University of Southampton

Faculty of Environmental and Life Sciences

School of Psychology

An exploration of factors influencing Parents from Minoritized Ethnic backgrounds views and experiences of accessing perinatal mental health services in the UK

by

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Abstract

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The first chapter is a systematic review exploring barriers to accessing perinatal mental health services for parents from Minoritized Ethnic Backgrounds in the UK. Searches were conducted on three databases and six studies met the inclusion criteria. A thematic synthesis was performed on the data and seven overarching themes were identified. The findings suggest that parents from Minoritized ethnic backgrounds experience barriers across various levels, particularly an individual level and structural level. Education and training are needed for both patients and professionals in understanding perinatal mental health, the impact of culture and ethnicity on this, and best practice in attending to cultural differences to reduce barriers to accessing perinatal mental health services.

The second chapter is an empirical paper exploring Black parents' views on accessing perinatal and/or maternal mental health services. Semi-structured interviews were conducted with sixteen parents; with one interview being conducted with a married couple. The data was analysed using thematic analysis and four overarching themes were identified. Black parents' weigh up a range of factors when considering accessing perinatal mental health services or not, this can be influenced by views and interactions with family and friends, as well as interactions with healthcare professionals, both of which have positive and negative elements. Greater collaboration between the Black community and healthcare professionals is needed, to identify how the needs of Black parents; in the context of perinatal mental health, can be met in a culturally safe and sensitive way in perinatal mental health services.

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Research Thesis: Declaration of Authorship

Print name: Melanie Nyamaah Osafo

Title of thesis: An exploration of factors influencing Parents from Minoritized Ethnic backgrounds views and experiences of accessing perinatal mental health services in the UK

I declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. None of this work has been published before submission

Signature: Date:10/06/2024

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Last but most definitely not least...To my amazing friends and family...I honestly can't begin to put into words how grateful I am for you all. Thank you for being part of every step of this Doctorate journey, all the ups and downs! You have all been so patient and understanding, and my biggest cheerleaders on the days the end felt so far away! Your love, encouragement, calls, messages, prayers, and support in all sorts of ways have carried me through. I wouldn't be where I am without you all. I hope I have made you all proud! WE DID IT!

And to my dear loved ones who are no longer here with us...This is for you x

To God Be The Glory!

Preface

The primary researcher has chosen to adopt the use of language and terms such as ‘Black people’, ‘the Black community’, ‘Minoritized Ethnic Backgrounds’ or will refer to specific descent such as African or Caribbean throughout the report. However, for accuracy and clarity, additional descriptions and terms referred to in previous research will also be used, such as ‘Black, Minority Ethnic Groups’ (BME) or Minority Ethnic Groups (MEG). Furthermore, whilst the use of words such as ‘women/woman’, ‘mother/maternal’ and ‘father/paternal’ will be adopted throughout this report, due to this commonly being used within the perinatal field and research, the researchers are aware that individuals may or may not identify with such terms.

Chapter 1 What are the barriers to accessing perinatal mental health services in the UK for Parents from Minoritized Ethnic Groups? A systematic review

Journal Specification: This paper was prepared in line with the guidance specified in the "PLOS Mental Health" journal (see Appendix H)

1.1 Abstract

10-20% of women experience perinatal mental health difficulties, including postnatal depression and postpartum psychosis. Women from "Black and Minority Ethnic (BME)" backgrounds are at a greater risk of perinatal mental health difficulties and are reported to experience greater barriers to accessing perinatal mental health services.

The aim of the review was to explore the barriers to accessing perinatal mental health services in the UK for Parents from Minoritized Ethnic Backgrounds.

Searches were conducted in the following databases: CINAHL, MEDLINE and PsychINFO. Reference lists of included studies were also hand searched to identify studies. Six studies met the inclusion criteria, and thematic synthesis was adopted to analyse and summarise the data.

Seven overarching themes were identified; 1. Lack of awareness, knowledge and understanding of perinatal mental illness and professional support, 2. Family and cultural expectations of mothers and women mean no capacity to acknowledge being depressed, 3. Stigma, shame and dismissive perceptions of perinatal mental illness, 4. Fear of negative consequences of accessing perinatal mental services, 5. Lack of cultural awareness, knowledge of mental health and ethnically diverse representation, 6. Reliance on non-professional forms of support and treatment, 7. Overcoming Barriers.

Barriers to accessing perinatal mental health services occur across various levels. Education on understanding perinatal mental health difficulties and how to access support is required for parents from Minoritized Ethnic backgrounds in the UK. There is a need for organisations and policy makers to acknowledge and deliver culturally appropriate and sensitive care, to improve barriers to accessing services. Future research is needed to explore the experience of perinatal

mental health difficulties and potential barriers to accessing services for men/fathers from Minoritized Ethnic Backgrounds.

1.2 Introduction

1.2.1 Perinatal Mental Health

Perinatal mental health (PMH) problems such as anxiety, postnatal depression and postpartum psychosis affect 10-20% of women during the perinatal period (the duration of pregnancy and the first year after birth) in the UK. (1, 2) 5-10% of fathers are also reported to experience mental health difficulties during this period. (3) Factors such as a lack of social support, socio-economic deprivation, loss of a child and other trauma; including racial trauma, are thought to contribute to the risk of developing perinatal mental health problems. (4-7)

1.2.2 Perinatal Mental Health and Ethnicity

There are ethnic disparities in perinatal mental health and ill-health worldwide. Women from “Black and Minority Ethnic Groups” (BME) are reported to be at greater risk of experiencing perinatal mental health problems. (8-10) Factors such as migration and racial discrimination are thought to contribute to the increased risks. (1, 10, 11) The Delivering Race Equality in Mental Health Action Plan (12) discuss ways to improve access to and the experience of engaging with mental health services for individuals from “BME” backgrounds, which involves actively working with “BME communities” and ensuring care that is provided is equitable, non-discriminatory, and culturally appropriate to meet the community needs, and reduce inequalities.

1.2.3 Consequences of Perinatal Mental Illness in parents from Minoritized Ethnic Backgrounds

Perinatal mental illness has multiple negative physical and psychological consequences, especially when left untreated. Mental ill health is reported as one of the leading causes of maternal mortality during the perinatal period. (13) Furthermore, the MBRRACE-UK report (13) highlights that maternal mortality is four times higher in women from “BME” ethnic backgrounds in comparison to women from White ethnic backgrounds. Black and Minority Ethnicity has been deemed a risk factor for maternal mortality. (14) Women from Minoritized Ethnic Backgrounds are also reported to be disproportionately affected by perinatal mental health difficulties and physical difficulties. (8,15) Not only does maternal perinatal illness impact the mother physically and psychologically, but there are also increased risks for the wider family. For example, untreated maternal mental illness such as postnatal depression, is associated with infants' cognitive, emotional, and physical development. (16,17) Furthermore, maternal mental ill health is associated with an increased risk of perinatal mental illness in fathers, which also has a negative impact on infant health and parent-child interactions. (1, 18)

1.2.4 Perinatal Mental Health Services

The NHS Long Term plan (3) highlights the risks illustrated above and discusses ways these will be addressed. For example, it specifies a plan and specific target for 75% of women from "BAME" backgrounds to receive continuity of care throughout the perinatal period, as this is expected to improve clinical outcomes. Furthermore, both the NHS Long term plan (3) and the NHS Implementing the Five Year Forward View for Mental Health report (19) plan to improve and increase access to specialist perinatal mental health support/services in England, providing evidenced based assessments and care, including evidenced based psychological interventions to support women. This is particularly important as it has been noted that women have reported that support offered in primary care is not specialised and sufficient. (2) Given what is known about risks of maternal health on the wider family, there are also plans to offer fathers/partners mental health support and family interventions. (3)

1.2.5 Previous research

Despite plans to improve and increase access to specialist perinatal mental health services for parents from Minoritized Ethnic Backgrounds, there are barriers to accessing such services. These barriers exist across four levels; individual (for example, the lack of awareness and knowledge of mental ill health and services), organisational (lack of continuity of care), sociocultural (lack of cultural appropriateness and understanding), and structural (lack of clear polices addressing barriers). (9, 21-24) There are ethnic disparities in access to specialist perinatal mental health services. Women from Minoritized Ethnic Backgrounds or "BME" groups, are reported to experience greater barriers to accessing perinatal mental health services, yet are more likely to experience involuntary hospitalisation, particularly for women from Black African, Asian, and White other backgrounds. (23, 25) Barriers to accessing services often result in less use of specialist perinatal mental health services for women from Minoritized Ethnic Backgrounds, rather than service use being the main or sole issue. (23)

Whilst previous research has explored barriers to accessing perinatal mental health services, there are limitations. For example, much research has solely reported barriers for women accessing perinatal mental services. Given what is known about the impact of maternal mental health on fathers'/partners' mental health, it is important to account for barriers to accessing services for partners/fathers and the wider family. There is also limited research looking at organisational and structural barriers. (24) The theory of planned behaviour (26, 27) describes how human behaviour, for example help-seeking behaviour, is based on an individual's intention to perform specific behaviours, and this intention is impacted by three main factors: an individual's perceived behavioural control – this being their confidence and perceived ability to perform a behaviour, personal attitudes – the beliefs and appraisals of the said behaviour, and subjective norms – the sociocultural norms around performing a behaviour. (26, 27) Therefore, it is important to gain an understanding of how these three factors impact help-seeking and access to perinatal mental health services, as barriers to accessing services may be influenced by the above. Hence, service user perspectives on barriers to accessing perinatal mental services are also required, (23) as research has often reported through the lens of healthcare professionals. Better understanding of barriers to accessing perinatal mental health services from a service user perspective could help identify and target specific actions to improve access and help-seeking, (24, 28) which is a key aim of the current review.

There are ethnic disparities in the prevalence of perinatal mental health difficulties, and subsequent access to perinatal mental health services (8-11), however there is sparse research addressing this. Reviews have started to identify and address the gaps in the literature on experiences of accessing perinatal mental health services for individuals from Minoritized Ethnic Backgrounds in the UK and Europe, (9, 23, 24) and have explored and amalgamated findings of experiences of mental ill health and access to mental health services, and factors influencing help seeking for individuals from Minoritized Ethnic Backgrounds across the UK. (23, 24) These reviews have reported only few barriers for women from Minoritized Ethnic Backgrounds, for example language barriers, the absence of cultural competence in healthcare professionals/services, and the potential negative impact of not having access to professionals from the same ethnic background. (9, 23, 24) Crucially, UK healthcare services and systems are unique, and these reviews have not limited their focus to women from Minoritized Ethnic Backgrounds in the UK. The health system in the UK, known as the National Health Service (NHS), is a government funded (mainly through general taxation) and managed service, providing health care that is mostly free at the point of access, with some exceptions. The delivery and management of the UK's health system therefore differs to many other European countries, hence the importance of this review focusing on the UK. Moreover, as highlighted earlier in the review, the NHS Long Term Plan and the Mental Health Implementation Plan outlined actions and goals to improve access to and the quality of perinatal healthcare, including perinatal mental health care, for mothers, partners, and families, with specific targets for women from "BAME" groups. Given that previous reviews were published before these plans were introduced, the present review seeks to explore how/whether the introduction of these plans and their targets have impacted the reported experiences of barriers to accessing perinatal mental health services specifically in the UK. Hence, an understanding of what is and is not known of experiences of parents from Minoritized Ethnic Backgrounds in the UK, specifically about barriers to accessing perinatal mental health services, is required, and this is the focus of the current review. The review seeks to address the gaps in research and identify ways to improve access to perinatal mental health services. Therefore, our review aimed to explore the following question:

What are the barriers to accessing perinatal mental health services in the UK for parents from Minoritized Ethnic Groups?

1.3 Materials and Methodology

The review is reported in line with the PRISMA guidelines for systematic reviews (29) and was pre-registered on PROSPERO (Registration number: CRD42023404743).

1.3.1 Search Strategy

The primary researcher searched three databases: CINAHL, MEDLINE and PsycINFO. The searches were undertaken on 17/03/2023. The search strategy consisted of a variation of the following keywords/terms: (1) barriers to access, (2) perinatal period, (3) mental health services, (4) Minoritized Ethnic Groups and (5) Parents (see table 1) The primary researcher then hand-searched reference lists of the included studies to identify further relevant papers to include.

Table 1.1. Search terms and strategies

Search Number	Search term	Search strategy
1	Barriers to access	Barrier* OR Obstacle* OR Difficult* OR Issue* OR Challenge* OR Problem* OR Hurdle* OR Obstruct* OR Access* or entry
2	Perinatal	Perinatal OR Pregnan* OR Antenatal OR Postnatal OR Maternity OR “Pre-natal” OR “post natal” OR “peri natal” or “ante natal” or postpartum

3	Mental health service	(Service* OR “health service*” OR treat* OR interve*) N1 (“Mental health” OR “Mental illness*” OR “Mental health condition*” Or Psych*)
4	Minoritized Ethnic Groups	“Minoritis?ed ethnic group*” OR “Minority Ethnic*” OR “Ethnic minort*” OR “Black and Minority Ethnic” OR “BME”, OR “Black, Asian and Minority Ethnic” OR “BAME” OR Global majorit* OR “racial* minorit*” or “people of colo?r”
5	Parents	Parent* OR Mother* OR Father* OR Caregiver* OR Maternal OR Paternal

1.3.2 Inclusion/exclusion criteria

Studies were eligible for inclusion if they were qualitative, quantitative, or mixed methods research, published in English. Studies were required to report data from parents who self-identified as being from Minoritized Ethnic Groups, on barriers to accessing perinatal mental health services in the UK. Studies were excluded if they did not contain primary data and did not consist of participants from Minoritized Ethnic Backgrounds/groups from the UK. Studies were not excluded on the basis of publication date.

1.3.3 Study selection

To determine whether papers were eligible for the review, two reviewers screened and assessed the retrieved papers. The first reviewer was the primary researcher, and the second reviewer was a voluntary research assistant. The two reviewers independently screened the titles and abstracts of all the papers retrieved.

The two reviewers then independently assessed the full texts of all the retained papers against our inclusion/exclusion criteria to determine their eligibility. Discrepancies regarding eligibility of papers were discussed and resolved together.

Whilst the study was designed to include qualitative, quantitative, and mixed methods research, identified quantitative studies and the quantitative aspects of mixed method studies, were excluded. This was because these studies did not consist of primary data looking at barriers to accessing perinatal mental health services for parents from Minoritized Ethnic Backgrounds. For example, some of these papers were systematic reviews, (9, 30), (31) looked at the relationship between ethnicity and mental health prevalence as opposed to barriers to accessing perinatal mental health services, and the quantitative aspect of (32) a mixed method study, looked at the feasibility and acceptability of a CBT based intervention (not specified as an intervention from a perinatal mental health service) for British Pakistani mothers with mild to moderate depression, therefore these papers were excluded, as illustrated in the PRISMA diagram (see appendix A). Hence, only qualitative studies were retained in the review.

1.3.4 Quality appraisal method

All papers meeting the inclusion criteria were critically appraised independently by two reviewers using the 10-item Critical Appraisal Skills Programme (CASP) checklist tool for qualitative research. (33) Outcomes and discrepancies were discussed and resolved between the two reviewers.

1.3.5 Data extraction

The following data were extracted from the studies: author(s), date of publication, study title, study aims, study design, setting, sample size, inclusion/exclusion criteria, participants' demographics, data collection, data analysis and key findings (see table 1.2.).

1.3.6 Data synthesis

Thematic synthesis (34) was used to analyse and summarise the data from the included studies. All study findings from the studies labelled as study findings or results were transferred verbatim into Nvivo 12 software. Findings were then synthesised following the stages outlined by Thomas and Harden (34):

- *Stage one: line-by-line coding* - The primary researcher read the findings/results sections of each paper and coded each line according to their content and meaning.
- *Stage two: development of descriptive themes* – The primary researcher looked at the similarities and differences between the codes, to then group them into descriptive themes.

- *Stage three: generating analytical themes* – The descriptive themes were then reviewed, analyse and re-themed, by taking the key review question into consideration, to ensure that these analytical themes were a true representation of the findings and implications.

1.4 Results

1.4.1 Quality Assessment

All studies received a minimum quality rating of 8/10 and can therefore be considered as having high quality in most domains. The main domains studies were deemed to have lower quality on, were researcher reflexivity, as some studies failed to consider and address the relationship between the researcher and participants. Furthermore, whilst all studies confirmed ethical approval, it was felt that further details of how ethical issues were taken into consideration would have been useful in two studies. Lastly the final item on the checklist explores how valuable the research is, and there were concerns regarding the generalisability of findings in three studies. Percentage agreement between the two raters was 66.67%. There were no papers that were excluded based on their quality ratings, given that the domains of the assessment tool are not derived from empirical evidence. (35) Furthermore, given the vast range of qualitative methods and variations in methodological strengths and limitations, the tool and associating research provides more of a general assessment and guidance of factors to consider when including or excluding papers. (35)

1.4.2 Study characteristics of included studies

The characteristics of the six included studies can be seen in table 1.2. Three of the papers specified were qualitative studies. Two papers identified as mixed-methods studies, and one paper did not specify its design. No studies included men; participants recruited in the studies were all women. Participants ages were not specified, however all but one study reported that participants were aged 18 and over. The number of participants recruited in the studies ranged from 12 to 42. Participants ethnicities were specified as Black Caribbean, British Pakistani or Self-identified as being from a Minority Ethnic Group.

