p>"This isn't an issue for me per se, but seeing a therapist that is from a similar background will help mums open up more".P2</p>
	The wider system	<p>"I'm not an expert but I think [fathers] may need to be seen more often". P3</p> <p>"we are treating the depression with the medicine and everything, I know is important but I feel like [partners] are important too because they can help us" P3</p> <p>"I just want him to understand a little bit more" P1</p> <p>"When my partner had support from the Dad's group, he understood it better, which helped my Dad change his perspective on it. So it was like a generational kind of influence". P2</p>
	The diverse mums group	<p>"what I loved the most was the diverse group" P3</p> <p>"[they] could understand how alone we can feel". P3</p> <p>"It really helped to break this barrier that we have in our culture of not talking about these things" P2</p> <p>"they made me feel like I'm not that bad person I thought I was" P3</p> <p>"one person speaks and it's like 'Oh my god, I'm going through the exact same thing'" P2</p>

Lack of knowledge about perinatal service/mental health. All of the women reported that they did not know that specialist perinatal mental health services existed. One of the women commented that she wondered if this was deliberate.

All of the women had suffered with their symptoms independently for some time before they recognised that they had a problem that they needed support with. The women in this sample were all accessing support for postnatal depression and all of them stated that they had not understood that symptoms of anger and irritability were part of this diagnosis. All of the women had sought help by asking for support from either their GP or health visitor. One of the women explained that she had only recognised that she needed support when a blogger that she follows had shared similar experiences but had named these postnatal depression. This woman also suggested that all women should be made aware of common symptoms of perinatal mental health problems as early as possible. She explained that otherwise, she would have been unlikely to recognise that she had a mental health difficulty because this was not discussed in her culture and that she was expected to be “strong”. She explained that her mother had recognised some difficulties in her daughter but had not raised these until she had mentioned seeking help. All of the women had been worried that seeking help might mean that their children could be taken away.

Barriers to accessing psychology

Patience and waiting. All of the women felt that the wait for psychology was longer than they would have liked. One woman had been able to be seen sooner due to opting for a trainee therapist. One woman explained that there had been confusion in how long she would need to wait and that despite chasing up the referral several times she did not know when she would be seen. She highlighted that it had taken effort from her to be patient and she wondered whether other people in her position would have been able to do this.

Fear of judgment. When waiting for therapy, all had been concerned about whether they would connect with the therapist and had fears that they might be judged. One of the women thought that it would be better if they could choose their own therapist and thought it would have been easier to choose someone who came from a similar cultural background.

Therapy location. The flexibility of formats in how the service is delivered appeared to be a strength. One woman commented that she would not have been able to access the service if she had not been able to attend remotely via video call, as it would not have fit in with her work commitments. In contrast, one of the women stated that she preferred to have a safe space outside of her home.

Transparency and collaboration

Being kept in mind. All of the women reported that the transition between the different parts of the service, including between the psychology service and the wider perinatal team, had felt like a smooth transition. The women tended to speak about the service overall rather than specifically about their therapy, which further highlighted how integrated the service was in their view. One woman shared that she had appreciated that communication between these different parts of the service meant that she did not have to keep retelling her story. One of the women's accounts indicated that the remit of the service was unclear. She explained that there was a time that she was in crisis and had struggled to find a third sector organisation to call, later to be told by her therapist that she should call the service in those moments. Alternatively, one woman highlighted that the service was present and supportive and she did not have the same difficulty.

Being involved in decision making. The women's description of the process of coming into therapy highlighted that they had little agency. The women did feel as though they were offered choices about the therapy that they received, such as the modality, but that they did not know what was best for them so trusted the professionals and followed the guidance offered to them.

Experience of therapy

Finding a connection and feeling understood. All women spoke about how their experience as an immigrant and being from an ethnically minoritised background meant that they were often isolated. They reported that the therapy they received was non-judgmental and that they felt heard and respected. The therapists took their social circumstances into account, and this included any cultural factors that had been shared. Discussions around

culture were not directly raised by the therapists, rather they were incorporated in discussions organically. All the women had different relationships with their own ethnicity and culture; one woman was an immigrant whose first language was not English, one woman was a second-generation migrant who had been raised in a western culture but acknowledge that her parents' cultural values had shaped her upbringing in some way, and one woman was a second-generation migrant who was more embedded in a community that shared her cultural heritage. This highlighted the extent to which their cultural backgrounds could vary in how prominent they might be in the discussions they had within therapy. Although the women all felt they had a good relationship with their therapist, some of them shared that no one could fully understand them unless they had similar experiences to them.

