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Understanding perceptions of perinatal and postnatal mental health screening tools among under-served groups: a qualitative study of women from non-English speaking communities.

Final Research Report - January 2025

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Operational definition of language and terminology

Ethnicity	A group of people who share a common culture, background, or experiences.
Health inequality	Unfair and avoidable differences in health across the population, and between different groups of people.
Immigrant	A person who leaves his or her home and move to a foreign country in order to live there permanently.
Mental health	A positive state of mind and body that allows people to feel safe and cope with daily life activities.
Minority group	A culturally, ethnically, or racially distinct group that coexists with but is subordinate to a more dominant group or are in a minority in a population.
Non-English-speaking	A person who cannot speak or understand or has difficulty with speaking or understanding the English language by reason of place of birth or culture.
Perinatal period	The period of time when a woman becomes pregnant and up until one year after childbirth.
Postpartum period	The period after childbirth and up to six weeks (42 days) after birth.
Refugee	A person who fled his or her country to escape conflict, violence, or persecution and have sought safety in another country.
Social determinants of health	All nonmedical conditions that impact an individual's health. They include economic, social, environmental and structural conditions.
Underserved communities	Groups of people who have limited access to resources or social services or are socioeconomically disadvantaged.

List of abbreviations

The abbreviations listed below were used in this report:

BREC	Barnardo's Research Ethics Committee
Chronic SMI	Chronic serious mental illness
EPDS	Edinburgh Postnatal Depression Scale
GAD -7	Generalized Anxiety Disorder Questionnaire
NICE	National Institute for Health and Care Excellence
OHID	Office for Health Improvement and Disparities
PPIE	Patient and Public Involvement & Engagement
SDOH	Social determinants of health
SRQR	Standards for reporting qualitative research
UoB	University of Birmingham
UK	United Kingdom
WHO	World Health Organization

This report has been produced by Sandwell Research and Intelligence Team within Public Health and the University of Birmingham on behalf of and in conjunction with Sandwell Family Hubs and Barnardo's.

The views expressed are those of the authors and not necessarily those of the Council, the University or the Family Hubs.

Executive Summary: Exploring perceptions of perinatal and postnatal mental health screening tools among under-served groups.

E1 This report presents the findings of a qualitative study exploring the perceived barriers and facilitators to the effective use of mental health screening tools in the perinatal and postnatal period from new and expectant mothers' experiences. Data collection occurred between the 20th and 25th of June 2024 at a Family Hub in Sandwell, UK.

E2 The overall aim of the study was to understand how expectant and new mothers from non-English speaking backgrounds perceive the effectiveness of screening tools for identifying mental health issues during the perinatal and postnatal periods. To achieve this aim, the research focused on three related objectives: capturing and describing women's experiences with mental health screening tools; exploring women's perceptions of the effectiveness of the screening tools; and identifying the barriers, facilitators, and approaches to effective use of these tools. These objectives provide a comprehensive understanding of the challenges and opportunities related to mental health screening for this demographic. Addressing these objectives will contribute to a better understanding of how to address maternal mental health in diverse communities.

E3 **Method:** The qualitative study design included the views of 15 women from non-English speaking communities in Sandwell. The women participated in semi-structured interviews (n=12) and one focus group discussion (n=3). All data collection was face-to-face, apart from one online (via Microsoft Teams) semi-structured interview conducted at the Family Hub.

E4 **Key findings:** Women from non-English speaking communities reported varied experiences of being screened for mental health concerns. These included feelings of relief from identifying and discussing concerns; feeling happy answering questions due to having a support network; feelings of vulnerability and discomfort with answering personal questions; feelings of worry and fear about disclosure; and appreciation of the time and screening approach employed by some professionals. Generally, women perceive mental health screening tools as effective for identifying perinatal and postnatal concerns because the questions are clear and straightforward. However, several factors can hinder the effective use of these screening tools, including a lack of awareness about mental health, and of the purpose, process, and results of screenings. Other barriers include concerns about privacy, fear of the consequences of disclosing outcomes, cultural norms, and language difficulties.

Providing information about screening results, addressing language barriers, building trust (such as through a consistent health provider), and ensuring confidential and adequate time for personalised care could enhance the effectiveness of these screening tools.