One study was conducted in South London, two studies were conducted in Northwest England, one was conducted in the North of England and two specified being conducted in Manchester. Further contextual details of where the studies were conducted include a large teaching hospital and community clinics (*n* = 3), community setting's including a "Black majority church hall" (*n* = 1), participants' homes (*n* = 1) and via telephone (*n* =1). All studies conducted interviews; with one utilising focus groups interviews. Three studies adopted a thematic analysis, two adopted a framework analysis and one did not specify its method of analysis.

Figure 1. PRISMA Diagram (see Appendix A)

Table 1.2. Data extraction table (study characteristics and findings)

Author(s)	Study Aim(s)	Study Design, Data collection and Analytic approach	Setting	Sample Size	Inclusion/Exclusion Criteria	Participants' Demographics	Key Study Findings
Edge (2008) (36)	To explore, in depth, Black Caribbean women's beliefs about perinatal depression and the inter-relationship between their beliefs and attitudes to	Qualitative study using in-depth interviews. Thematic Analysis.	Northwest of England, United Kingdom	12	Inclusion: self-identified as being of White British or Black Caribbean origin (at least one parent of Caribbean origin), were aged 18 years or older, capable of self-completing the EPDS. Exclusion:	Black Caribbean women	Two main themes: (1) Social and structural barriers to help-seeking; (2) Personal barriers to help-seeking

	help-seeking for symptoms of perinatal depression. It also sought to explore the impact of Black Caribbean women's experiences of engaging with healthcare professionals on their help-seeking practice				Women were excluded from the study if they were taking psychotropic medication. Those who had experienced stillbirths or perinatal deaths were also excluded.		

Edge (2011) (37)	To examine stakeholder perspectives on what might account for low levels of consultation for perinatal depression among a group of women who are, theoretically, vulnerable.	Qualitative study using focus group interview. Framework analysis.	Northwest of England, United Kingdom	42	Inclusion: Self-identification as 'black Caribbean' and being aged 18 or over.	Black Caribbean women	Two main themes: (1) Experiences of current services and barriers to care; (2) Alternative models of care

Edge, Baker and Rogers (2004) (16)	To estimate the prevalence of depressive symptoms during and after pregnancy among black Caribbean women compared to white British women in the same geographical area, and to explore black Caribbean women's beliefs about	Mixed-method, longitudinal cohort study using interviews. Thematic analysis.	Manchester, United Kingdom	12	Inclusion: Of White British or Black Caribbean origin, aged 18 years or older, did not have a learning disability, were not receiving treatment for serious mental illness, were literate in English.	Black Caribbean women	Two main themes: (1) Factors which mediate between adversity and diagnosis with depression; (2) Factors which influence help-seeking for depressive symptoms

	perinatal depression and their attitudes to help-seeking.						
Edge and Mackian (2010) (38)	To examine prevalence and psychosocial risks for perinatal depression among Black Caribbean women. The study also sought to explore	Data collected using in-depth interviews. Study design and analytic approach not specified.	North of England, United Kingdom	12	Not specified	Black Caribbean women	Two main themes: (1) Approaches to help-seeking; (2) Structural and professional barriers to receiving help

	women's models of help-seeking.						
Khan, Lovell, Lunat, Masood, Shah, Tomenson and Husain (2019) (32)	This study presents British Pakistani women's experiences of depression, their explanatory models about depression, and their views about the type of help they may find acceptable, through in-	Mixed-Methods Feasibility study using in-depth interviews. Framework analysis.	Central Manchester, United Kingdom	15	Inclusion: British Pakistani mothers aged 18 years and above, scoring ≥12 on EPDS Exclusion: Women diagnosed with physical or learning disability, postnatal or other psychosis or actively suicidal.	British Pakistani mothers	Three main themes: (1) The perceived causes of maternal depression; (2) Previous help sought for maternal depression; (3) The type of help needed for maternal depression

	depth interviews.						
Pilav, De Backer, Easter, Silverio, Sundaresh, Roberts and Howard (2022) (8)	To explore minority ethnic women's experiences of access to and engagement with perinatal mental health care.	Qualitative research design using semi-structured interviews conducted via telephone. Thematic analysis.	South London, United Kingdom	18	Inclusion: Self-Identify as being from a Minority Ethnic Group (Black, Asian, or any other minority ethnic backgrounds, including White Other). Under the care of the community perinatal mental health service. Over 18yrs of age at the time of recruitment.	Women who self-identified as being from a Minority Ethnic Group (Black, Asian, or any other minority ethnic backgrounds, including White Other)	Three main themes generated: (1) Expectations and Experiences of Womanhood as an Ethnic Minority; (2) Family and Community Influences; (3) Cultural Understanding, Empowerment, and Validation

1.4.3 Findings (Themes)

The thematic analysis identified seven overarching themes with additional subthemes.

Table 1.3. Summary of themes

Overarching Themes	Sub-themes
1. Lack of awareness, knowledge and understanding of perinatal mental illness and professional support	
2. Family and cultural expectations of mothers and women mean no capacity to acknowledge being depressed	
3. Stigma, shame and dismissive perceptions of perinatal mental illness	3.1 Fear of stigmatisation 3.2 Perinatal mental health difficulties dismissed and normalised
4. Fear of negative consequences of accessing perinatal mental services	
5. Lack of cultural awareness, knowledge of mental health and ethnically diverse representation. *(Organisational, socio-cultural and structural barriers)*	5.1 Practical barriers 5.2 Professionals' dismissal and lack of knowledge of perinatal mental health presentations 5.3 Lack of cultural awareness, sensitivity and representation
6. Reliance on non-professional forms of support and treatment	
7. Overcoming Barriers	7.1 Building on existing support systems 7.2 Family and community group approach

1. *Lack of awareness, knowledge and understanding of perinatal mental illness and professional support*

Several studies identified participants' lack of awareness, knowledge and understanding of perinatal mental ill-health personally as well as within their community, as a barrier to accessing perinatal mental health support and services. (8, 16, 36, 38) Participants described a lack of understanding of what perinatal mental health conditions such as postnatal depression are, thus being unable to recognise or understand what this may look like within oneself or within others. (16)

> "I don't know, I don't know what postnatal depression is ... I don't know what postnatal depression is supposed to be, how you're supposed to feel, look or whatever, I don't know. I have no idea. (Respondent 9)" (16)

The lack of understanding of perinatal mental illnesses also stemmed from the fact that participants felt this was not something they had observed within their communities. (36, 38)

> "I'm just going by what I've seen on chat shows. I keep thinking 'what do they mean they're depressed, what do they get so depressed about?' I mean, I've never met a Black person who's said they've got it [postnatal depression] (#5)" (36)

Participants felt that being unfamiliar with mental health conditions in the community; particularly within the Black community, and being unable to recognise it within themselves, thus impacted help seeking behaviour, (38) i.e., making it less likely to seek and access support.

> "I'm not saying it's [depression] totally a White person's thing. I think it is amongst Black people but it's just that it's unheard of…Therefore they're not going out there to seek help, are they?…if they haven't recognised that there is a problem [they're] not going to seek help. (Participant 9)" (38)

2. *Family and cultural expectations of mothers and women means no capacity to acknowledge being depressed*

Women described the cultural and family expectations of being a mother, which meant they were unable to accept or acknowledge mental illness or consider engaging with support for perinatal mental health difficulties, as is it assumed that once this role of a mother has been ascribed to, this should be the focus and priority. (8, 38)

> "... it's quite a matriarchal society and therefore you've got to cope. You've got to sort your family out, and so therefore you are not allowed to be depressed. (Participant 7)" (38)

Women also felt a sense of shame and loss for experiencing mental health difficulties in the context of motherhood; a period they should be enjoying, which further prevented them from wanting to access support. (8)

> "I felt hugely, hugely ashamed of how I was feeling, and that stopped me from accessing services. And I don't think that's necessarily the Arabic culture influencing that, I think that's just the culture of motherhood (Participant 13, Arabic)" (8)

Women also felt that it was culturally unacceptable to access professional support for perinatal mental health difficulties and reported that family members could directly deter or stop them from accessing professional support if they were aware of what it was for. (8, 32)

> "...the whole thing of having a psychiatrist and therapy and all that is not...in that culture that is...you have to be a strong person... (Participant 9, Arab) (8)

> "I mean if my husband finds out that this is a group for (depressed) women, he's not going to let me come to it." (P11) (32)

Participants reported an emphasis on expectations and narratives of Black women to be perceived as "strong", thus anything that would indicate "weakness" such as perinatal mental health difficulties, (8, 36) was unacceptable. Black women therefore felt the need to uphold the title of being "strong Black women", despite not always feeling "strong". (8, 36) Concerns about how they would be perceived by others was therefore a barrier to accessing perinatal mental health support/help-seeking.

> "But I was worried about how I was going to be perceived ...there's always a thing about being a strong black woman, and sometimes that's not always the case [of how you feel]. We're not as strong as society expects us to be. (Participant 12, Black British)" (8)

3. *Stigma, shame, and dismissive perceptions of perinatal mental illness*

Participants described the stigma and shame associated with perinatal mental illness. Two subthemes were identified.

3.1. Fear of stigmatisation

Women described a great sense of fear of the stigma and negative connotations/perceptions of mental health; both within their communities and general society, which presented as a barrier to accessing support. (32, 36, 38)

> "I think there's a stigma as well... about failure and not being able to cope. The whole word 'depression'... it's got such negative connotations... So perhaps that actually keeps us from actually going to ask for help." (Participant 12) (36)

Some women felt that the experience of mental health difficulties would bring shame to their families. (32) Women also stressed the importance of having to give or maintain "good" or positive impressions" (30, 33) despite experiencing difficulties. Thus, resulting in them hiding their mental health difficulties. (32, 36)

> "There is lot of stigma about mental health and concerns about the community grapevine. This largely relates to the concept of 'Izzat' meaning family honour that is very important in Pakistani families. Keeping face and maintaining the family honour results in a lot of things being kept hidden and a need to maintain appearances within the community and thus issues such as mental health problems can be covered up." (32)

3.2. Perinatal mental health difficulties dismissed or normalised

It was suggested that both within the healthcare context, and within social networks, depression or mental health difficulties were viewed as normal or a "natural" response to childbirth and various other hardships, as opposed to being an illness that would require formal treatment (16, 36, 38) This affected attitudes to accessing support.

> "Women's accounts also suggested that they may regard depression as the natural sequelae of dealing with adversity in their everyday lives rather than legitimate illness." (38)

The general normalisation of mental health experiences impacted the explanations and terminology women used to describe their difficulties. Some women would dismiss the idea of presenting problems such as depression completely, providing alternative explanations for their difficulties or downplaying the severity of experiences, (8, 16, 36) and seeking professional support only when their difficulties had reached a significant point (8)

> "...there were strong social imperatives to normalise and minimise distress. This might account for women's reluctance to use the word 'depression' during interviews. Instead, they preferred to use terms such as feeling 'down','flat' or 'low'." (36)

Participants felt their mental health concerns and difficulties were often dismissed by health care professionals; particularly in primary care settings, as well as by family members, and described how this exacerbated their difficulties. (8, 37)

> "They [my family] would just say... 'there's nothing wrong with you, you have such a beautiful life, you have a child, you have a nice husband, you have a nice house and you're a beautiful girl, so what is wrong with you?' I used to hear a lot of comments that were very hurtful. (Participant 14, Black British)" (8)

4. Fear of negative consequences of accessing perinatal mental health services

There appeared to be both a general fear of negative outcomes, and a fear of specific negative outcomes that could arise following engagement with perinatal mental health services, (8, 16, 32, 36-38) for example social care involvement, child removal (8, 32) or diagnoses of "serious" mental health conditions, (16) which would impact women's likelihood of seeking professional support. Black Caribbean women specifically identified ethnicity as a key factor contributing to such negative outcomes. (16)

> "Ethnicity was the primary source of a deep-seated fear of contact with mental health services, which made them [Black Caribbean women] reluctant to seek help. Unlike their white counterparts, these women believed that contact with mental health services, including those in primary care, would have an inevitably negative outcome." (16)

A fear of being "labelled" with mental illnesses was expressed, particularly for Black women. (16, 38) It was felt that these labels may result in them being treated differently by others and further negative consequences. (38)

> "... it's just that you don't want to be labelled...I certainly haven't told other people ... because I don't want them to label me. They treat you differently and I think that makes you worse. (Participant 7)" (38

Participants also expressed concerns about medication being readily offered as treatment for mental health difficulties as opposed to alternative forms of support. (8, 37) Participants felt that medication was not a useful method of treatment to address mental health difficulties, and were thus reluctant to disclose difficulties to professionals, due to fears of this intervention. (32, 36, 37)

> ' ... one of my friends got really depressed ... [her] GP offered her antidepressants and she refused ... all they are interested in is giving you drugs. They don't really give you

> social support. It's not about, "what are your needs?" It's about "how much can I drug you? Do you need sleeping tablets? Do you need antidepressants?".' (Community woman 20) (37)

Participants expressed a fear of becoming reliant on medication, (8) as well as fears of further complications that may arise as a result of being on medication. (37)

> "I was scared of taking the medication because I just didn't want to be on something that I'm going to rely on... It took me months to actually start those anti-depressants. I was taking one or two and then stopping completely and being scared" (Participant 9, Arab) (8)

It was evident that the fear of negative consequences was one not only held by participants themselves, but also by family members who therefore discouraged participants from accessing support from perinatal mental health services (8)

> "Participants who identified as Black or Mixed ethnicity spoke of family members discouraging disclosures about mental health for fear of the implications, such as social care involvement and removal of their baby at birth." (8).

5. *Lack of cultural awareness, knowledge of mental health and ethnically diverse representation.*

Five subthemes were identified and are described below.

5.1. *Practical barriers*

Studies described structural barriers relating to the practicalities of being able to access perinatal mental health support from services, for example long waiting times/lists, and the lack of childcare. (32, 36, 38)

> "You have to have someone to look after your baby. So who am I going to get to look after [baby]? You know, my family aren't here, she's being breast fed as well (#7) (36)

Participants expressed the pressure of having to seek support themselves through self-referrals, which is difficult to do when actively experiencing mental health difficulties. (8)

> "I think the service is amazing once you're in it, but doctors [General Practitioners] are very reluctant I found, when you're pregnant. The doctor I saw initially referred me to [a mental health charity], you have to self-refer which doing yourself is not easy. Then you wait for a call, then an interview, it's all difficult to do when you're in a bad place. (Participant 5, British Asian)". (8)

5.2. Professionals' dismissal and lack of knowledge of perinatal mental health presentations

There was a shared felt sense of professional (typically GP) dismissal of/ disregard towards experiences of perinatal mental health difficulties, (36, 38) which consequently had a negative impact on participants willingness to engage with perinatal mental health services. This was particularly evident for those already ambivalent and opposed to psychiatric diagnoses and treatment. (38)

> "He [GP] says 'you're not depressed...' He said 'you're doing too much, you're doing far too much'...He said, 'you're not depressed' He said, 'will you stop thinking you're depressed?' He said, 'I will send you for counselling'. He said, 'if you want to go counselling so you can talk, but you are not depressed'. He was saying I wasn't depressed, I was doing too much and running myself down. (Participant 1)" (38)

Limited resources and capacity in services was also a barrier to accessing mental health support, as participants felt unable to raise concerns about their psychological wellbeing, in the context of professionals appearing too "busy" to facilitate such discussions. (37)

> "...the health visitor said something like, "you know in this community we have to look after a thousand and something babies" and that instilled in me the feeling like "oh they are very busy these people and I don't have to be bothering them all the time". So sometimes when you think of just calling them for something, you don't.' (Community woman 6)" (37)

Participants also described issues with the nature of discussions and support offered by health care professionals. This often seemed to be solely focused on the infant's health, with no opportunities for the mother to discuss and reflect on personal needs, specifically their mental health needs. (36, 37)

> "Furthermore 'I remember when she [health visitor] came to my place ... she only talked about my baby — nothing about me. So I was thinking "maybe it's nothing to do with the mothers, it's just about the baby". So, in my mind ... if your baby is not well you can ring them, but nothing about you.' (Church attender 5) (37)

Women described how professionals' lack of awareness of perinatal mental health conditions, such as perinatal depression, can pose as a barrier to receiving professional support. Some women described how they have socially learned to mask or minimise their physical or emotional difficulties (8, 36) for reasons such as the fear of negative consequences of accessing professional support, which some professionals seem be oblivious to. (36) This may then result in individuals not being referred or signposted to the professional support needed.