The wider system. The women all reported that they were pleased that the service also offers support to partners of the mothers and stated how important it was for partners to understand them and be able to support them. However, they reported that they thought that they would benefit from more intensive support for partners than was offered to them.

The diverse mums group. The women were able to find connection within the diverse mums group, which was seen as an important element to their overall recovery, as well as individual therapy.

Discussion

The evaluation identified that women of the global majority appear to be well represented throughout the Leeds perinatal mental health service; the proportion of referrals, medical and therapy appointments are all in line with expected figures. Although it may be that the service's attempts to promote the service have helped to raise awareness among ethnically minoritised populations, the women interviewed all reported that they had no awareness of the service beforehand and that it had been a GP or a health visitor who had initiated the referral after they shared their concerns. In line with previous research from Watson et al. (2019), the women in this evaluation indicated that they had struggled to recognise their symptoms of mental illness and some of them attributed this to their culture;

discussions around mental health were not common within their families and communities. Despite this, it is positive that this potential barrier to engagement does not appear to have impacted referrals into the service. It seems likely that the knowledge and skills from professionals have afforded equity of access to perinatal mental health support through noticing difficulties and facilitating a referral for specialist help.

An interesting observation was the finding that women of the global majority have more medical appointments, that is, appointments that aren't therapy, than White women in the service. The data appears to show that they are offered a substantial number of appointments and that these are usually well attended, which could indicate that the service exceeds expectations. However, the data only shows that they attended appointments, it does not offer any clarification as to how many appointments were offered or cancelled, or the nature of the appointments that were offered. Due to the data being comparative, we cannot rule out alternative hypotheses, for example, the data in this format could also indicate that white women tend to refuse appointments or DNA more than women of the global majority, despite being offered more appointments.

Waiting times for accessing psychotherapy were a concern for the women interviewed. Evidence indicates that people from ethnically minoritised backgrounds tend to have greater delays for medical treatment, and these delays are increased for those on a lower income, and they also tend not to feel well informed about their treatment (Healthwatch, 2022). Long waiting times have been identified as a factor that impacts relationship with the healthcare provider for people from minoritised communities (Memon et al., 2016). It is notable that one of the women shared that it had not been easy for her to be patient in waiting for her therapy appointments. This may indicate that other women may not attend for therapy due to the waiting times. The women wondered when their therapy would begin, why they could have medication but not therapy yet, had anxieties about what their therapist would be like and whether their therapist would understand them. Although waiting times cannot necessarily be helped in a service, providing more transparency during these waiting times may help reduce anxieties for service users and then reduce the likelihood that

they may not attend for therapy. The women's fears about being misunderstood or not connecting with their therapist are similar to views from other women in the literature. Nevertheless, the women in this study did report that they managed to connect with their therapist. This is only the experience of three individuals and so we cannot draw conclusions for all women of the global majority. One of the women thought that matching clients with service users with a therapist of a similar background could help other women. However, people from ethnically minoritised backgrounds are poorly represented among psychiatrists and psychologists (Health and Social Care Information Centre, 2013) and so it is difficult to facilitate this. Instead, fears about connecting with their therapist could be ameliorated by offering earlier initial meetings with their therapist and offering a choice of therapist where possible.

The three women reported good experiences in therapy where they felt heard, understood and respected. Conversations about their culture came up organically as part of discussions about their social circumstances. This evaluation highlighted that, in some cases, therapy can be perceived as culturally sensitive without direct discussions about culture and ethnicity. However, previous literature does highlight that service users of the global majority felt it was important for their clinicians to be aware of their specific culture and how they related to them as this made them more likely to engage with that clinician (Pilav et al., 2022). Similar to findings from Watson et al. (2000), the women in this project shared how important it was to engage with a group of women of the global majority experiencing similar difficulties. They described how this helped to mitigate any sense they had that their therapist could never truly understand their experience and reduced self-stigma. In this way it is possible that offering support groups such as this can help to reduce potential barriers that impact engagement in therapy.

The women in this project reported that having their partner involved in their therapy was important to them as they wanted their partner to understand their difficulties. They spoke of the benefits to their wider family as the fathers could then share this knowledge with other men in the family. This in line with previous research from Watson et al. (2000)

that indicated that women of the global majority feel isolated when their partners do not understand. Pilav et al. (2022) also found that women rely on partners for invaluable practical and emotional support, which highlights how important their role is in supporting their mental health treatment.