R1 **Recommendations:** There is a need to raise awareness and formally inform women about mental health and related screening, specifically women from underserved communities and immigrant backgrounds to help address cultural barriers.

R2 Healthcare professionals should explain the purpose and benefits of screening in local languages using familiar, clear words, and interpreters if required. They should engage women in discussion about their results and share information about maternal mental health services and how to access them. Screening tools should be easy and clear, and the use of polysemous words or phrases should be avoided. Additionally, language barriers should be addressed by removing words that are hard to translate into other languages from screening tools. It is important to maintain a consistent healthcare provider, have more ethnic representation among healthcare staff, and ensure effective communication with pregnant and new mothers to build a sustainable and trusting relationship.

R3 There is a need to ensure privacy during screening, raise awareness of mental health screening, and provide culturally sensitive information in women's own languages. Maternal mental health services could consider applying a community champions model by training interpreters as champions in mental health and effective communication. This would help to bridge the communication gap and foster trust between women from non-English-speaking communities and healthcare providers.

R4 There is a need to follow up with women after screening to check if anything has changed, refer to services if needed, and provide support navigating these services.

R5 It is important to provide person-centred care and allow sufficient time during mental health screening appointments. Women can be supported to create peer support networks or social groups to foster essential information sharing.

R6 This was a small-scale, exploratory study evaluating data from fifteen (15) participants from a single local authority and diverse ethnic backgrounds. However, the demographics are not representative of the non-English-speaking population of Sandwell. Further studies are therefore needed to explore the perspectives of a larger and more diverse sample. This study explored women's perceptions and experiences of maternal mental health screening tools. Additional research could explore the social factors that significantly impact maternal mental health within

various communities. Understanding these influences may support the development of effective systems and interventions.

1.1 Introduction

This report describes the findings from a maternal mental health project that explored how expectant and new mothers from non-English speaking backgrounds in Sandwell perceive the effectiveness of current screening tools for identifying mental health concerns in the perinatal and postnatal periods. It highlights the prevalence of perinatal mental health conditions, their associated risk factors, social determinants, and health consequences. The method deployed for data collection, analysis and recommendation is described. The qualitative research that informs this report was undertaken by the Public Health Research and Intelligence team at Sandwell Council and reviewed by researchers from the University of Birmingham (UoB). In addition, staff from Barnardo's based in Sandwell Family Hub provided interpreter services and support with recruiting and interviewing participants. The research findings are intended to inform maternal and child health service delivery in Sandwell.

The report has been structured into five main sections:

Section 1: Literature review

An overview of the literature on women's perceptions of mental health screening tools used in the perinatal and postpartum periods. This section describes the search strategy deployed and highlights two major themes regarding women's perspectives on maternal mental health assessment and screening tools.

Section 2: Methodology

Describes the aims and objectives of the study and how it was achieved. The study design and method of data collection and analysis are illustrated. This section highlights how participants are recruited and discusses the ethical principles and guidelines applied when conducting research involving human subjects.

Section 3: The research findings

This section presents the findings from the study.

Section 4: Discussion

This is the section in which findings are summarised and critically appraised in relation to previous studies. The implications of the current study findings are discussed, and recommendations are offered in the subsequent section.

Section 5: Conclusion and Recommendations

This is the final section where recommendations are made in relation to the research findings. The conclusion and recommendations section provides a conclusive summary of the report followed by the limitations faced while conducting the research and the recommendations for policy and health professionals.

1.2 Literature review – Prevalence of Maternal Mental Health conditions

Maternal mental health is a common public health concern worldwide as women may experience considerable biological, social, and psychological changes during and after pregnancy.

Perinatal mental health problems are significant complications of pregnancy and the postpartum period (O'Hara and Wisner, 2014). These include, among others, depression, anxiety disorders and postpartum psychosis, which usually manifests as bipolar disorder, maternal obsessive-compulsive disorder, and postpartum posttraumatic stress disorder (O'Hara and Wisner, 2014; Kurtz, Levine and Safyer, 2017). It is estimated that 1 in 10 women in developed countries (Dennis *et al*., 2017) and 1 in 5 in low-income and middle-income countries are affected by perinatal anxiety and depression (Gelaye *et al*., 2016). These figures indicate the universal need for perinatal and postnatal mental health screening.