> "Went to see the consultant about my hypertension a couple of weeks and when I told him [about health visitor's 'diagnosis'], he said, 'you haven't got postnatal depression. You're too cheerful and bright and laughing'." (36)

5.3. Lack of cultural awareness, sensitivity, and representation

Absence and/or anticipated absence of cultural awareness and sensitivity was a significant barrier to engaging with or continuing to engage with perinatal mental health services, (8, 32, 36) for those who had previously engaged with services/treatment, (32) and those who had not previously accessed services. (36)

> "The counselling was seen as helpful to a certain extent; however, it lacked cultural knowledge and sensitivity which in turn made all three of the participants not attend further sessions." (32)

> "Whilst these women had little or no personal experience of primary care mental health services, they expressed reservations about being able to access culturally sensitive or culturally appropriate services." (36)

Participants felt that the combination of them having learnt to mask their difficulties alongside professionals' lack of awareness of cultural differences in this, may be an additional factor resulting in them not receiving appropriate care and treatment.

> "Participants from Asian backgrounds frequently described being socialised to minimise conventional overt expressions of physical and emotional pain or suffering. This was, at times, reinforced in services by staff not recognising the cultural differences in how pain is expressed." (8)

> Demonstrating knowledge and understanding of cultural differences and illustrating cultural sensitivity, were important factors that contributed to mothers' willingness to engage, as the absence of this would result in subsequent needs not being understood and met appropriately. (8, 36)

> "Understanding cultural differences is a big thing. In our society in Bangladesh, we are just with partner, we accept a lot of things which are not accepted in British society so

> if my counsellor doesn't understand, they [the counsellor] cannot help me" (Participant 4, British Asian)". (8)

Participants expressed concerns regarding the lack of representation of professionals from the same or similar ethnic background as themselves. (8, 38)

> "With the perinatal, with culture... if you was a black lady with mental health, maybe you wouldn't want to talk to a white girl...you think white privilege is there and as a black lady you think: does she understand? Does she get me?" (Participant 17, Black British)". (8)

Participants suggested the importance of and a preference for professionals from the same/similar ethnic backgrounds, who they feel would demonstrate cultural sensitivity and would understand their experiences. (8, 32, 36, 38)

> "You need someone who's on the same wavelength as you, who shares the same cultural experiences as you, which sometimes isn't available. I wouldn't wanna particularly unburden myself to some White woman, if I'm honest about it. And that's the bottom line. It's about having someone who you can chat to who understands where you're coming from (Participant 12). (36)

6. Reliance on non-professional forms of support and treatment

Some women preferred to use non-professional alternative forms of support and treatment; those they were personally familiar and comfortable with, or those they felt were more culturally appropriate, to manage/counter their mental health difficulties instead of/prior to accessing formal support and treatment from mental health services.

Black Caribbean women described a strong obligation to personally manage or cope with mental health difficulties and exhaust all resources in this way, before seeking social support if required, followed by professional support as a last resort. (36) They would involve medication, only when self-management and social support have not worked, (37, 38) and/or if the consequences of the difficulties are impacting their children and family. (38)

> "it's about where you get the strength from to cope, within your structure before you actually go to the GP. It's in the home. It's from your mates and your family circle and stuff like that. (Participant 12)". (38)

Great emphasis also was placed on women seeking support from religious or spiritual sources during times of difficulty and the usefulness of this, as opposed to professional support, even for those who did not regularly practice a faith. (8, 16, 32, 36, 38)

> "They were therefore disinclined to seek help from mental health providers…. Most prominently, there was evidence of seeking and receiving help from spiritual and religious sources and from their peers. Drawing on earlier (predominantly childhood) experiences, some women sought solace in private prayer and meditation." (38)
>
> "…. the support brought me through it, believe me—the support pulled me through it! There's no doubt about it! I was reading my Bible and I do follow, like, the Rastafarian faith. (#1)". (36)

7. Overcoming Barriers

Participants described various ways barriers to accessing perinatal mental health services could be overcome, for example through the type of interventions and support offered, and who it is offered to, for example delivering group psychoeducation interventions.

7.1. Building on existing support systems

Studies highlighted the importance of faith, religion, and spirituality as a protective factor for mental health and general life difficulties. (32, 36, 38) The importance of this being known to professionals and policy makers and being implemented into existing interventions was therefore emphasised. (32, 38)

> "Most women showed an interest in exercise, building social networks, practising religious activities, and emphasised that religious activities should be incorporated in modern day psychosocial interventions. The women believed that prior to the onset of depression their faith in religion had helped them to cope better with life difficulties. (32)

Some participants described the positive impact of having support, reassurance and validation from friends and family, peers, and professionals. The formation of trusting relationships was important in order to discuss difficulties, feel justified in doing so, and not feel so alone in their experiences. (8)

> "One thing that was really important to me was that feeling when he [the psychiatrist] kept saying I treat so many people in similar situations…no one talks about it. The reassurance…it makes you feel like this is something that people can go through and you're not the only one. (Participant 5, British Asian)". (8)

7.2. Family and community group approach

Participants described their ideal service provision as those offering groups interventions addressing a range of needs, as opposed to individual treatment. (32, 37) Participants described the usefulness of group approaches, as they provide opportunities for valued community and social support with individuals they can share experiences with; helping them feel less isolated as well as noticing improvements in their emotional wellbeing. (32, 37)

> "I would love that (group treatment), just to share your emotions with people, talk to people because I can't just go out there and talk to anybody. I can't find anyone who can mix with me (P11)." (32)

> "…if it's something minor, you know … create something like this [focus group], where people get together and start talking. It does help. It does uplift you.' (Community woman 2)". (31)

Some women reported the need for culturally adapted and specific interventions, (8, 32) demonstrating "cultural humility" to address and reduce biases and meet the specific needs of individuals from Minoritized Ethnic Backgrounds. Women emphasised the need for this, particularly in the context of support offered to families/partners, as they reported that marital disputes contributed to their mental health difficulties, and thus felt culturally specific interventions for men would be required to support their (men/partners) understanding of this. (32). However, some women suggested the need for multi-ethnic group interventions rather than "mono-ethnic" group interventions, as they felt individuals would feel more inclined and willing to engage, share experiences, receive psychoeducation, and learn from individuals from other ethnic groups, in such groups compared to "mono-ethnic" group interventions. (37)

> "If you sit in a room with all black people, they will all just sit there looking at each other … Even if they were depressed, they would hide it as much as possible. I think we need to integrate with other people … to talk our way through the different experiences that we have. (Community woman 13)". (37)

Participants expressed a desire for a holistic community based, multi-agency approach, which considers the value of informal support in improving mental health; thus, can be equally and effectively delivered by the community. (37)

> "Most women agreed that care and support need not be delivered by professionals; they suggested that community-based support could be an effective mechanism for restoring and maintaining mental health and wellbeing, but perceived that informal care and support is largely ignored and/or undervalued by formal caregivers." (37)

Participants suggested that promoting interventions as education support for families, with an emphasis on positive outcomes for children, would be more accepted in the community, and a useful way to reduce stigma associated with metal health and treatment. (32, 37)

> "...Treatment for depression should be advertised to wider family members as an educational course for positive ways of coping with motherhood and stressing the beneficial outcomes for children. This was important because if the focus is on the child rather than the mother it would be more acceptable to the extended family and the wider community and thus, there will be little stigma attached which could affect the "honour" of the family." (37)

1.5 Discussion

1.5.1 Summary of findings

This systematic review aimed to gain an understanding of barriers to accessing perinatal mental health services in the UK for parents from Minoritized Ethnic Backgrounds, and the findings suggest a range of factors, some in isolation and others combined, that act as barriers. The review included six qualitative papers – none including men, and seven themes were generated. Women highlighted barriers on an individual level including the lack of awareness and understanding of perinatal mental health difficulties, (16, 30, 32) as well as the fear of stigma associated mental health difficulties and how they may be treated negatively by others as a result (32, 36, 38) as key barriers to accessing support from services. For women from Minoritized Ethnic Backgrounds, the fear of stigmatisation does not only occur on a general societal level, but a significant part of this lies within the shame and stigma that exists within their specific ethnic communities, with women feeling concerned about how their families would perceive them if they disclosed perinatal mental health difficulties, as well as how their communities would perceive their family. (32, 36)

(9) describes the experience and fear of double stigma, which impacts help-seeking and access to perinatal mental health services. These fears appear to stem back to the lack of knowledge and understanding of perinatal mental health difficulties within the community. Our findings illustrate the need for education on perinatal mental health difficulties, to support women from Minoritized Ethnic Backgrounds in firstly being able to recognise and understand perinatal mental health difficulties, and secondly feel able to access external support if required. Given what is known about the key role of family and community during the perinatal period, (16, 36, 39) and what the findings highlighted regarding the impact of cultural expectations of motherhood and stigma, (8, 32, 36, 38) it is important for education to not only

be delivered to mothers alone, but interventions should be targeted at a family and community level.

The experience of perinatal mental health difficulties being dismissed or normalised was described as a response from family/community as well as professionals. (8, 16, 36-38) This suggests there is also a need for education on perinatal mental health difficulties to be conducted on an organisational level with the health care providers individuals may encounter during the perinatal period, such as GP's, midwives, and health visitors. Whilst there is not an expectation for these professionals to deliver specialised interventions for perinatal mental health difficulties, there is a duty to have an awareness and understanding of this to signpost to specialised services, as similarly discussed in previous reviews. (9, 24)

Women's fears of negative consequences of engaging with perinatal services made them reluctant to access perinatal mental health services. (8, 16, 32, 36-38) Such negative consequences are thought to be influenced by ethnicity, whereby women from Minoritized Ethnic Backgrounds are more likely to experience such consequences. (16) This is an example of where barriers across levels interact, which to our knowledge has not been addressed in research before, thus requires collaboration between health care providers and service users to identify ways to address and reduce the occurrence/impact of such barriers.

Sociocultural and structural barriers were salient in the findings and has been a longstanding barrier reported in research. (9, 24) Whilst previous research has placed emphasis on sociocultural factors such as language barriers, (24) the present review highlights the lack of and subsequent need for cultural sensitivity and understanding, as well as the need for greater representation of professionals from Minoritized Ethnic Backgrounds, (8, 32, 36, 38) as these needs often go unmet. (36, 37) It is important for culture and ethnicity to be considered at all stages of care, from assessment to intervention, to ensure individual and cultural needs are met, enabling women and families to feel confident in being able to share difficulties without fears of the consequences of doing so, due to a lack of cultural understanding. Furthermore, this helps create a level of trust and reassurance that equitable care and support will be provided. Culturally appropriate and sensitive interventions, which consider cultural values and needs (20) can help reduce stigma associated with mental health and mental health support, and ultimately improve and increase help-seeking and access to perinatal mental health services.

Our findings illustrate what is described in the theory of planned behaviour (26, 27) in relation to factors impacting behaviours, in this case, factors impacting access to perinatal mental health services, and therefore highlights the importance of understanding how these factors may contribute to barriers to accessing perinatal mental health services. For example, themes around participants' lack of awareness and knowledge of perinatal mental health services, as well as professionals' dismissal, lack of knowledge, and the lack of cultural awareness and ethnically diverse representation, impacted individuals' ability to access suitable perinatal mental health services, which is an example of perceived behavioural control. The shame and stigma held by participants regarding perinatal mental illness illustrates the impact of their attitudes towards perinatal mental health and accessing support for perinatal mental health. Finally, the theme describing cultural and family expectations of mothers/women, is an example of how subjective norms in this context can present as a barrier to accessing perinatal mental health services. Whilst the review did not have an explicit focus on identifying facilitators to accessing perinatal mental health services, our results demonstrate the importance of understanding factors that can help overcome barriers. This echoes (28) reflection on the importance of identifying how to improve help-seeking as opposed to solely outlining and focusing on barriers.

A great sense of support to manage during times of difficulty, was described in the context of religious, spiritual and community sources, (8, 32, 38) and it is therefore imperative that services build on and empower such existing support systems. Women also described the role peer group interventions have in reducing isolation and enhancing connectedness. It is evident for that women to feel comfortable and safe to share mental health difficulties and access support, they require support from family, peers and professionals that is validating and free from judgement. (32, 37) Women thus need the time and space to build trusting relationships with professionals. It is therefore important that women from Minoritized Ethnic Backgrounds are able to receive continuity of care before, during and after pregnancy, as suggested in the NHS Long Term Plan. (3)

1.5.2 Strengths and limitations

The screening and selection of papers, as well as the quality assessment stages of the review were conducted by two reviewers independently, highlighting the rigor and trustworthiness of the review. All of the studies used interviews which enabled them to gain in-depth information on participants experiences. The review adds to existing literature, and ongoing understanding and explanations of barriers to accessing perinatal mental health services experienced by parents from Minoritized Ethnic Backgrounds, across various levels, and specifically captures this from a service user perspective, which is key when identifying clinical implications.

The review only consisted of six peer reviewed qualitative studies, which may be a result of our strict inclusion and exclusion criteria, however the papers provided rich in-depth data, enabling the review to draw useful conclusions. Caution must be taken when generalising the findings and drawing implications of the review, as the studies consisted of small samples (participant numbers ranging from 12 to 42) and were conducted in specific regions of the UK, i.e., five out of six studies were conducted in the Northwest region of England, and one study conducted in London. Furthermore, whilst the review aimed to explore barriers for parents from Minoritized Ethnic Backgrounds, only one paper recruited a diverse group of participants who self-identified as being from a “Minority Ethnic Background”. Participants from one study were all British Pakistani women, and the remaining four studies recruited only Black Caribbean women. Moreover, none of the studies reported experiences from the perspective of men/fathers, despite us hoping to gain an understanding of this. The findings therefore report the views and experiences of women from mostly/majority homogenous groups, which may not be representative of the experiences of all Minoritized Ethnic Groups in the UK. Future research should seek to explore the views of experiences from a larger pool of parents from a range of Minoritized Ethnic Backgrounds across the UK, to understand and address the potential varied needs. However, it is important to note that studies (36, 37) purposefully sought homogenous samples, as there is limited research focusing on this.

1.5.3 Clinical and research implications for policy and practice

Perinatal mental health services should consider developing interventions that can include or be facilitated by community leaders/community groups including religious leaders, or family. To reduce stigma and improve said barriers; particularly a lack of knowledge and understanding, and to improve experiences of engaging with perinatal mental health services, services may benefit from developing a reciprocal (or shared)/co-produced learning programme for professionals and services users and community members to exchange education, ideas and understanding of perinatal mental health , as well as reflect on key factors needed to ensure culture and ethnicity are sensitively considered and accommodated for during all stages of engagement with services.

Perinatal mental health services should review the ethnic representation of professionals and identify goals to recruit and represent a diverse workforce. Delivering culturally appropriate and sensitive care should also be a key goal for all professionals and perinatal mental health services to strive for. Producing specific training co-developed by parents from Minoritized Ethnic Groups and other key stakeholders as similarly suggested by (21) and regularly assessing and reviewing specific cultural competencies when assessing and delivering interventions, will therefore be important in achieving this goal. Such competencies should also be initiated on a structural government policy level, to ensure these are actioned in line with additional goals outlined in the NHS long term plan (3) and NHS Mental Health Implementation Plan (19), with a focus on improving access, experience, and outcomes for individuals from Minoritized Ethnic Backgrounds. Factors health care professionals, perinatal mental health services and policy makers should thus consider exploring and/or implementing, to ensure they are delivering culturally sensitive care to parents from Minoritized Ethnic Backgrounds, might include the following:

- Cultural and family norms, practices, and values on childrearing/parenthood/parenting
- Cultural, familial, personal and spiritual beliefs of physical and mental health and how these may influence understandings and management of perinatal mental health difficulties
- Cultural and personal appraisals and interpretations of signs and symptoms of perinatal mental health
- Cultural and personal attitudes towards help-seeking and decision making around healthcare and treatment
- Sources of support (formal and informal) and what influence these may have on help-seeking behaviour
- Previous experiences/knowledge of others' experiences of engaging with perinatal mental health services (including possible experiences of discrimination, microaggressions)
- Consideration of the impact of conscious/unconscious biases
- Preferred or required adaptations/amendments in healthcare settings in line with cultural, personal, spiritual beliefs or needs
- Reflection of how all the above may differ across cultures/families
- Statistics/prevalence of perinatal mental health difficulties and experiences of access to services/treatment across different ethnic groups and the impact of this on parents/families
- Existing/planned cultural adaptations and cultural competency/humility training in services

Whilst the review did not explicitly focus on barriers and facilitators to accessing perinatal mental health support within primary care, several studies referred to their interactions with primary care professionals and the impact this then had on engaging with services. Given that people often first seek support for concerns via primary care services, it will be useful for perinatal mental health services to liaise with primary care settings/professionals to provide education on understanding perinatal mental health, conducting brief assessments and information on signposting to services, as this may be a useful gatekeeping tool, ensuring individuals/families are directed to the correct support, rather than being dismissed.