Due to the recruitment method and sample size, the sample of women interviewed may not be representative of the population that we had sought to understand within this evaluation. The women were identified and recruited by the clinicians within the service using broad inclusion criteria, and so the sample achieved may have been biased. Two potential participants who were approached and had expressed an interest in being involved had difficulties attending for their scheduled interview times and eventually did not respond to contact. The difficulties that some of the women in the service had in accessing the evaluation may also reflect their ability to engage with the service as a whole. Had they been interviewed, their views may have offered a different narrative to the themes generated. Waheed et al. (2014) explains that it can be difficult to recruit people from an ethnically minoritised background in mental health research due to stigma, lack of trust, logistical issues and lack of culturally aware researchers. Within this project, participants were recruited via clinicians and so this could have impacted participants' ability to trust the researcher. Waheed et al. (2014) suggests that trust can be improved by having a culturally competent "insider", who can think and act in a way that is sensitive to the needs of participants. For this service, the Access and Inclusion Coordinator and other professionals involved in the Diverse Mums group may have better been able to support potential participants so that they feel safe to be involved in the project.

The small sample did not cover a range of different cultural backgrounds. Henderson et al (2013) stated that there are difficulties in grouping together all mothers from racialised communities in perinatal mental health research as they do not have the same experience, however, this project was particularly limited by such a small sample which did not allow for a greater variety of experiences. The three women who did attend for interview were articulate, educated women who described themselves as "western". Some of the barriers

that are documented within the literature, e.g. language barriers, accommodation of religious/cultural beliefs, may not have been relevant for those women. In this project we weren't able to recruit women who had not been offered therapy, and the service does not hold data on the reasons why women may not have been suitable for a psychotherapy referral. This information would help to clarify any systemic/professional barriers to therapy for women of the global majority in this service. Evidence suggests that people from ethnic minority backgrounds are less likely to receive an assessment after referral and are less likely to be offered treatment (Harwood et al., 2021). Therefore, informal methods of referral might mean that any implicit racial bias among professionals could hinder equity of access.

In summary, this evaluation indicated that there are promising signs that the Leeds Perinatal Mental Health Service offers equity of access for women of the global majority. The data available limits our ability to draw substantial conclusions or speculate about some of the factors that have facilitated this access. From interviews with service users, it appears that the transition into the psychology service is relatively smooth, aside from long waiting times, and that once in the service they felt the therapy was culturally sensitive and they felt heard and respected. It is acknowledged that the small sample size is unlikely to represent all women of the global majority but offers an indication of some of the potential strengths and areas for improvement in the service.

Recommendations

This evaluation has helped to highlight some of the barriers to equity of healthcare access for women of the global majority. It has also highlighted some areas where research could be improved upon in future.

These considerations for clinical practice and future research are detailed in Table 2.

Table 2. Recommendations for services and future research

<p>Recommendations For Services</p>	<ul style="list-style-type: none"> • Services should strive to reduce service users' anxiety during long wait times. This could be done through earlier meetings with therapists and opportunity to choose an alternative therapist if they prefer. Regular communication about the length of their wait would help reduce uncertainty. • Ensuring ethnicity data is recorded appropriately will help to aid future evaluations. This could be done by ensuring that data is routinely collected and that this is self-reported by service users and is recorded accurately. • Having more formal methods of referral within the service may help to highlight decision making processes which could help ensure that these processes follow anti-racist practice. • Outreach efforts to raise awareness of the perinatal mental health service and the therapies available would likely be beneficial.
<p>Recommendations For Future Research</p>	<ul style="list-style-type: none"> • More flexible and less intrusive methods of data collection might increase levels of participation, such as anonymous questionnaires. • To better explain the differences in equity of access to psychological therapy in this project, services could attempt to record and analyse the differences in missed appointments, appointment cancellations (from both service and service user), the number of contracted therapy sessions offered/completed.

Appendix 1. Interview Schedule

Coming into the service

What were your expectations of the perinatal mental health service?

(prompts: Had you heard of this type of service before? What did you know about it/ or expect it to be like?)

What was the process of coming to the service like?
Who referred, any barriers, delays.

How easy/difficult was it to come to therapy here?

How open was the service, did you feel like you had choices? How much were you included in the decision about being put forward for therapy?

Being in the service

What support did you receive/ How did the service help you?

What did you like about the care you received?

What could have been better about the care you received?

Do you have any ideas for how the perinatal mental health service could be improved?

Have you accessed other forms of support outside of the service? How do these compare?

Culture specific

To what extent did you find the service to be culturally sensitive?

Is this a service you would recommend to other mothers from within your culture?
Why/why not?

To what extent [did your therapist?] take cultural similarities/differences into account?
Did you talk about those differences? How helpful was it? How was it?

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