In the United Kingdom (UK), maternal depression and anxiety disorders are estimated to affect between 10%-20% of women who access maternity services (National Institute for Health and Care Excellence (NICE), 2014). In 2019, the estimated prevalence of perinatal mental health conditions in Sandwell is 28.4%, which is slightly above the national estimate of 25.8% (Office for Health Improvement and Disparities (OHID), 2025).

1.2.1 Health consequences

Evidence suggests that poor mental health during pregnancy is associated with several negative maternal health outcomes, including preterm labour and preterm birth (Staneva *et al*., 2015), poor infant outcomes and cognitive and developmental delays in young children (Waters *et al*., 2014). According to Price *et al*. (2021), poor perinatal emotional wellbeing and mental health can negatively impact women's physical health, their parenting capacity, and children's health and parent-child bonding. Notably, the 2024 MBRRACE-UK - Saving Lives, Improving Mothers' report attributed a substantial proportion (34%) of deaths occurring between six weeks and a year after the end of pregnancy to mental health-related causes (Felker *et al*., 2024). Figure 1 presents other health complications of poor maternal mental health.

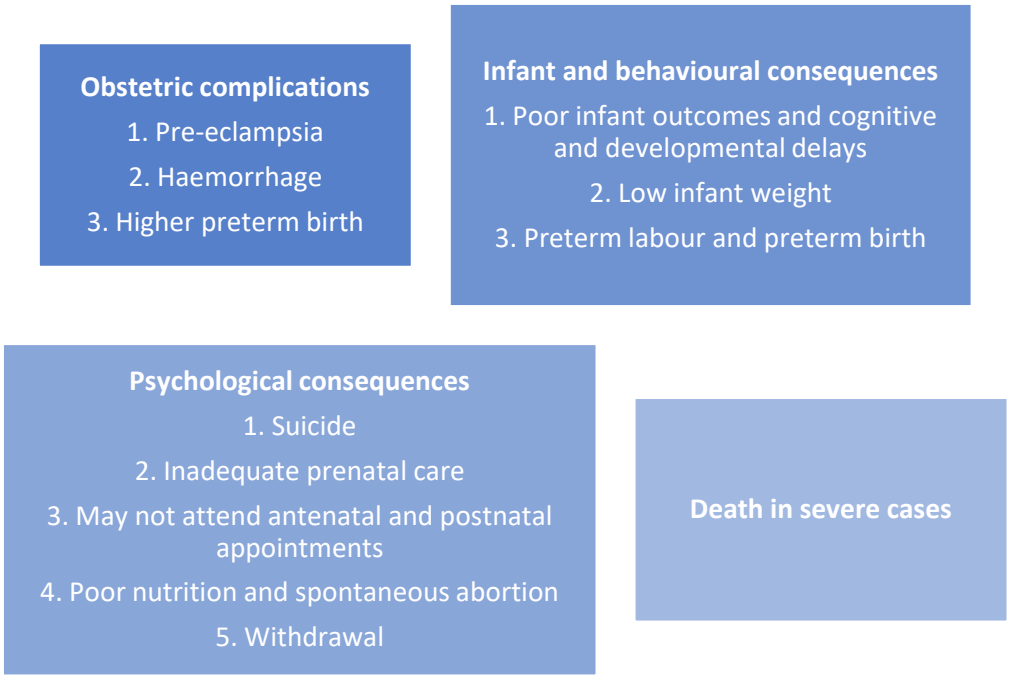

Figure 1: Some examples of poor maternal mental health outcomes. Sources: Staneva et al., 2015; Waters et al., 2014; Price et al., 2021.

1.2.2 Social determinant of maternal mental health

Beyond pregnancy, other factors also contribute to maternal mental health. These include the social determinants of health (SDOH), which encompass all the conditions in which people live and grow (Pardo *et al*., 2024), the life course, lifestyle, and wider policy and economic climates. The SDOH include, among other things, socioeconomic status, social resources and support networks, environmental and structural factors, and cultural norms that represent the ethnically diverse population we serve. For instance, an online survey of over 500 pregnant women and new parents in the United States revealed that material resources, social resources, and pandemic employment-related stress were significantly associated with perinatal mental health, with social resources having the most substantial association relative to other factors (Endres *et al*., 2023).