Regarding research implications, the review highlights that there is still a significant gap in research exploring experiences of accessing perinatal mental health services from the perspective of men/fathers/partners. Given that the NHS Long term plan (3) describes the intention to improve access to perinatal mental health services; specifically for assessment and intervention for partners, it is important that the progress of this is explored, monitored, and reviewed, capturing these individuals' voices. As previously highlighted, reflexivity was poorly considered or, in some of the selected papers, not considered at all, and was an area of low quality in these studies. It is therefore important that future research incorporate and appropriately reflect upon reflexivity when designing, conducting, and reporting research.

1.5.4 Conclusion

The review identified barriers to accessing perinatal mental health services for UK parents from Minoritized Ethnic Backgrounds across individual, organisational, sociocultural, and structural levels. The barriers highlight the need for increased knowledge of perinatal mental health difficulties for parents from Minoritized Ethnic Backgrounds as well as general healthcare professionals and healthcare professionals working within perinatal and maternity services, the importance of support and the need for culturally appropriate services and interventions. The review also highlights the paucity of research illustrating the views and perspectives of fathers/partners on barriers to accessing perinatal mental health services. Therefore, future research should investigate this, to develop a better understanding of barriers, and how these can be addressed in future directions and steps towards improving access to perinatal mental health services. Future directions should consider the co-production of interventions and resources by parents and families from Minoritized Ethnic Backgrounds, additional key stakeholders and healthcare providers.

Chapter 2 An exploration of Black Parents views and perspectives on accessing perinatal mental health services and/or maternal mental health services in the UK

2.1 Abstract

People from Minoritized Ethnic Backgrounds are at greater risk of experiencing perinatal mental health difficulties, and experience greater barriers to accessing perinatal mental health services. Research has begun to explore the views and experiences of mothers from Minoritized Ethnic Backgrounds and the impact of these on accessing perinatal mental health services. Little is known about the experiences of more homogenous ethnic groups, such as Black parents living in the UK. This is important because needs may vary across ethnic groups and better understanding of this may support work with parents from specific ethnic groups with cultural differences.

The study aimed to explore Black parents' views on accessing perinatal mental health services and/or maternal mental health services in the UK.

An indicative topic guide was co-developed with our advisory group and used to conduct semi-structured interviews via Microsoft Teams with 13 mothers and 3 fathers who self-identified as being of Black Ethnicity. Interviews were transcribed verbatim and analysed with our advisory group using reflexive thematic analysis.

Four overarching themes were identified, with additional subthemes: *1. Assumptions, Narratives and Perceptions of Black people, 2. Communication and responsibility plays a role, 3. Negative experiences of perinatal healthcare for Black people, 4. Barriers and facilitators to using in/formal perinatal support.*

Black parents highlighted various factors that influence their views on accessing perinatal mental health services. Co-facilitation and co-production of education and interventions between Black parents and healthcare providers are required to improve Black parents' views and experiences of accessing perinatal mental health services.

2.2 Introduction

2.2.1 Parents' perinatal mental health

The perinatal period (the duration of pregnancy and up to a year after birth) is a time of great change and adjustment biologically, psychologically, and socially. (1) In this period, one in five women experience mental health difficulties; up to 12% of women may experience depression, and 13% of women may experience anxiety, whilst postnatally 15-20% of women may be affected by depression and/or anxiety. (2) Postpartum psychosis also affects between 1 and 2 women per 1000 after birth regardless of psychiatric history. (2)

Maternal and paternal mental health difficulties or illness such as perinatal depression, particularly when left untreated, can pose serious risks and long-lasting consequences to one another's physical and psychosocial health, functioning and wellbeing and predict negative consequences for parent-child interactions, infants'/children's cognitive, physical, and psychological/emotional health and development. (3-10)

Research on perinatal mental health and illness has focused most often on understanding and addressing experiences of mothers/maternal health, the mother-infant relationship, and interventions to support this. (7, 11) However, fathers' mental health is associated with maternal depression, interparental/relationship distress, adjustment to parenthood, increased stress/stressful life events and/or a history of depression. (5, 9) Furthermore, fathers can feel distressed and helpless in the context of maternal mental illness, due to limited knowledge and understanding of mental illness (12) thus support for fathers/partners during this period is just as crucial as support for mothers. The above evidence highlights the experience of maternal and paternal perinatal mental illness and its impact on the family, as well as fathers/partners support as a protective factor for maternal mental health (13) and the subsequent need for fathers/partners and wider families to be included in assessments and treatment where appropriate. (5, 7, 10) Young Black fathers have described feeling excluded from maternity services, (14) and Black men's role as fathers/partners and their involvement in the family has often been negatively stereotyped and stigmatized without exploration, particularly in the USA, (13, 15) however little is known about experiences of mental health and mental health support within families, particularly with Black families in the UK.

2.2.2 Perinatal mental health services

There are various NHS services offering mental health care during the perinatal period, for example community mental health teams or primary care services. There are also specialist perinatal mental health community services in all local NHS areas in the England, offering specialist advice, assessment, support, and treatment to women with mental health difficulties during the perinatal period, as well as those planning a pregnancy (16) and this support is suggested to also be offered to partners, as outlined in the NHS Long Term Plan. (7) It was estimated that by 2023/2024 66,000 women experiencing moderate to severe mental health difficulties, would access specialist perinatal mental health care. (7) Maternal mental health services or maternity outreach clinics are services for women with moderate to severe mental health difficulties, providing psychological support, reproductive health support and general maternity care. (7) Mother and baby units (MBUs) are inpatient services providing care and treatment for women with complex or severe mental health difficulties, allowing them to remain with their baby during this time. (17)

2.2.3 Ethnic disparities in perinatal mental health and access to and use of perinatal mental health services (PMHS)

2.2.3.1 Ethnicity and parents' perinatal mental health:

Black people's experiences of racism, racial discrimination, and racial trauma, across various levels and contexts, in the UK and other high-income countries, contribute to experiences of mistreatment in healthcare settings, being dismissed by healthcare professionals, and pose greater risks to mental health and mortality during and after pregnancy. (18, 19) Maternal mortality rates amongst women from Black ethnic groups are four to five times higher than women from White ethnic groups in the UK. (20, 21) There is a link between social deprivation, mental and physical health inequalities, and ethnic disparities in mortality statistics. (22) Whilst these are important factors to consider, it is also reported that the lack of culturally sensitive and individualised care is a contributing factor to ethnic disparities in physical and mental health inequalities. (22) Partners who provide support and advocate for Black mothers in the context of racism experienced in perinatal mental and physical healthcare, are a protective factor in managing psychological distress. (13) Further information is required on how birthing individuals currently manage or cope with such difficulties, and how they can best be supported.

2.2.3.2 Ethnicity and perinatal mental health support

2.2.3.2.1 NHS Services

Women accessing and engaging with a perinatal mental health services face barriers at four levels to including an individual level (stigma and lack of knowledge of mental health), sociocultural level (language and cultural barriers), organisational (lack of resources to provide support) and structural level (lack of clear policies, assessment tools and pathway guidance). (24, 25). Such barriers are greater for women from “BME backgrounds” who are reported to have poorer access, experiences, and outcomes from perinatal mental health services (24,26-28) which is of concern, as we know that women from Minoritized Ethnic Backgrounds are at a greater risk of experiencing mental health difficulties, and there is a relationship between perinatal mental illness and maternal mortality. (27-30)

Culturally, for some women from Minoritized Ethnic Backgrounds, discussing difficulties and seeking professional support (that is, outside the family) is unacceptable and discouraged. (29, 30). Furthermore, women from Minoritized Ethnic Backgrounds report being less likely to access professional support due to concerns about being prescribed medication as opposed to other preferred forms of treatment such as psychological therapy, holistic approaches, or social support. (27, 31, 32) Black women are also less likely to be referred to secondary healthcare, and the lack of medication adherence can often result in the increased likelihood of involuntary hospitalisation where individuals from Black Ethnic Backgrounds are over-represented. (24, 31)

Service-users and professionals report the absence of cultural awareness, knowledge and understanding in healthcare professionals as a significant barrier to accessing perinatal mental health services for individuals from Minoritized Ethnic Backgrounds. (24, 25, 27, 33) Women from Black Caribbean Backgrounds describe the negative impact of the lack of cultural competencies and sensitivity in understanding and meeting their needs. (31, 34) Healthcare professionals’ such as midwives’ views on providing perinatal care (including mental health) to women from Minoritized Ethnic Backgrounds similarly highlight cultural barriers. They describe how the lack of relevant training and cultural competencies, and the absence of diversity within healthcare professionals impact their ability to provide sufficient quality of care for women from Minority Ethnic Backgrounds (34, 35) and impacts their confidence and competence in detecting perinatal mental health difficulties and identifying the subsequent needs of Black women specifically. (34) Professionals also attributed the lack of culturally sensitive and appropriate care to unconscious biases and racism, having a direct negative impact on delivery of care, and service user experience and perceptions of accessing and engaging with perinatal health care services. (35)

Representation of ethnic diversity in services is required to encourage help-seeking, (35) as well as mandatory training to improve staff cultural awareness, enabling services to deliver support and culturally adapted interventions where required, in a culturally safe and sensitive way, (25, 27, 33, 36) which is evidenced as being more effective for people from Minoritized Ethnic Backgrounds. (37).

The NHS Long Term Plan (7) outlines the need for services to consider ethnicity when supporting families and the importance of providing equitable continuity of care. Services are yet to meet specific needs of individuals from Minoritized Ethnic Groups, and there are issues in the delivery of equitable care, reported by service users and healthcare professionals, (27, 31, 34) which can further exacerbate difficulties and create distrust with healthcare providers.

2.2.3.2.2 Support outside NHS services

Coping with mental health difficulties

Family, faith, and spirituality are often key origins of social support, (26, 27) particularly in Black communities. However, some are more reluctant to seek family or professional support for mental health difficulties due to cultural narratives about mental illness and cultural expectations for Black parents to appear “strong”. (10, 31) Moreover, lack of knowledge about service availability and previous negative health care experiences can also impact professional help-seeking. (25, 37)

Women from Minoritized Ethnic Backgrounds, compared to women from White Ethnic Backgrounds, are reported to be more likely to seek practical and emotional support for perinatal mental health difficulties from family (including partners), friends and faith/religious communities (even for those with no religious associations), and benefit from support from those who have shared similar experiences (peer support networks) (4, 27, 28, 31, 32) than professional support. However, it is important to acknowledge that this is not the case for all women from Minoritized Ethnic Backgrounds, as research highlighted that some women are more likely to downplay their difficulties due to fears of consequences (10, 19, 25, 27, 31, 34, 37) and others preferring to be self-reliant. (27, 31) (31) reported that Black Caribbean women would only seek formal support when their preferred methods of self-reliance, followed by social support from friends and family failed. Some women from Minoritized Ethnic Backgrounds are also reported to be unfamiliar with perinatal mental illnesses and lack the knowledge and understanding to identify and manage such difficulties, and often report being unaware of where to go to access support. (32, 34, 35, 37)

However, it is important to consider that Minoritized Ethnic Backgrounds or BME groups are not a homogenous group, therefore the extent to which barriers impact specific ethnic groups may vary. For example, women from Minoritized Ethnicities in the UK identified barriers to accessing/seeking perinatal mental health support including expectations of other women/mothers, cultural perceptions and the stigma associated with mental illness, as they described the importance of being perceived as strong and able to cope with challenges. (27, 32) Therefore, any indication of mental illness would result in others (with great emphasis on family/the community), viewing them as not as strong, and consequently bad/not good enough mothers. (25, 27) This individual and community level barrier is especially pronounced for Black women endorsing stereotypes such as the “strong Black woman”, (27, 31) where this narrative is also described as historically instilled in Black women to look after their families and overcome adversities such as slavery, racism, and discrimination, (4) and is not a shared experience reported from women from other Minoritized Ethnic Backgrounds.

2.2.4 Limitations of previous research

There is limited research capturing the accounts and experiences of Black parents regarding perinatal mental illness and accessing perinatal mental services. Whilst research has attempted to address this by exploring barriers, facilitators, and experiences of accessing perinatal mental health services for women from Minoritized Ethnic Backgrounds (specifically Black African, Black Caribbean, Asian and White Other Ethnic Groups), there has been a lack of sensitivity in the research of people of global majority, for example, investigating perspectives of “Ethnic Minority” or “Black and Minority Ethnic” heritage as if they are homogenous ethnic groups. (29) highlight the importance of acknowledging and addressing differences between ethnic groups and the importance of thus targeting specific ethnic groups when devising treatment and interventions. Similarly, (19) argue that research focusing on racially homogenous groups is likely to provide better informed understanding of race-specific experiences of perinatal health difficulties.

(31) explored the experiences of perinatal depression and primary mental health service engagement for Black Caribbean women in the UK. To the best of our knowledge, the perspectives of Black women in relation to specialist perinatal services has yet to be well researched. It is noted that whilst this is a “relatively homogenous group”, (34) Black Caribbean women in the UK are typically English speakers and may also have been settled in the UK for a long period of time, the Windrush Generation, and descendants of this generation, therefore may not experience overt barriers such as the language barriers often reported in research. (24, 25, 34) Therefore, it is important that research considers the exploration of the wider Black Ethnic Group, which this present research seeks to do. Whilst previous research has explored the experiences of perinatal mental health, specifically depression, and help-seeking, this has mostly been explored through interviews conducted with Black Caribbean women. (4, 31, 34, 38) (27) explored the experiences of accessing and engaging with a specialist perinatal mental health service in South London, United Kingdom, of women who identified as being from a “Minority Ethnic Group”, this included mothers from the following ethnic groups: Black/Black

British, Asian/Asian British, Arab, Mixed Other, White Other, and reported recommendations and conclusions for working with women from Minority Ethnic Groups, despite the fact that these ethnic groups are not homogenous. Little is known about the experiences of Black women beyond this specific “Black/Black British” and “Black Caribbean” ethnic group, as well as Black fathers’/partners’ views and experiences of perinatal mental health and access to perinatal mental health services. Further understanding of the perspectives of Black mothers/fathers/partners is required. The present research therefore differs to previous research, as it focuses on exploring the views of accessing perinatal mental health and/or maternal mental health services, not only amongst Black Caribbean women, but focuses on exploring the views of parents (both mothers and fathers) who self-identify as being Black (as described in the UK census), to address these gaps in the literature.

2.2.5 Aims of the current study

The present study aimed to explore Black parents’ views and perceptions of accessing perinatal and/or maternal mental health services, and to further understand what factors influence these. To the researcher’s knowledge, this is the first study of Black parents’ voices directly and specifically.

It is hoped that gaining further knowledge and understanding will contribute to ongoing research and initiatives addressing inequalities, and support improving access to, and experiences of, perinatal mental health services for Black parents in the UK. This is particularly important as previous research has mostly focused on the barriers and experiences of women from “Minority Ethnic Groups” broadly or “Black Caribbean” women. The present study thus uniquely focuses on both mothers and fathers who self-identify as Black and their views and experiences within the UK and within the context of the National Health Service in the UK.

2.3 Method

2.3.1 Research Design

A qualitative research design using semi-structured interviews and thematic analysis was adopted to explore Black parents’ views on accessing Perinatal and/or Maternal mental health services.

2.3.2 Participants

Participants were recruited between November 2022 and May 2023 using snowball sampling and volunteer/self-selection sampling, whereby participants independently responded to the study advert and volunteered to participate. Poster advertisements advertising a study for Black parents to share their views on accessing perinatal and/or maternal mental health studies (see Appendix B) were shared via social media platforms. The inclusion criteria were: 1) self-identification as being Black; as described in the UK 2021 Census (Black, African, Caribbean, Black British or Any other Black/African/Caribbean background) 2) resident in the UK; 3) have a child or children age 5 years & under, and/or are currently pregnant; 4) are over age 18 years, 5) are able to communicate their views in English or their native language. (We did not want to exclude participants based on language, therefore independent interpreters to co-facilitate interviews were available on request).

Five did not complete the initial screening questionnaire. One father and one mother were excluded from the research following completion of the initial screening questionnaire as their children were over 5 years old. The final sample consisted of sixteen participants (participant characteristics are described in the results).

2.3.3 Patient and Public Involvement

Stakeholders including perinatal healthcare professionals, adult and child mental health professionals, general healthcare professionals and Black parents with lived experience of mental ill health formed our Patient and Public Involvement (PPI) group. Stakeholders engaged in identifying participant recruitment strategies, developing research posters/advertisement, and revising questions in the interview schedule. The PPI group had an additional active role in the research process by attending and contributing to consultation meetings, where themes were discussed, developed, and refined. This process followed the stages outlined by (39, 40) and involved: searching for/generating themes, reviewing themes, and defining and naming final themes.

2.3.4 Materials/Apparatus

An initial screening questionnaire was devised to capture participant demographic information (see Appendix C). In this questionnaire participants were first asked to report their age, as an aspect of our screening inclusion criteria was that participants were over the age of 18. Participants were then asked to self-described their ethnic and cultural background in free text. This was to ensure participants were given an opportunity describe their identities in their own terms because ethnic and cultural identity can often be assumed and restricted both in day-to-day health and social care interactions and in research, which individuals may not always identify with, and may consequently present as a barrier. Participants were then asked a question on how their ethnic identity is best described from the UK 2021 census categories. Our screening criteria outlined that participants must self-identify as Black, African, Caribbean, Black British or Any other Black/African/Caribbean background, as described in the UK 2021 census categories, therefore responses to this question supported the researcher in establishing whether participants met this criterion. Participants were also asked to confirm that their children were under age 5, as this was an additional inclusion criterion.

The indicative topic guide (see Appendix D) was devised to address the research question.

2.3.5 Procedure

People who contacted the primary researcher to register their interest in participating were sent the research information sheet (see Appendix E) and a unique Qualtrics link that directed them to a consent form (written informed consent) (see Appendix F), followed by an initial screening questionnaire.

Following completion of the consent form and initial screening questionnaire, participants were sent a Microsoft teams invitation for their interview with the primary researcher. All semi-structured interviews were conducted via Microsoft Teams. Participants were asked to provide and confirm verbal informed consent at the start of the interviews. Interviews lasted between 30 and 80 minutes and were audio and video recorded. Participants were reimbursed for their time with a £20 online retailer voucher. Participants were recruited until the research team believed that data (thematic) saturation had been achieved, where no new themes were emerging from the data.

2.3.6 Data Analysis

Interviews were transcribed verbatim and anonymised by the primary researcher before analysis. Transcripts were then uploaded to and thematically analysed in NVivo 12 following (39, 40) methodology. This comprises six iterative stages: familiarisation of the data, generating initial codes, searching for themes, reviewing the themes, defining, and naming the themes and finally, producing the report. Methodological rigour was maintained throughout the data collection and analysis stages, through regular consultation and reflection with the research team and PPI group. This process enabled the primary researcher to discuss and verify final themes.

A reflective log was also used throughout the research process.

2.3.7 Epistemic position

The primary research adopted a critical realist epistemological position. Critical realism combines realist ontology and constructivist epistemology to describe the way in which reality exists through a combination of what is "real" and understood empirically through science, theory, and research, which exists independently of human interpretations, and by what is socially constructed through the beliefs, interpretations, and meanings individuals place on events. (40-43) This epistemological position therefore aligns well with the research, as it in enables the researcher to identify how both components contribute to participants perceptions and experiences of accessing perinatal mental health services for Black parents and can be useful method in identifying ways to address inequalities and bring about change. (43)

The primary researcher identifies as a Black woman of childbearing age and is a trainee clinical psychologist, both working clinically and conducting research, and was conscious of how these identities would interact with and influence the process of the interviews and subsequent analyses. However, by adopting a critical realist epistemological position, the researcher was able to acknowledge and account for ways in which their identity, and external structures and processes may have influenced the research in a reflexive way, which is encouraged in qualitative research, (39, 40) given that the research process itself can be considered a social interaction/event, whereby both participants and the researcher can be influenced by one another as well as existing structures, and thus contributes to their perceptions and interpretations. The primary research reflects further on this in the discussion.

2.3.8 Ethics

The research project obtained ethical approval from the Psychology Faculty Ethics Committee of the University of Southampton, (Ethics and Research Governance Online number: 77410).

Pseudonyms have been assigned to participants, and these pseudonyms are used throughout this paper to maintain the anonymity of participants.

Information was provided on relevant sources of support if required (see Appendix G), for example "The Black, African and Asian Therapy Network".

2.4 Results

2.4.1 Participant demographics

The 16 participants' ages ranged between 26 and 50 years old (*m* = 33.9 years old). With reference to the UK 2021 Census categories, 14 participants described their Ethnic identity as African, and 2 described their Ethnic identity as Caribbean. Table 1 shows the varied self-descriptions participants shared to define their Ethnic identity. Fifteen participants were parents (12 mothers and 3 fathers) to one or more children whose ages ranged between 2 months and 5 years. One participant was pregnant at the time of the interview. None of the participants had accessed a perinatal and/or a maternal mental health service.

Participants were asked about their mental health during and after pregnancy. Four participants reported that their mental health was good during this time. Twelve participants reported personally experiencing mental health difficulties during or after pregnancy, two also reported their partners' experience of mental health difficulties. Of the twelve participants, eight did not seek or access professional support (including from perinatal and/or maternal mental health services). Four participants reported that they sought professional mental health support but did not obtain it. Two participants reported that they were "dismissed". One participant reported that they were unable to attend an initial mental health appointment and were then discharged.

Table 2.1. Participant demographics

Demographic Question/Characteristic	*n (%)*
Age (mean = 33.9)	
26 - 30	5 (31.25%)
31 - 35	6 (37.5%)
36 - 41	3 (18.75%)
42 - 46	1 (6.25%)
46 - 50	1 (6.25%)
Gender	
Female	13 (81.25%)
Male	3 (18.75%)
Self-described Ethnic Identity	

"Black African"	8 (50.0%)
"African Black British"	1 (6.25%)
"Black British – Caribbean"	1 (6.25%)
"Black British"	1 (6.25%)
"Black African – Ghanaian"	1 (6.25%)
"Black African British"	1 (6.25%)
"Black British Ghanaian"	1 (6.25%)
"Ghanaian"	1 (6.25%)
"Jamaican"	1 (6.25%)
Ethnic Identity (Census Category; Black, Black British, African, Caribbean)	
African	14 (87.5%)
Caribbean	2 (12.5%)
Number of children	
Currently Pregnant	1 (6.25%)
1 child	6 (37.5%)
2 children	2 (12.5%)
3 children	6 (37.5%)
4 children	1 (6.25%)

One interview was conducted with a couple (at the request of the interviewees), all other interviews were conducted as one-to-one interviews. We retained and analysed the data from the couple's interview because previous research (24, 25, 27, 30, 45) has highlighted a range of barriers to parents of Minoritized Ethnic Backgrounds in the UK, including Black parents, accessing support, and opportunities to feedback on experiences. We wanted to facilitate their participation rather than be an additional barrier to the couple being able to share and reflect on their thoughts and experiences.

Following analysis of the data, four super-ordinate themes and additional sub-ordinate themes were identified. Each theme and subtheme will be discussed and presented with illustrative quotations.

2.4.2 Themes

Table 2.2. Summary of themes

Super-ordinate Theme	Sub-ordinate Theme
Assumptions, Narratives and Perceptions of Black people	How others view Black people within healthcare settings Black people's internalized perceptions of Black people
Communication and responsibility plays a role	The power of communication Everyone has a level of responsibility
Negative experiences of perinatal healthcare for Black people	Negative experiences of care Fear of negative consequences of engaging with perinatal services
Barriers and facilitators to using in/formal perinatal support	

Theme 1. Assumptions, Narratives and Perceptions of Black people

This theme describes the various assumptions and misconceptions held about Black people, particularly regarding their strength, and how this can negatively impact the quality of care they receive from both non-Black and Black healthcare professionals. The theme highlights the additional layer of such narratives being internalised by Black people themselves, which has an impact on their willingness to seek professional support, as well as Black professionals treatment towards Black service users.

How others view Black people within healthcare settings

Participants described ways non-Black people's negative assumptions and biases about Black people can impact interactions in general society, and the quality of care they, as Black people, receive in healthcare settings. Participants specifically referred to narratives of Black people being seen as physically and mentally strong, and able to manage/tolerate greater physical and psychological pain than non-Black people, thus resulting in their concerns being taken less seriously, with there being a lower threshold for other ethnic groups.

> "I do feel like a Black woman is viewed upon as, she has to be strong, and you know...she wouldn't go through mental health...she must always have this strong armour when it comes to certain things... And this is why I feel like it becomes a... touchy subject when going to the GP...they probably think that I'm supposed to be this strong person, like this strong Black woman. "Like why? Why would I be going through mental health? Like, why would I be, you know, feeling low or stuff like that?" But I think that's just based on my view on how I feel like society has you know, viewed black women. So yeah, I do feel like my ethnicity...Would probably... change the way in which maybe they may view me" Monique

Black people's internalized perceptions of Black people

Participants described how Black people may internalise ideas and expectations of appearing strong, which impacts their likelihood of help-seeking.

> I feel like as a Black woman or it's just very easy for everyone to...kind of just ignore us because we're, there's that label of "I'm a strong independent Black woman"...And naturally as well I feel like we hold that title where we just get things done, we look okay, we're smiling, can do attitude...So it's very easy just to move on when everybody might not even know you're actually struggling." Keisha

Participants reflected on Black men having to be "strong Black men" who support and advocate for their partners but not themselves, as well as the lack of support and stigma around men's mental health.

> "Like if you're Black, especially a Black man. You're seen to be strong and so they shouldn't have any weaknesses in terms of mental health or anything at all. So, it does put a lot of pressure...on me as a Black man, to be able to do some things and obviously not show any sort of vulnerability, if you understand?" Oliver

Participants described experiences of having their concerns minimised by Black healthcare professionals or where they observed differences in the care Black professionals offered to them compared to people from other ethnic groups. Some participants suspected that this may be because Black professionals also internalise narratives of Black parents' strength.

> "I feel like she [a Black midwife] treated me like that because she felt like I'm, like I could handle certain things. I mean. So, if I was White, I don't think she would have treated me like that. I think she would have been a bit more empathetic towards me. But I felt like she just thought, "Oh, like this girl, like you know, like, she's strong", you know. I feel like they have this thing coming from African backgrounds to be strong women, you know. So, I feel like that's what was kind of getting on me at that time. Yeah, I definitely feel it would be different if I was a white lady, 100%" Hazel

Theme 2. Communication & Responsibility Plays a Role

This theme describes the importance and usefulness of communication and information sharing within the Black community when considering accessing support for perinatal mental health difficulties. It emphasises the importance the community place on advocating for, supporting and protecting oneself and other Black parents/Black people (for example the researcher who identifies as a Black woman) to improve their experiences.

The theme also highlights the shared responsibility between healthcare professionals and Black parents in educating one another, as well as seeking further education and training on factors such as understanding perinatal mental health difficulties, cultural differences in understanding and managing perinatal mental health difficulties, and where/how to seek support perinatal mental health difficulties both formally and informally, to improve the experiences of Black parents.

The power of communication

Participants described how within the Black community, the sharing of positive and/or negative experiences, as well as general knowledge and advice about accessing support during the perinatal period, can be a useful tool for Black parents i) when thinking about ii) during the process of accessing and iii) when engaging with informal or formal support, as "word of mouth travels in Black communities".

> "...I think if people [Ethnic Minorities] were able to access these type of programs or somebody put on something... where they could just sit down, other mothers maybe could come and give you some advice or, you know, break down the information and make it a little bit more bitesize, easier to digest, um, I think it would be very helpful for people...Instead of just, what I think Black people do, is just go based on what we've

> seen. So how we were raised, we kind of just pass it on. What we've seen from other families or other aunties, uncles, we pass that on. Whatever we liked from our past or our history or our, you know, childhood, we take those pieces, and we try and put it together, and try and see if that kind of fits for our ideology of how we're trying to do things better as a parent." Nathalie

Eight participants described the lack of communication and support from NHS services offered to men/partners during the perinatal period, and the importance of providing this provision.

> "Maybe someone that my husband could have spoken to outside of me. Because he just felt like everyone was just focused on me and the baby and what we need...So yeah, the father, you know how they're coping, because he really struggled a lot as a new parent, he really struggled more than I thought at the time" Faith

Everyone has a level of responsibility

Participants described the sense of responsibility they feel that have to i) advocate, educate and share their knowledge and experiences of cultural differences and existing inequalities with professionals, ii) to raise their awareness and provide opportunities to learn, and in turn iii) improve experiences for Black parents when engaging with these mental health services/professionals.

> "I think it's about also creating an awareness across communities as well. And I think once we're able to do that, it shows people "oh, there is an actual difference [in the experiences of treatment in healthcare and the needs of Black people compared to other ethnic groups] and then it allows like professionals to see if there is a difference, "actually, what are we doing about it, how are we changing these things you know." Eve

> "...You kind of have to let other people [professionals] be aware, that when it's, maybe for their own good as well, for them to learn...Because they might automatically think, you see a Black Caribbean woman comes into you and you think like, 'yeah, she must have the support of her family'...But I need them to understand that it's not always the same, because of somehow, in some ways we're all brought up differently, which means that certain cultures are not necessarily on board yet with the whole mental health situation." Monique

Participants who were healthcare professionals themselves, reflected on difficult experiences they have heard/observed Black people face, and how this impacts their own willingness to engage with services as services users, and the subsequent responsibility within their professional capacity to decide whether to signpost service users to such services.

> "From what I've seen...um some professionals, maybe not taking you seriously and I, and I've seen it. Sometimes I do think it is down to uh, race? And...This is from my professional...it's all factors into why I would be reluctant ... I'm a Black woman and I've worked with a lot of Black women and their experiences is that, that they don't feel listened to, they don't feel heard too. They are made to feel like they, you know, that they're overexaggerating, you know or they're lying. Those types of things. So, when in context in my professional life, if I know that's how people like me...And just to add more context, I'm a social worker in the Borough that I live in, grew up in right. So, these services... that my service users would be accessing, would be the same exact services that I would access if I was to. So, seeing how they're treated... Doesn't give me much hope." Christina

Participants expressed the need for healthcare professionals and services to engage in mandatory in-depth education and training on working with people from different cultures and ethnicities and understanding the needs of Black families, to learn and identify ways to reduce inequalities and provide equitable care. Participants reported that specific goals and evidence of training/learning would provide reassurance, when thinking about engaging with services.

> "I think um healthcare professional need to all be trained about different backgrounds and different cultures regardless of what their skin colour is and just have some level of understanding. So, when you do approach somebody of a different ethnicity to yourself um... you're in a known about certain things. So maybe certain things that they may say to you, does not come as a surprise...I feel more training needs to be given". Beverley

Participants suggested that the Black community needs education on understanding mental health presentations and where/how to obtain professional support. Participants suggested the responsibility of professionals to provide such information to Black parents, and the importance of ensuring Black men and wider family are also given support.

> "From my point of view from the Caribbean cultures...I feel like it's important...for the families or for people...to be able to have access, because they need to be educated on mental health at a deeper level and maybe even at a surface level... There should be...something to be put in place, where they're educated or know more about mental health. And, you know, the signs and stuff like that because they don't know the signs." Monique

> “Education is always key to be making sure that this, Black men in general, [are] um able to access the services, and also to ensure that they're able to contribute. Because not being able to access the services is one thing, however, not knowing what to do in this situation, um similar to having a breakdown or having any sort of mental health issue, it's another thing, and that might lead to other incidents as well.” Oliver

Participants described the benefits of professionals and services users sharing their knowledge and expertise, to help normalise experiences of mental health difficulties, and support families in receiving support where required.

> “Maybe having like an informative interactive website where there's like a forum…, where people can ask questions, people can talk, people to share their experiences and then also to have like professionals who run that, who maybe answer questions and who maybe like have polls and things like that…Because then you're more likely to be able to get people” Eve

Theme 3. Negative experiences of perinatal healthcare for Black People

This theme describes participants’ reports of their own and/or knowledge of other Black parents’ negative experiences of engaging with healthcare professional/services and this being a shared experience amongst Black people. This theme also describes participants’ fear of these negative experiences and additional negative consequences that may arise for Black parents as a result of engaging with perinatal health services, and how this can therefore contribute to feeling less willing to engage with services.

Negative experiences of care

Participants described that *their* experiences of being dismissed, ignored, silenced or not taken seriously by healthcare professionals, particularly when voicing concerns about their health, are typical experiences for Black people. Some participants felt this experience varied depending on where they reside in in the UK, and/or the location of the hospital they have received care/treatment, with negative experiences or expectations of this being more likely in areas with relatively less ethnic diversity.

> “I honestly have noticed a big difference and that's in the way like professionals are with you…, undermining certain things, like maybe when you have a concern or opinion about something and just not being heard enough. Like our voice is not being heard enough, whereas I've seen people of other … like races or ethnicity and it's something where they’ve said, “oh well we were automatically offered that service straight away or oh we were told about that” Eve

Participants therefore feel the need to and/or have been advised to “exaggerate” their pain, “shout to be heard” or persistently report/be “more vocal” about their concerns regarding their health and/or treatment, to ensure they are heard and taken seriously. However, some participants expressed worry about following this advice, due to fears of being viewed negatively by healthcare professionals, for example being seen as “aggressive” despite their concerns being valid.

> “...basically, screaming from the top of my lungs...that's always the mindset. Wherever, whatever it is, we just exaggerate until they actually take a look at it. Otherwise, they will ignore till it gets worse, and I don't wanna wait for anything to get worse, when it could be alleviated.” Lloyd

> “They might react in a way just like an any other human being would react. But because of maybe your skin colour, it will be perceived as you being aggressive or being disrespectful, but yet, ... when it comes to your child, you're, you're gonna, sometimes you're not in control of how you might react, depending on what the situation may be.” Beverley

Participants described a sense of lack of empathy, compassion and equitable care towards Black people compared to other ethnic groups, and care being provided at different extremities for different ethnic groups.