In a recent systematic review of primary care among Black communities in the UK, Ojo-Aromokudu *et al*. (2023), reported that people from Black ethnicities are more likely to report being in worse health conditions and have poorer experiences of healthcare services than their white counterparts. Furthermore, for women from minority ethnic and refugee backgrounds, migration and resettlement processes have been identified as risk factors for mental health concerns and non-psychotic mental disorders, particularly among those with low social support (Howard *et al*., 2014; Biaggi *et al*., 2016). Other risk factors and relevant determinants of poor maternal mental health are illustrated in Figure 2.

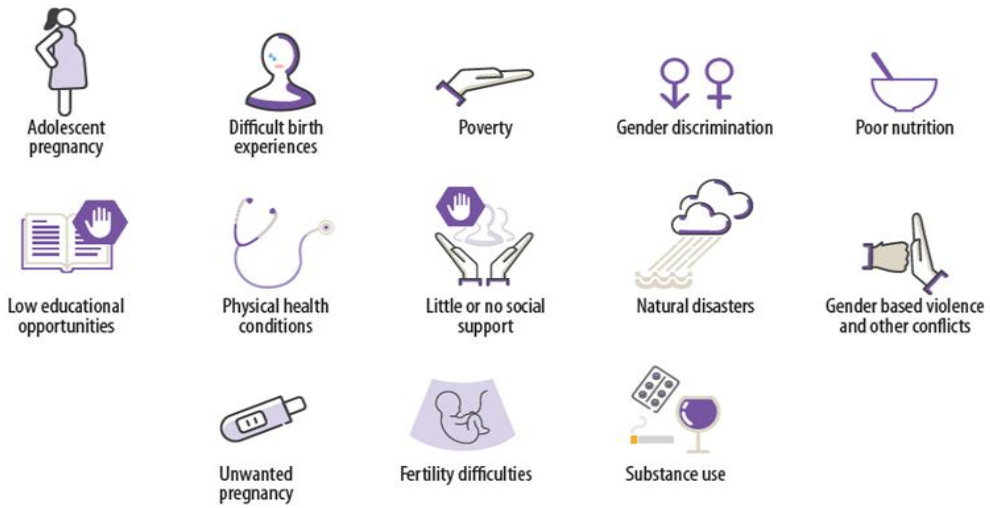

Figure 2: Illustration of some determinants of poor perinatal and postnatal mental health. Source: World Health Organization (WHO), 2022.

It is therefore crucial to explore the experiences and opinions of mothers, especially those from non-English speaking backgrounds, regarding the effective use of mental health screening tools. This exploration will help inform the development of culturally sensitive screening tools and approaches aimed at addressing the social inequities in perinatal and postnatal mental health screening of these women. This study therefore explores non-English-speaking women's experiences and views about the effective use of perinatal and postnatal mental health screening tools. This study also investigates the perceived barriers and facilitators to effectively using these screening tools.

1.2.3 Mental Health Screening

The associations between poor maternal mental health and several negative maternal health outcomes underscore the importance of screening for prenatal and postnatal mental health problems, ensuring the effectiveness of screening approaches and tools. This is because effective screening during pregnancy and in the postpartum period can help with the early detection and management of mental health symptoms and their severity (O'Connor *et al*., 2016) as well as identify wider support needs and signpost or refer to appropriate services. Accordingly, NICE recommends screening for both depression and anxiety disorders at a woman's first contact with primary care or her booking visit during pregnancy and postnatally (usually at 4 to 6 weeks and 3 to 4 months). This screening process involved asking specific questions aimed at identifying depression, along with the use of the Generalized Anxiety Disorder scale (GAD) to assess anxiety (NICE, 2024).

If a woman responds affirmatively to any of the depression screening questions, is deemed at risk of developing mental health issues, or if there are other clinical concerns, additional assessments such as the Edinburgh Postnatal Depression Scale (EPDS) or the Patient Health Questionnaire (PHQ-9) can be utilised as part of a comprehensive assessment (NICE, 2014).

Nevertheless, there is no consensus on the optimum tool or technique for screening perinatal mental health concerns (Fairbrother *et al*., 2024) or on how to capture the relevant risk determinants (Endres *et al*., 2023). Thus, a broad range of tools have been used for screening symptoms of mental health concerns, including among others, those in Figure 3. In the current study, we used the EPDS, GAD-7, and Whooley questions, which are commonly used by health professionals in the study setting.

Generalised Anxiety Disorder Questionnaire (GAD-2 or -7) (Swinson, 2006; Spitzer *et al*., 2006)

The Patient Health Questionnaire (PHQ-9 or -2) (Kroenke *at el*., 2003)

The 10-item Edinburgh Postnatal Depression Scale (EPDS) (Cox, Holden and Sagovsky, 1987)

Whooley questions (Whooley *et al*., 1997).

Figure 3: Examples of mental health screening tools.

1.3 Justification for this research

Despite the importance of early screening and detection of maternal mental health concerns, limited evidence exists regarding the perceived effectiveness of perinatal mental health screening, particularly among ethnically diverse populations (Hsieh *et al*., 2021). For instance, mental health concerns are not consistently recognised in routine maternal care, predominantly among women from Black, Asian, and non-English speaking communities (Manso-Córdoba *et al*., 2020; Sidebottom *et al*., 2021). This is important because negative perceptions of these tools and the process of screening could lead to low detection rates. Women with mental health issues may worry about stigma, fearing that their baby could be taken into care or that they may be viewed negatively as mothers (Gelaye *et al*., 2016). Consequently, most women in the postpartum period do not seek help for depression (Manso-Córdoba *et al*., 2020), and many of those with perinatal mental health concerns remain undiagnosed (Fonseca, Gorayeb, and Canavarro, 2015).

Additionally, the ethnic disparity that exists in the identification and management of postpartum depression is noteworthy. For instance, studies suggest that help-seeking behaviour is influenced by ethnicity, with Black, Asian, and non-white women less likely to initiate postpartum mental health care than their white counterparts (Kozhimannil *et al*., 2011; Manso-Córdoba *et al*., 2020; Sidebottom *et al*., 2021).

Although studies indicate that mental health screening in pregnancy is generally acceptable by women and seen as a feasible means of diagnosing prenatal mental conditions (Kingston *et al*., 2015), evidence around acceptability for non-English speaking women and those of refugee background is scant (Willey *et al*., 2020). Therefore, an in-depth investigation is required to understand non-English speaking women's experiences and views about the effectiveness of the mental health screening tools used in the perinatal and postpartum periods and how they influence comfort and ability to disclose mental health concerns.

1.3.1 Sandwell profile

Sandwell is a metropolitan borough of the West Midlands and was formed in 1974. The borough comprises six towns - Oldbury, Rowley Regis, Smethwick, Tipton, Wednesbury, and West Bromwich. Sandwell is super diverse, with an estimated 42.8% of its population classified as belonging to minority ethnic groups (Sandwell Metropolitan Borough Council, 2024a). Similarly, Smethwick town is highly ethnically diverse, with 76% of its population from ethnic minorities (Sandwell Metropolitan Borough Council, 2024b). This makes Smethwick a suitable geographical area for this research. The figure below depicts Sandwell's ethnicity.

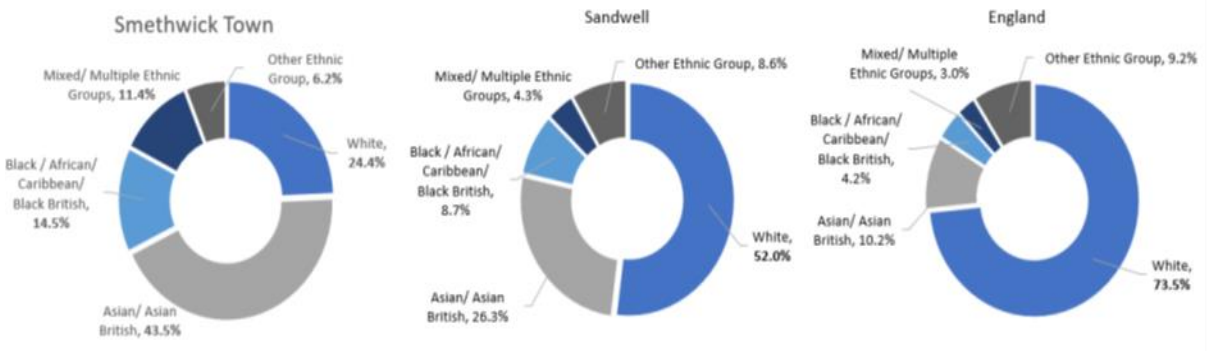

Figure 4: Sandwell 2021 ethnicity profile. *Source:* Sandwell Metropolitan Borough Council, 2024b.