> “We all know, you know, the White woman comes in crying with... postpartum depression or perinatal depression...and receives a tea, biscuits, and a shoulder to cry on if necessary. Whereas Black people, we usually get ‘mental health? Oh, maybe you need to go to a mental health hospital and you need to seek support there and you need to be put somewhere that someone else can deal with you’” Andrea

There were exceptions to this subtheme as two participants reported positive experiences with perinatal healthcare services, where their ethnicity *was* considered during explanations and management of health concerns, and additional examples of where they felt listened to, and respected by healthcare professionals.

> “I'm in an interracial relationship. My husband is white British. Umm, I guess when I gave birth, my child had jaundice and I would have never known because he's mixed race and I guess mixed race children look yellow when they're first born. So it’s those kind of things where... I had two Black midwives. And they made the experience so amazing for me. I felt so understood and they explained everything in terms of this is what it might look like on this skin colour. And sometimes I would Google something..., I don't know like a rash, what it might look like on a baby. And they all come up with,

> you know, white children. And that's not helpful for me because I don't know what it would look like on my child.” Keisha

Fear of negative consequences of engaging with perinatal services

Participants described fears of negative consequences that could occur for Black parents/families specifically, following engagement with perinatal services for physical or mental health. Participants reflected on being gaslighted and made to feel as though such fears are irrational, despite their own experiences of these negative consequences and/or what they have seen or heard from other Black people and in the media.

Unhelpful social care involvement. Participants expressed concerns about disclosing mental health difficulties, due to fears of being deemed as “not fit to parent”, which would result in actual or threats of social care involvement. Participants described smaller margins of error for Black people, therefore input or “support”, would be more harsh, harmful, and disruptive for Black families compared to non-Black families, for example, children being removed.

> “I think... in my culture... like Black people in general, we don't like medical professionals. Sorry. But we don't like, go to professionals. We're very wary of them... There's a fear that if we discuss our mental health, something will be taken away from us, so therefore you'd be very cautious to go and tell a doctor, your GP, um a health professional, information in regards to mental health in case there was some sort of repercussion of that, i.e. losing your kids, losing your home, having some sort of, I don't know, involvement with something.” Nathalie

Reality of mortality statistics for Black people. Participants reported an awareness of high mortality statistics for Back women and infants during the perinatal period compared to other ethnic groups, and therefore being fearful, anxious and apprehensive about engaging with perinatal services throughout pregnancy, as services feel unsafe for Black parents.

> “The statistics that they've put of how women of ethnicity are treated... they're not taken seriously, they're not listened to...Black...women of ethnicity at risk during their pregnancies because they're not, you know, the care, isn't there...There's documentaries out there. There's everything out there that will, you know, that tell you that these things are going on and not just in this country. Seems like, you know, a lot of Western countries don't seem to take women of ethnicity seriously when it comes to maternal health or just our health in general.” Georgina

Theme 4. Weighing up the barriers and facilitators to using in/formal perinatal support

This theme describes the process Black parents reported going through when trying to identify who/where they can access informal or formal support from for perinatal mental health difficulties, by weighing up barriers and facilitators faced when considering accessing this support, as these have an influence on their help-seeking behaviours.

Barriers

Lack of awareness of perinatal mental health provisions. Participants reflected on their personal lack of awareness and knowledge of where and how to access formal support, and the importance of professionals providing this information and what it entails to help build trust.

> "I didn't seek any support, because at the time I still didn't know how to access, and I didn't, maybe, perhaps it's where, how I was brought up, possibly? That it's very difficult for me to ask for help." Oliver

Cultural and generational differences. Participants described cultural and general differences in the understanding and knowledge of mental illness, how it manifests, presents, and can be managed. Participants reported that the perspectives of some Black communities and older generations, can impact their willingness to seek support due to fears of disproval and judgement, for seeking help and not meeting expectations of being a parent.

> "I held a lot back because the fear of being judged, the fear of being labelled and the fear of being probably being looked at as a bad mum...the fear of getting, being judged by both outside world, and I'm dealing with two older generations. Very, you know, strong African background, that did not also understand what even probably mental health was at the time." Beverley

Participants reflected that culturally, whilst faith and spirituality play a protective role in managing difficulties, some felt that perceptions of mental illness presentations and management through these lenses can deter them from seeking support.

> "Obviously when you're maybe raised in a certain way or you come from certain cultural or religious background, it's very much like, obviously, so I'm Ghanaian, African and it's very much trust in God. Let's believe. Let's you know, let's not rush...And so that could prevent, that actually prevented me accessing a lot of services I'll say from early on or not being so open to it" Eve

Participants expressed that professionals, particularly non-Black professionals', attitudes towards, lack of understanding of, and respect for, cultural and generational differences in child rearing practices, presentations and management of mental health difficulties, and assumptions that the “western approach” is better, was a negative feature of services, because this results in Black families’ fears and reluctance to engage with perinatal healthcare professionals/services. Participants expressed sometimes preferring cultural practices or a balance of both cultures, although sometimes difficult.

> “The consensus is, that a lot of people are coming across non-Black professionals and feel like they're being judged or like they're misunderstood. Feel like you know, they made me all these things, so I don't know if it's like training professionals need, I don't know. But I would say people just need a better understanding of Black women. And like they need to leave, what is it their...unconscious bias.” Christina

Participants also expressed concerns about Black people often being offered medication as treatment, which is not preferred.

> “Yeah, given my experience. I think they wouldn't understand us better. Straight away, start giving you medication.... I think it's based on cultural differences.” Rhoda... “So immediately that is where they jumped to isn’t it... instead of talking, trying to engage you in more talking more conversation, the immediate response is to write medication for you to go and take.” Peter

Participants described having a good understanding and perception of the severity of their difficulties, and adequate personal coping skills to manage rather than requiring external support. However, some participants felt that should they require additional support, they would prefer more informal professional support, due to being unsure of whether formal support would meet their needs.

Facilitators

Representation. Participants described how greater representation of Black healthcare professionals they could identify with, and advertisements of Black people accessing services, would help them feel less fearful and more comfortable, safe, and willing to engage with perinatal mental health services. Participants felt they were more likely to be heard and understood by Black healthcare professionals and gave examples of this.

> “I think with a lot of things it's about representation and like seeing yourself in places where you could seek help...seeing normal Black people that you see every day... if you were to see, like more adverts in relation to, like, accessing mental health services...you would just feel that it's probably a bit more accessible than you originally thought it would be.” Jasmin

Some participants suggested that the lack of representation of Black healthcare professionals could result in Black parents being less likely to engage with services, due to reasons such as fear of negative consequences.

> "I know I personally couldn't do it. I wouldn't wanna be in an environment where I'm the only Person of colour or there's no one of colour working, you know, who understand my experience or can't relate and sort of thing." Georgina

Comfortability, Familiarity and Accessibility. Participants described feelings of comfortability, respect, safety, and trust that they have with family, friends, faith groups and/or support groups, which acts as a facilitator to such informal support. Participants also described relying on friends and family to point out when they have exhausted personal resources and require additional formal support. Some participants however, report familiarity as a barrier to seeking support due to worries about being judged and misunderstood.

> "Comfort and familiarity, first of all...But yeah, just, I seek information from various sources that I have immediate access to. Like Google, like friends, like family, just feels more familiar [than professional services]." Jasmin

Participants reflected on which professionals they have immediate access to and this influencing who/where they would seek professional support.

> "My main person who I go to in terms of mental health would be either my GP or my midwife if I was feeling any sort of um way during my pregnancy, but um, those are the only two people that, that seems to be an access to me at the moment". Monique

2.5 Discussion

2.5.1 Summary of findings

The present research sought to gain an understanding of Black parents' views and experiences of accessing perinatal mental health services. Four main themes were identified, highlighting various factors Black parents' take into consideration, based on personal knowledge and experiences, as well information gathered from others such as friends, when thinking about accessing support for perinatal mental health difficulties.

The theme *"Assumptions, Narratives and Perceptions of Black People"* illustrated how the combination of Black people's internalized view of being strong and others' perceptions of Black people's strength, impacts both the likelihood of help-seeking, and the quality-of-care Black people receive. Fulfilling narratives and "self-concepts" (4, 34) "strong Black woman/man" has been extensively reported as a barrier to acceptance of mental health difficulties and help-seeking. (4, 27, 31, 34) It is thought that Black people have/have had to be “strong” to manage and overcome longstanding adversities such as racial discrimination (4) and uphold expectations of them, (27) which our findings echo. Our findings particularly highlight this for Black fathers, who described needing to be strong for their families, and to advocate for mothers particularly in the context of racism and mistreatment, as well as having to fulfil societal expectations of men being strong, thus not disclosing mental health difficulties, as similarly reported in previous research. (5, 10, 13) Our findings present an important additional factor less frequently reported, this being the impact of others’ assumptions and perceptions of Black people’s physical and psychological strength, and how this can consequently prevent Black parents’ from accessing perinatal mental health services, (19, 27) as they feel their concerns are often being dismissed or not taken seriously.

Experiences of mental and physical health concerns being dismissed by healthcare professionals, as well as what participants deemed as lack of empathy and compassion towards Black parents compared to non-Black parents; as noted in our theme *“negative experiences of perinatal healthcare for Black people”,* contributed to their reluctance to access perinatal mental health services. Parents described having to be more vocal and persistent about concerns, to be listened to and receive adequate care; a process often described as emotionally taxing and disempowering for Black parents. (19, 35) Our findings described potential consequences of this, where Black parents may then be deemed as “aggressive”, creating further barriers to support, however this is yet to be explored in research.

The fear of the consequences of disclosing mental health difficulties and/or engaging with perinatal mental health services for Black people specifically, was also a significant contributing factor to participants’ reluctance. *“The fear of unhelpful social care involvement”* was a prominent theme in this study, which echoes that reported in previous research exploring experiences of perinatal mental health and access to perinatal mental health services. (4, 27, 31, 34, 38) Parents also spoke of fears regarding the high maternal mortality rates for Black women. (20-22) Whilst there is evidence of racial inequalities, for example higher rates of involuntary hospitalisation for women from Black and Minoritized Ethnic Backgrounds (24, 27, 29, 31) as well as higher maternal mortality rates for Black women compared to White women in the UK (20-22) , there appears to be a lack of research and policies addressing such concerns that present as barriers to accessing perinatal mental health services for Black parents’ and families. (22) report that the absence of such policies is a result of the lack of representation of Black women in research.

Our findings compliment and expand on existing literature highlighting barriers and facilitators to accessing perinatal mental health support across various levels, such as individual and structural levels. (25) Parents as well as some professionals' lack of awareness and knowledge of perinatal mental health conditions and services, was key barrier to accessing perinatal mental health services. Where some parents were able to recognise symptoms in themselves and/or partners, the barrier to accessing support was rather not knowing where to access support, as well as the fear of being judged by family and/or professionals, and the implications of this. These findings mirror what has been widely reported in existing research. (4, 18, 25, 30, 32) Both our findings and that reported in previous research therefore emphasise the need for education on perinatal mental health conditions for parents and importantly wider families, as well as education and training for professionals to increase knowledge and reduce stigma (10, 25, 30)

Socio-cultural barriers to accessing perinatal support, have been identified both in previous research (25) and in our findings. Professionals lack of knowledge, awareness and respect for cultural differences in child rearing, understanding and management of mental health difficulties, contributed to participants apprehension and unwillingness to engage with perinatal mental health services, as they felt their needs would not be met and heard in a culturally sensitive and appropriate way (31, 34, 35) This emphasises the need and responsibility of healthcare providers to deliver better culturally informed, sensitive and appropriate practice, demonstrating "Cultural humility" (27, 29) to meet Black parents' needs. Cultural humility refers to the process of an individual's active lifelong commitment to self-reflection, self-evaluation, and self-critique in redressing power imbalances between healthcare professionals and service users.(46-49) Furthermore, it refers to the important shift from a relatively static place of cultural competency, this being the acquired knowledge of different cultures/groups, often obtained through cultural competency training, which can result in biases and stereotyping, to the dynamic process of cultural humility, whereby individuals first actively reflect on and acknowledge their own identities, assumptions, beliefs and biases, in order to adopt an endlessly curious approach to exploring the fluid and intersecting nature of the cultural identities of others. (46-49) The variation in the results obtained from participants' self-described ethnic identity was greater than the variation in responses to participants' ethnic identity described using the UK census ethnic categories (see table 2.1.). This demonstrates that even within communities, in this case the Black community, there are differences in how individuals view their identities and experiences, which further highlights the importance of demonstrating cultural humility when exploring experiences, and understanding different factors that may shape the views and perceptions of accessing perinatal mental health services and doing so by moving away from assumptions of ethnic groups/ethnic identities and their experiences. From a critical realist perspective this also demonstrates the importance of acknowledging what can be considered “real” and objective in ethnic identity and how participants self-describe and construct their cultural and ethnic identities.

Participants described an additional layer to the barrier of cultural differences, this being combination of cultural and generational differences in understanding and managing mental health, and how this can further deter them from accessing both informal support from family or formal support from professionals, due to concerns about being judged and misunderstood. This sheds light on the dilemma some Black parents may face when considering accessing support, as on the one hand, cultural and generational perspectives on mental health do not encourage help-seeking, and on the other hand healthcare providers lack of sensitivity towards culture discourages accessing support. As a result, some participants suggested a preference for relying on their own resources, until these are exhausted. Participants then hold the responsibility of providing some insight and education on the above to others in the community and to professionals to improve their experiences, which can be challenging.

It is therefore understandable why greater representation of health care professionals from Minoritized Ethnic Backgrounds; particularly Black healthcare professionals is described as a facilitator to accessing perinatal mental health support, as participants described feeling safe to share their experiences with professionals from the same/similar ethnic background who have a shared cultural understanding of various factors relating to perinatal mental health presentations and management, as well as their general understanding of perinatal mental health, as this can encourage help-seeking, and support Black parents in hearing and meeting their needs appropriately. (35) However, it is important to acknowledge that whilst the above may be hoped for and expected, such positive interactions cannot be guaranteed, as parents may engage with Black professionals who have particular “*internalized perceptions of Black people”* as described in our first theme, which may result in their needs being unmet.

A key facilitator in accessing support for perinatal mental health difficulties our parents identified, was the *sense of comfortability, familiarity and safety* with family, friends, and faith connections, and for some, a preference for informal social support. Seeking social support and what is considered “positive appraisals” in turning to faith, have been previously described as key coping strategies within Black communities and often thought to be more effective than treatments such as medication, (3) that some Black people are opposed to. (32). However, our findings also highlight the importance of not making assumptions of what support Black parents may have or and prefer, as for some these sources may equally deter parents from accessing formal support, moreover such social support may not always be available for all Black parents for various reasons, and the absence of this can increase vulnerability to perinatal mental health difficulties. (4, 37) For some parents seeking formal support from professionals, they have direct and regular access too, was a key facilitator, which supports the need for greater continuity of care for parents from Minority Ethnic backgrounds in the UK. (7)

2.5.2 Limitations and Strengths

Despite hoping to gain insight on Black parents' experiences of accessing perinatal mental health services, none of our participants had gained access to a perinatal mental health service, despite identifying as having experienced perinatal mental health difficulties. Furthermore, most participants were mothers, and all participants specified residing in South-East England, UK, therefore we do not have an understanding of Black parents' experiences nationwide. Whilst participants were asked to self-describe their cultural and ethnic identity, and select an option from the UK census categories, participants were not explicitly asked about migrant status, despite some participants alluding to different experiences based on this factor. Future research may wish to consider this because migration status is a risk factor for postpartum depression as well additional social determinants/factors that further exacerbate difficulties to accessing services. (27, 35) Migration status may contribute to differences in exposure to education and knowledge on mental health/mental health literacy and service availability in the UK, which may also impact Black parents' views and experiences on accessing perinatal mental health services.

Bias in interpretations is often reported as a limitation when using thematic analysis, and such bias may have presented in the research as the primary researcher was responsible for conducting and transcribing the interviews, as well as coding the data. Furthermore, as previously stated, the primary researcher identifies as a Black woman of childbearing age therefore interpretations may have been influenced by potential explicit and/or implicit resonance with the subject area.

However, a strength of the research and the research process lies within its reflexive approach. The primary supervisor acknowledged their subjectivity, thus shared, and discussed ideas and interpretations through regular supervision and PPI meetings throughout the research process, with hopes of addressing and overcoming potential issues of bias. Perinatal mental health has often been reported as an under researched area, particularly the exploration of experiences from specific communities, i.e., Black Ethnic Group, as previous research has often reviewed experiences "BME groups", despite this not being a homogeneous group. Furthermore, the experiences of fathers/partners and support is also under researched. Therefore, the novelty of the present study directly and specifically focusing on Black parents' voices/experiences, to the researcher's knowledge, is the first study of this kind and is a strength of the research. The study conducted semi-structured interviews using an indicative topic guide co-developed with the PPI group. This enabled the researcher to expand on responses and introduce additional key questions where appropriate, and overall gained rich in-depth qualitative data on the important subject area, with novel findings and useful implications.

2.5.3 Reflexivity

The primary researcher is Black British African woman and is a trainee clinical psychologist. They kept a reflective journal throughout the research process and attended regular supervision. The primary researcher was aware of the possibility of researcher bias in the interview process and/or interpretation, due their personal identity and connections to the subject area, thus felt pressured to prevent this impacting the research. However, during a supervision session where the primary researcher was asked to reflect on the first set of interviews they had conducted so far, the primary researcher became aware that in trying to minimise the possibility of bias, they were rather detaching (or disconnecting) from being present in the research process, and that this was impacting both how they were engaging in the interviews and processing the interview content. During the research process there was also media coverage of various incidents and ongoing investigations of Black maternal deaths. It was apparent that all the above also had an emotional impact on the researcher that they had possibly been avoiding, to minimise its influence on the research. It was thus arranged for the researcher to have additional supervision with an external Black Clinical Psychologist/Research supervisor to support with reflecting on the process and impact of conducting research on a sensitive topic with Black people as a Black researcher, and to enhance their skills of continuing to engage in the research in an authentic way. More frequent research team supervision was also put in place. This enabled to the researcher to feel able to connect to and validate participants experiences where appropriate, whilst acknowledging their own emotions, and transparently interpret interviews both in supervision and their own reflective periods, which the primary researcher felt helped make a difference to the research.

(50) discuss ways of incorporating reflexivity into the research process. This helped the primary researcher acknowledge how they were navigating through their position of being "within" the participant group as a Black woman of childbearing age, whilst also feeling part of the "outsider" group, representing the mental health profession. The researcher noticed the position of power ascribed to them within the interview context, which they initially found difficult due to this dual position. However, they were able to use the position to provide a positive experience to participants, by demonstrating empathy and respect, supporting

participants to feel safe, heard and empowered in sharing their stories and ideas, in a way many suggested may not be the case when engaging with professionals/perinatal mental health services. Being able to connect to and reflect on what can be gained from the research from both positions enabled the primary researcher to immerse themselves in the data from different perspectives, to identify useful implications for professionals and service users.

2.5.4 Implications and recommendations for clinical practice and policy makers

The research provides various useful clinical implications, including specific suggestions identified by participants, to improve access to and the experiences of Black parents engaging with perinatal and or/maternal mental health services.

Our results suggest an important need for informative shared learning spaces or groups between professionals/services and parents or families from Black ethnic backgrounds. Such groups will ideally serve two functions; first, for professionals to have consultation with Black parents to explore their cultures/cultural differences, their experiences of mental ill health, managing mental health, help-seeking and any existing barriers and/or facilitators to accessing perinatal mental health services. This would increase professionals' awareness and understanding of how differences may impact the presentation and management of mental health difficulties. This will also help identify how the needs of Black parents in this context may best be met, in a way which previously has not been considered thoroughly. It will be important for professionals and services to demonstrate openness to learning from the community and to integrate ideas in a community psychology approach, (51, 52) as opposed to making assumptions and dismissing cultural experiences, practices, and values. Second, informative groups will enable professionals and/or community leaders to provide psychoeducation to Black parents, as well as provide parents an opportunity to ask key question about perinatal mental health and managing this. The key topics psychoeducation should cover include:

- General information on mental health and wellbeing during the perinatal period
- What perinatal mental health difficulties are (including common perinatal mental health conditions)
- Warning signs and risk factors for perinatal mental health difficulties, and how to notice/recognise these
- Examples of types of support (formal and informal) and treatment for perinatal mental health difficulties and information on where/how to access this support
- Self-help resources on managing perinatal mental health difficulties

This psychoeducation can be delivered to parents as a couple or individually as part of a one-to-one therapeutic support, as well as informative groups as previously suggested.

Services should also consider the importance of offering support and the above suggestions to both parents and additional family members where appropriate, as participants highlighted the key role of the family during the perinatal period and the importance of them also having support. This is particularly imperative for partners/fathers where there continues to be a lack of support, as well as the societal stigma for men and mental health difficulties, and the additional social and cultural narratives of men needing to be “strong”, and this being further emphasised for Black men. (5, 10, 15, 53) Professionals may need to explore how this can be offered to family members, in a way that they will be receptive, for example one participant suggested describing groups as a place not only for personal support, but a space for them to identify ways to support their family during difficulties.

Whilst services and organisations provide a range of mandatory and optional forms of training focused on equality, diversity, and inclusion, such as unconscious bias training, there continues to be ethnic disparities in perinatal health experiences and outcomes. (20-22) It is thus important that the content of such training and completion of training is regularly monitored and reviewed, and completed with stakeholders, to ensure key information on ethnic disparities in perinatal mental health and how services are/should be addressing this are provided, as well as education on working with different communities. This will also ensure professionals and services are adhering to goals and recommendations for delivering equitable care for parents from Minoritized Ethnic Backgrounds. Services will benefit from liaising with community leaders or organisations who specifically work with/support Black parents and families, and/or those with lived experiences to support with the delivery of training where appropriate. Services should also consider delivering bespoke perinatal mental health training to community leaders, organisations, and outreach peer support groups, that they can be equipped to deliver to parents in the community in informal settings.

Our findings suggest that the issues with access to perinatal mental health services for Black parents occur across various levels, for example and individual level and structural level, as similarly identified in previous research. (24, 25) The findings thus highlight the fact that such issues are not situated within one group, i.e., Black parents/the Black community or healthcare professionals, but rather suggests the importance of marrying the two groups together, acknowledging and addressing key barriers and facilitators that exist within and between both groups, to improve access to and the experiences of engaging with perinatal mental health services for Black parents. Therefore, co-production between the Black community, including community leaders and healthcare professionals are required, enabling healthcare professionals/service to empower community leaders, and for community leaders to provide their knowledge and expertise of the experiences and needs of the Black community. Co-development of resources and materials for individuals, groups, and additional forums such as interactive informative websites, are vital, and it is important that this can be offered in both formal and informal settings. A group forum will also allow parents to share experiences and ideas with one another, which our findings suggest is key as "word of mouth travels in the community", and some individuals may be more receptive to information derived from others' lived experiences.

There is a need for more representation of Black healthcare professionals in the workforce, particularly in perinatal mental health care. Services should therefore consider reviewing representation, explore potential reasons for the lack of representation and identify ways to improve this. However, our findings highlight that it is important to not assume a preference for a professional from the same ethnic background, rather service users should be informed about whether this can be facilitated or not and given a choice where possible, as this may improve their experience of care.

Key take home messages for clinicians and/or service providers:

- Actively strive to move from cultural competencies to cultural humility by individually reflecting on one's own cultural and ethnic identity and consider how differences may impact engagement with Black parents. Identify, acknowledge, and address possible assumptions/biases held about other Black parents/families and other Minoritized Ethnic Groups. This can also be done in clinical supervision and discussion within teams where appropriate.
- Request/attend suitable training on cultural humility, as well as engaging in wider reading and research on this area.
- During consultation and engagement with Black parents, discuss and explore their self-described cultural and ethnic background/identity – including cultural ideas, norms, practices, and values regarding childrearing. It is important to approach this with curiosity and sensitivity, acknowledging what one does/does not know and potential biases.
- During consultation and engagement with Black parents, explore personal and cultural experiences and perceptions of perinatal mental health/ill-health, managing perinatal mental health and engagement with perinatal mental health services. Again, it is important to explore this with sensitivity.

- During consultation and engagement with Black parents and community leaders, explore and identify avenues of social support/networks, the preferences within these networks, and the possible influence/impact networks have on help-seeking.
- Consider migrant status and the impact this may have on social support, and knowledge of the UK health care system – this can be done both directly or indirectly with Black parents and/or community leaders.
- Demonstrate openness and sensitivity to exploring Black parents' experiences of discrimination/microaggressions/racism and health inequalities within perinatal healthcare and reflect on how these experiences could be improved. It is important to approach this with compassion and sensitivity.
- Increase awareness of ethnic disparities in perinatal mental health, consider how this may impact Black parents/families, and explore ways to begin to address this.
- During consultation and engagement with Black parents, explore preferences in care and treatment (e.g., gender, ethnicity, and language preferences), giving choice where possible, with consideration for the importance of continuity of care.
- Regularly review existing policies and training on working with diverse communities with community leaders and service managers/providers to ensure services are equitable.

2.5.5 Future directions

Future research should aim to look at the experiences of Black parents who *have* gained access to UK perinatal mental health services, to explore their views and experiences, to complement our findings from parents who have not. It is important that future research further explore the views and experiences of fathers/partners given what is known about the relationship between maternal and paternal mental health, both identified in previous research, (5,8,9) and our study findings. Consideration of all the above in future research, will enable researchers to identify key factors parents report as barriers or facilitators, to support policy makers and health care providers in improving access to and the experiences of perinatal mental health services.

2.5.6 Conclusion

The study aimed to explore and gain an understanding of Black parents' views on accessing perinatal mental health services and/or maternal mental health services and identified various factors influencing this both on an individual level and organisational/structural level. Our findings highlight the key role interpersonal interactions between Black parents/the Black community and healthcare professionals has in shaping views and experiences of accessing perinatal mental health, thus suggests further collaborative work between Black families and healthcare professionals is required to ensure the needs of Black parents are appropriately met.

Appendix A PRISMA Diagram

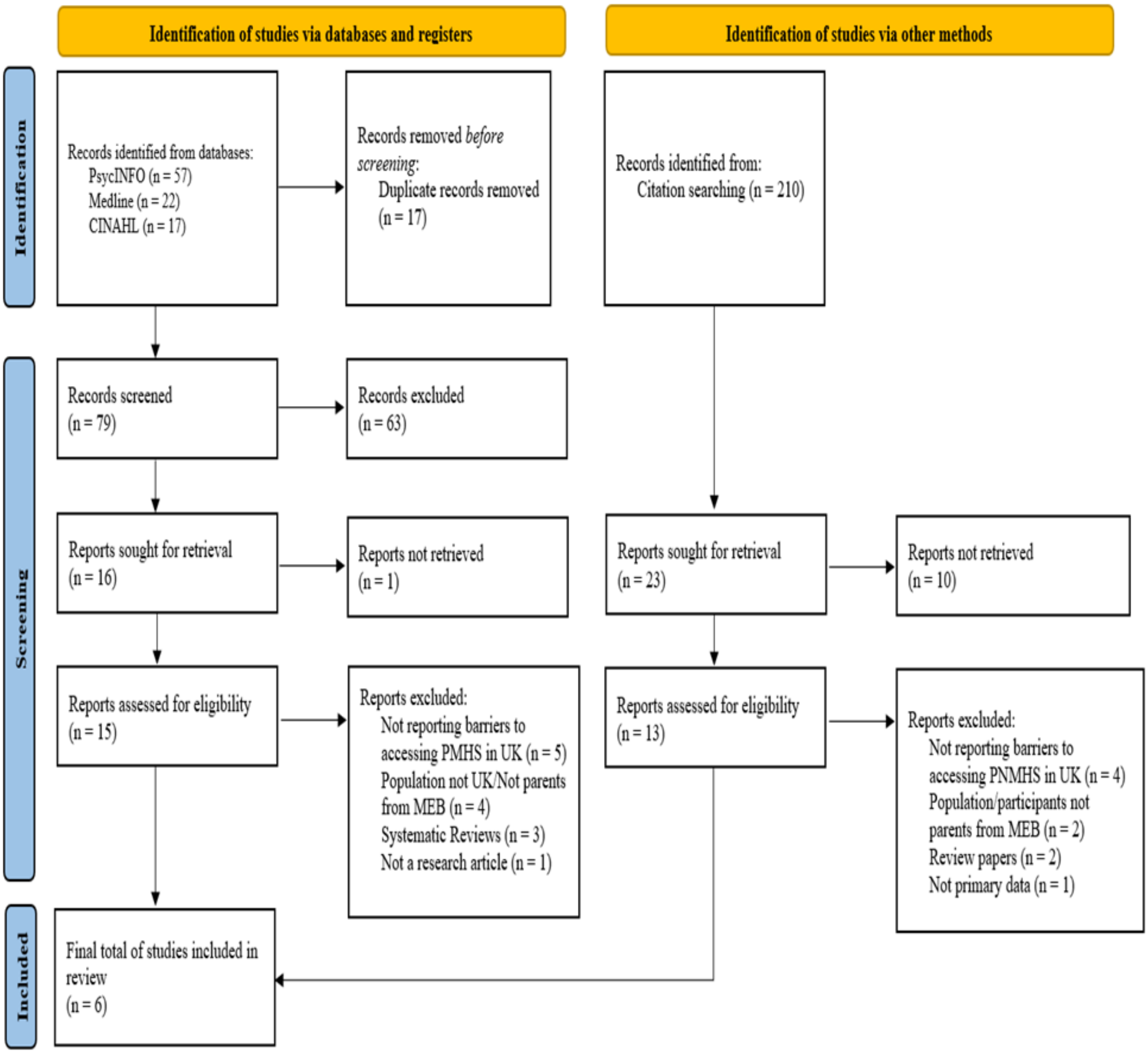

Figure 1. PRISMA Diagram

Appendix B Advert

UNIVERSITY OF Southampton

PARTICIPANTS WANTED FOR RESEARCH

BLACK PARENTS' VIEWS ON ACCESSING PERINATAL & MATERNAL MENTAL HEALTH SERVICES

WHAT IS THIS RESEARCH ABOUT?

WE WANT TO HEAR BLACK PARENTS' VIEWS ON ACCESSING PERINATAL AND/OR MATERNAL MENTAL HEALTH SERVICES DURING PREGNANCY AND AFTER GIVING BIRTH. WE WANT TO UNDERSTAND FACTORS THAT IMPACT OR INFLUENCE THIS.

WHAT WILL HAPPEN?

YOU WILL BE INVITED TO AN ONLINE INTERVIEW
THE INTERVIEW SHOULD TAKE 30- 60 MINUTES
ALL PARTICIPANTS WILL RECEIVE A £20 VOUCHER FOR YOUR TIME

WHO WE ARE LOOKING FOR?

- BLACK MOTHERS AND/OR FATHERS
- YOU HAVE A CHILD OR CHILDREN 5 YEARS AND UNDER
- OR YOU ARE CURRENTLY PREGNANT
- YOU CAN SHARE YOUR VIEWS IN ENGLISH OR YOUR NATIVE TONGUE (WITH AN INTERPRETER)
- YOU ARE OVER 18 YEARS OLD

IF YOU ARE INTERESTED IN SHARING YOUR VIEWS OR WOULD LIKE MORE INFORMATION PLEASE CONTACT:

MELANIE OSAFO
MNO1N20@SOTON.AC.UK

ERGO NUMBER: 77410
VERSION 2, DATE: 30.09.2022

Appendix C Initial Questionnaire

Initial Online Questionnaire

(Version 1, Date: 26/08/2022)

Initial questionnaire to be completed online via Qualtrics

1. How old are you?

2a. How would you describe your cultural and ethnic identity?

2b. From the UK Census categories, which best describes your ethnic identity?
Black, African, Caribbean, or Black British: African, Caribbean, Any other Black, African, or Caribbean background (tick box)

3. How many children do you have?
4. Are your child/children under the age of 5?
5. Have you ever accessed a Perinatal Mental Health Service or Maternal Mental Health Service in the UK for yourself and/or your partner?

6. Do you consent to participating in the interview?

7. What time of day would suit you best, to participate in the interview? Morning, afternoon, or evening.

8. Will you require an interpreter for the interview?

Appendix D Indicative Topic Guide

Indicative Topic Guide

(Version 1, Date: 26/08/2022)

Interview Topic Guide

1. What is your understanding of accessing support during and after pregnancy and how you would access this?
2. If you and/or your partner were experiencing physical or mental health difficulties during or after your pregnancy, who would you go to for support and why?
3. Have you ever accessed support from a mental health service in the UK for yourself and/or your partner whilst pregnant or in the last 5 years? If so, what was this like?
4. What factors would influence you seeking support for yourself and/or partner from a mental health service during and/or after pregnancy?
5. If you have accessed a mental health service, were you asked about your culture and ethnicity? If so, what was your experience of this? (Was this asked sensitively/respectfully?)
6. Do you feel your culture and ethnicity are taken into consideration during and/or after pregnancy by health care professionals/services? And why?
7. Do you think your ethnicity has or would impact your experience with mental health services during and/or after pregnancy?
8. Is there anything you feel would improve access to and/or the experience of Black mothers and/or partners with mental health services, specifically during and/or after pregnancy?

Appendix E Participant Information Sheet

Participant Information Sheet
(Version 2, Date: 30/09/2022)

Study Title: An exploration of attitudes to accessing perinatal mental health and/or maternal mental health services in Black parents in the UK

Researcher: Melanie Osafo
ERGO number: 77410

You are being invited to take part in the above research study. To help you decide whether you would like to take part or not, it is important that you understand why the research is being done and what it will involve. Please read the information below carefully and ask questions if anything is not clear or you would like more information before you decide to take part in this research. You may like to discuss it with others, but it is up to you to decide whether or not to take part. If you are happy to participate you will be asked to sign a consent form.

What is the research about?
I am a trainee Clinical Psychologist conducting this research for my thesis.
The aim of the research is to explore the views of Black parents on accessing perinatal mental health and/or maternal mental health services and to develop an understanding of factors impacting this (i.e., possible barriers and/or facilitators).

Why have I been asked to participate?
You have been asked to participate as the research intends to hear perspectives of Black parents who are currently pregnant and/or have had a child/or children in the last five years.

What will happen to me if I take part?
You will be invited to complete a short questionnaire to ensure that you meet the criteria for the research and to specify the best time of day for an interview.
You will then be invited to participate in an online 1 to 1 interview via Microsoft Teams with the primary researcher, which will take approximately 30-60 minutes. The interview will be audio/video recorded and transcribed by the researcher.

Are there any benefits in my taking part?
This study will support our current understanding of Black parents’ views on perinatal mental health and/or maternal mental health services and will further support the understanding of potential ways to improve the experiences of support for Black Parents during and after the Perinatal period.

You will also receive a £20 voucher as a thank you for participating in the research.

Are there any risks involved?
As the study is exploring issues of a sensitive nature, there could be a possibility of psychological discomfort or distress. If you require support after participating in the research, you can contact your GP or health visitor. The researcher can also signpost you to support services such as The Black, African and Asian Network - https://www.baatn.org.uk/

What data will be collected?
Your personal data such as your name, email address will be collected so we can contact you to arrange and complete the interview, as well as arrange payment.
Data on your demographics, specifically your age and ethnicity will be recorded so we can ensure you meet the criteria of the research, this information will also be useful to report in the research findings, however you will not be personally identified.
The interview will be audio and video recorded, this will then be transcribed into written data and the recording will be destroyed, and you will not be identifiable.

Will my participation be confidential?
Your participation and the information we collect about you during the course of the research will be kept strictly confidential. Your personal information as outlined above, as well as consent forms will be stored in a separate location to data obtained from the interview (non-identifiable data) and will be password protected.

Audio and video recordings will be transcribed, then the recordings will be destroyed. Written transcripts will not have any identifiable information. Each participant will be given a pseudonym, and there will be a separate document in which their name is linked to the given pseudonym.
Only members of the research team will be able to access this document.

If you participate in an interview with an interpreter, the interpreter will sign an agreement form prior to the interview, to confirm that they will maintain confidentiality of the participant and the information discussed in the interview.

All data obtained will be stored on the primary researcher's university Microsoft One Drive and will be password protected, which only those in the research team will be able to access for the duration of the research. As data will be retained for 10 years, the data will be transferred from the primary researcher's OneDrive and stored securely on the supervisors' university network drive once the primary researcher has completed their academic course.

Only members of the research team and responsible members of the University of Southampton may be given access to data about you for monitoring purposes and/or to carry out an audit of the study to ensure that the research is complying with applicable regulations. Individuals from regulatory authorities (people who check that we are carrying out the study correctly) may require access to your data. All of these people have a duty to keep your information, as a research participant, strictly confidential.

Do I have to take part?
No, it is entirely up to you to decide whether or not to take part. If you decide you want to take part, you will need to provide consent via the online consent form, by ticking the relevant boxes and printing your name to show you have agreed to take part.

What happens if I change my mind?
You have the right to change your mind and withdraw at any time without giving a reason and without your participant rights being affected, up to four working days after the interview. You can withdraw from the research by contacting the primary researcher via email.

What will happen to the results of the research?
Your personal details will remain strictly confidential. Research findings made available in any reports or publications will not include information that can directly identify you without your specific consent. You can request to receive a copy of the results.

Where can I get more information?
If you have any questions after reading this information sheet, and would like to discuss further, please contact Melanie Osafo (primary researcher) via email **mno1n20@soton.ac.uk**

What happens if there is a problem?
If you have a concern about any aspect of this study, you should speak to the researchers who will do their best to answer your questions.

Melanie Osafo (Primary Researcher): mno1n20@soton.ac.uk
Dr Pete Lawrence (Supervisor): p.j.lawrence@soton.ac.uk
Dr Tess Maguire (Supervisor): t.l.maguire@soton.ac.uk

If you remain unhappy or have a complaint about any aspect of this study, please contact the University of Southampton Research Integrity and Governance Manager (023 8059 5058, rgoinfo@soton.ac.uk).

Data Protection Privacy Notice

The University of Southampton conducts research to the highest standards of research integrity. As a publicly-funded organisation, the University has to ensure that it is in the public interest when we use personally-identifiable information about people who have agreed to take part in research. This means that when you agree to take part in a research study, we will use information about you in the ways needed, and for the purposes specified, to conduct and complete the research project. Under data protection law, ‘Personal data’ means any information that relates to and is capable of identifying a living individual. The University’s data protection policy governing the use of personal data by the University can be found on its website (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page).

This Participant Information Sheet tells you what data will be collected for this project and whether this includes any personal data. Please ask the research team if you have any questions or are unclear what data is being collected about you.

Our privacy notice for research participants provides more information on how the University of Southampton collects and uses your personal data when you take part in one of our research projects and can be found at http://www.southampton.ac.uk/assets/sharepoint/intranet/ls/Public/Research%20and%20Integrity%20Privacy%20Notice/Privacy%20Notice%20for%20Research%20Participants.pdf

Any personal data we collect in this study will be used only for the purposes of carrying out our research and will be handled according to the University’s policies in line with data protection law. If any personal data is used from which you can be identified directly, it will not be disclosed to anyone else without your consent unless the University of Southampton is required by law to disclose it.

Data protection law requires us to have a valid legal reason (‘lawful basis’) to process and use your Personal data. The lawful basis for processing personal information in this research study is for the performance of a task carried out in the public interest. Personal data collected for research will not be used for any other purpose.

For the purposes of data protection law, the University of Southampton is the ‘Data Controller’ for this study, which means that we are responsible for looking after your information and using it properly. The University of Southampton will keep identifiable information about you for 10 years after the study has finished after which time any link between you and your information will be removed.

To safeguard your rights, we will use the minimum personal data necessary to achieve our research study objectives. Your data protection rights – such as to access, change, or transfer such information - may be limited, however, in order for the research output to be reliable and accurate. The University will not do anything with your personal data that you would not reasonably expect.

If you have any questions about how your personal data is used, or wish to exercise any of your rights, please consult the University’s data protection webpage (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page) where you can make a request using our online form. If you need further assistance, please contact the University’s Data Protection Officer (data.protection@soton.ac.uk).

Thank you for taking the time to read this information sheet and considering taking part in the research.

Appendix F Consent Form

CONSENT FORM

(Version 2, Date: 30/09/2022)

Study title: An exploration of attitudes to accessing perinatal mental health and maternal health services in Black parents in the UK

Researcher name: Melanie Osafo
ERGO number: 77410

Consent form to be completed online via Qualtrics

Please tick the box(es) if you agree with the statement(s) or N/A if not applicable:

I have read and understood the information sheet (Version 2, Date: 30/09/2022) and have had the opportunity to ask questions about the study.	
I agree to take part in the interview as part of the research project for the purposes set out in the participation information sheet and understand that these will be recorded using audio/video/written notes.	
I understand that taking part in the study involves audio/video recording *which will be transcribed (written in full) and then destroyed* for the purposes set out in the participation information sheet.	
I understand my participation is voluntary and I may withdraw *(up to four working days after the interview)* for any reason without my participation rights being affected.	
I understand that I may be quoted directly in reports of the research but that I will not be directly identified (e.g. that my name will not be used).	
I understand that any personal information collected about me, will not be shared beyond the research team. However, if an interpreter is present during the interview, they will know my name, but no additional personal information. *(Interpreters will also complete an agreement form to confirm that they will maintain confidentiality).*	
I can confirm that I have discussed the content of the information sheet and consent form with an interpreter and have had the opportunity to ask questions.	

I confirm that I have read and agree to the statements I have ticked above.	
Please tick (check) this box to indicate that you have read and understood the information on this form, are aged 18 or over and agree to take part in this study.	

Name of participant (PRINT NAME) ……………………………………………………………………………

Appendix G Participant Debrief

Debriefing Form
(Version 2, Date: 30/09/2022)

An exploration of attitudes to accessing perinatal mental health and maternal mental health services in Black parents in the UK

ERGO ID: 77410

The aim of this research was to explore the attitudes of Black parents to accessing Perinatal mental health and/or Maternal mental health services and to develop an understanding of factors impacting this (i.e., things that help gain access and/or possible barriers).

This research will not include your name or any other identifying characteristics. The research did not use deception. You may have a copy of a summary of the research findings once the project is completed. This can be requested via email at the end of the research.

If you have any further questions, please contact
Melanie Osafo - mno1n20@soton.ac.uk
Dr Pete Lawrence - p.j.lawrence@soton.ac.uk
Dr Tess Maguire - t.l.maguire@soton.ac.uk
Dr Hannah Wilson - hannah.wilson@southernhealth.nhs.uk

Thank you for your participation in this research.

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the University of Southampton Head of Research Integrity and Governance (023 8059 5058, rgoinfo@soton.ac.uk).

If this research has caused any psychological discomfort or distress, please seek support from your GP or your health visitor. If you are interested in identifying further areas for support, please see the link below:
The Black, African and Asian Network - https://www.baatn.org.uk/

Appendix H Author Guidelines

PLOS Mental Health Author Guidelines

Style and Format

File format	Manuscript files can be in the following formats: DOC, DOCX, or RTF. Microsoft Word documents should not be locked or protected. LaTeX manuscripts must be submitted as PDFs. Read the LaTeX guidelines.
Length	Manuscripts can be any length. There are no restrictions on word count, number of figures, or amount of supporting information. We encourage you to present and discuss your findings concisely.
Font	Use a standard font size and any standard font, except for the font named “Symbol”. To add symbols to the manuscript, use the Insert → Symbol function in your word processor or paste in the appropriate Unicode character.
Headings	Limit manuscript sections and sub-sections to 3 heading levels. Make sure heading levels are clearly indicated in the manuscript text.
Layout and spacing	Manuscript text should be double-spaced. Do not format text in multiple columns.
Page and line numbers	Include page numbers and line numbers in the manuscript file. Use continuous line numbers (do not restart the numbering on each page).
Footnotes	Footnotes are not permitted. If your manuscript contains footnotes, move the information into the main text or the reference list, depending on the content.
Language	Manuscripts must be submitted in English. You may submit translations of the manuscript or abstract as supporting information. Read the supporting information guidelines.
Abbreviations	Define abbreviations upon first appearance in the text. Do not use non-standard abbreviations unless they appear at least three times in the text. Keep abbreviations to a minimum.
Reference style	PLOS uses “Vancouver” style, as outlined in the ICMJE sample references. See reference formatting examples and additional instructions below.

Manuscript Organization

Manuscripts should be organized as follows. Instructions for each element appear below the list.

Beginning section	*The following elements are required, in order:* • Title page: List title, authors, and affiliations as first page of the manuscript • Abstract • Introduction
Middle section	*The following elements can be renamed as needed and presented in any order:* • Materials and Methods • Results • Discussion • Conclusions (optional)
Ending section	*The following elements are required, in order:* • Acknowledgments • References • Supporting information captions (if applicable)
Other elements	• Figure captions are inserted immediately after the first paragraph in which the figure is cited. Figure files are uploaded separately. • Tables are inserted immediately after the first paragraph in which they are cited. • Supporting information files are uploaded separately.

Title page

The title, authors, and affiliations should all be included on a title page as the first page of the manuscript file.

Abstract

The Abstract comes after the title page in the manuscript file. The abstract text is also entered in a separate field in the submission system.

The Abstract should be succinct; it must not exceed 300 words. Authors should mention the techniques used without going into methodological detail and should summarize the most important results.

While the Abstract is conceptually divided into three sections (Background, Methodology/Principal Findings, and Conclusions/Significance), do not apply these distinct headings to the Abstract within the article file.

Do not include any citations. Avoid specialist abbreviations.

Introduction

The introduction should put the focus of the manuscript into a broader context. As you compose the Introduction, think of readers who are not experts in this field. Include a brief review of the key literature. If there are relevant controversies or disagreements in the field, they should be mentioned so that a non-expert reader can delve into these issues further. The Introduction should conclude with a brief statement of the overall aim of the experiments and a comment about whether that aim was achieved.

Materials and Methods

The Materials and Methods should provide enough detail to reproduce the findings. Submit detailed protocols for newer or less established methods. Well-established protocols may be referenced.

Results, Discussion, Conclusions

These sections may all be separate, or may be combined to create a mixed Results/Discussion section (commonly labeled “Results and Discussion”) or a mixed Discussion/Conclusions section (commonly labeled “Discussion”). These sections may be further divided into subsections, each with a concise subheading, as appropriate. These sections have no word limit, but the language should be clear and concise.

Together, these sections should describe the results of the experiments, the interpretation of these results, and the conclusions that can be drawn.

Authors should explain how the results relate to the hypothesis presented as the basis of the study and provide a succinct explanation of the implications of the findings, particularly in relation to previous related studies and potential future directions for research.

PLOS Mental Health editorial decisions do not rely on perceived significance or impact, so authors should avoid overstating their conclusions. See the *PLOS Mental Health* Criteria for Publication for more information.

Consult our reporting guidelines, and include an ethics statement in the Materials and Methods section when reporting results from human subjects research and animal research.

Acknowledgments

Those who contributed to the work but do not meet our authorship criteria should be listed in the Acknowledgments with a description of the contribution.

Authors are responsible for ensuring that anyone named in the Acknowledgments agrees to be named.

References

Any and all available works can be cited in the reference list. Acceptable sources include:

- Published or accepted manuscripts
- Manuscripts on preprint servers, providing the manuscript has a citable DOI or arXiv URL.

Do not cite the following sources in the reference list:

- Unavailable and unpublished work, including manuscripts that have been submitted but not yet accepted (e.g., “unpublished work,” “data not shown”). Instead, include those data as supplementary material or deposit the data in a publicly available database.
- Personal communications (these should be supported by a letter from the relevant authors but not included in the reference list)

- Submitted research should not rely upon retracted research. You should avoid citing retracted articles unless you need to discuss retracted work to provide historical context for your submitted research. If it is necessary to discuss retracted work, state the article's retracted status in your article's text and reference list.

Ensure that your reference list includes full and current bibliography details for every cited work at the time of your article's submission (and publication, if accepted). If cited work is corrected, retracted, or marked with an expression of concern before your article is published, and if you feel it is appropriate to cite the work even in light of the post-publication notice, include in your manuscript citations and full references for both the affected article and the post-publication notice. Email the journal office if you have questions.

References are listed at the end of the manuscript and numbered in the order that they appear in the text. In the text, cite the reference number in square brackets (e.g., "We used the techniques developed by our colleagues [19] to analyze the data"). PLOS uses the numbered citation (citation-sequence) method and first six authors, et al.

Do not include citations in abstracts.

Make sure the parts of the manuscript are in the correct order *before* ordering the citations.

Formatting references

Because all references will be linked electronically as much as possible to the papers they cite, proper formatting of references is crucial.

PLOS uses the reference style outlined by the International Committee of Medical Journal Editors (ICMJE), also referred to as the "Vancouver" style.

Supporting information

Authors can submit essential supporting files and multimedia files along with their manuscripts. All supporting information will be subject to peer review. All file types can be submitted, but files must be smaller than 20 MB in size.

Authors may use almost any description as the item name for a supporting information file as long as it contains an "S" and number. For example, "S1 Appendix" and "S2 Appendix," "S1 Table" and "S2 Table," and so forth.

Supporting information files are published exactly as provided, and are not copyedited.

Supporting information captions

List supporting information captions at the end of the manuscript file. Do not submit captions in a separate file.

The file number and name are required in a caption, and we highly recommend including a one-line title as well. You may also include a legend in your caption, but it is not required.

Example caption

S1 Text. Title is strongly recommended. Legend is optional.

In-text citations

We recommend that you cite supporting information in the manuscript text, but this is not a requirement. If you cite supporting information in the text, citations do not need to be in numerical order.

Read the supporting information guidelines for more details about submitting supporting information and multimedia files.

Figures and tables

Figures

Do not include figures in the main manuscript file. Each figure must be prepared and submitted as an individual file.

Cite figures in ascending numeric order at first appearance in the manuscript file.

Figure captions

Figure captions must be inserted in the text of the manuscript, immediately following the paragraph in which the figure is first cited (read order). Do not include captions as part of the figure files themselves or submit them in a separate document.

At a minimum, include the following in your figure captions:

- A figure label with Arabic numerals, and “Figure” abbreviated to “Fig” (e.g. Fig 1, Fig 2, Fig 3, etc). Match the label of your figure with the name of the file uploaded at submission (e.g. a figure citation of “Fig 1” must refer to a figure file named “Fig1.tif”).
- A concise, descriptive title

The caption may also include a legend as needed.

Read more about figure captions.

Tables

Cite tables in ascending numeric order upon first appearance in the manuscript file.

Place each table in your manuscript file directly after the paragraph in which it is first cited (read order). Do not submit your tables in separate files.

Tables require a label (e.g., “Table 1”) and brief descriptive title to be placed above the table. Place legends, footnotes, and other text below the table.

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