1.3.2 Women's views of perinatal and postnatal mental health screening

An overall literature review of women's perceptions of mental health screening tools used in the perinatal and postpartum periods was conducted. A comprehensive and thorough search of a computerised database of the Cumulative Index of Nursing and Allied Health Literature (CINAHL), Medline, Psychinfo, Embase, BNI, and Pub Med was conducted by Dudley Metropolitan Borough Council Knowledge Services. The search terms used were expectant*, pregnant*, mother*, midwife*, nurse*, "health worker*", "mental health screening", depression, perinatal, postnatal, perception, perceive*, impression*. Other relevant literature sources from the reference lists of identified articles were also consulted. The literature search was conducted from 2013 to 2023. Findings from the review highlight two major themes regarding women's perspectives on maternal mental health assessment and screening tools.

1.3.3 Women's positive view of mental health screening

There is a small body of literature investigating women's perception of maternal mental health screening and processes. A qualitative study conducted among 22 women of refugee and migrant background who attended the antenatal clinic in the south-eastern suburbs of Melbourne, Australia revealed that in general, women found the digital perinatal mental health screening to be acceptable and viewed it as an important aspect of their first visit with the midwife (Willey *et al.*, 2020). However, this study was conducted in Australia and among a small number of women who attended one antenatal service. As such, it could be that most of the sample were women who already had positive views about the screening program because they were attending it.

Contrasting results come from data that was part of a randomised controlled trial conducted by Kingston *et al*. (2017). The trial was carried out among women from community-based family physician-led maternity clinics in Alberta, Canada to compare the opinions of 636 (94.2%) pregnant women randomised to a Web-based screening intervention group (n=305) versus a paper-based screening control group (n=331). Data was collected on the level of risk and benefit they perceived in disclosing mental health concerns to their prenatal care provider.

The results showed that although three-quarters of pregnant women in the intervention and control groups perceived mental health screening as beneficial, a substantial number of pregnant women in both groups reported feeling very vulnerable during their mental health screening. Accordingly, this study highlights the potential importance of reducing women's vulnerability during the perinatal screening process with strategies such as addressing women's concerns, explaining the purpose for screening, and showing women how their results will be used. Therefore, research is needed to explore how mothers from non-English speaking backgrounds in the UK perceive the effectiveness of maternal mental health screening tools to proffer tailored strategies for improving maternal mental health and reducing health inequality amongst this group of women.

1.3.4 Barriers and enablers to screening perinatal and postnatal mental health concerns.

There are many different barriers and facilitators to maternal mental health screening, as reported in elsewhere (Bayrampour *et al*., 2017; Forder *et al*., 2020; Willey *et al*., 2020). In a qualitative descriptive study, Bayrampour et al. (2017) conducted qualitative interviews with 11 White (Caucasian) women and four women from diverse ethnic backgrounds in Calgary, Canada. All participants were pregnant with a single baby and were attending a community maternity clinic and a mental health clinic. The results showed that communicating mental health concerns during screening was challenging due to not being able to recognise and understand the symptoms, fear of disclosure outcomes or consequences of being judged, lack of continuity of care, and lack of feedback. Accordingly, clarity around the outcomes of disclosing mental health concerns, and the availability of immediate support, could help to dismantle the barriers to communicating mental health issues and encourage honest answers during screening (Bayrampour *et al*., 2017). This study raises important issues; however, it was conducted in a Canadian context that could have different challenges than a UK context due to differences in population demographics and healthcare systems. The present investigation focuses on mothers from non-English speaking backgrounds in the UK.

Another study analysed qualitative and quantitative data from 1,597 women from a cross-sectional perinatal mental health sub-study (part of the Australian Longitudinal Study on Women's Health). The authors concluded that women who are most likely to need mental health care during the perinatal period are those least likely to be honest about their mental health (Forder *et al*., 2020).

A possible explanation for this is the stigma associated with mental health and fear of disclosure consequences, both contributing to lack of honest response during screening.

This research builds upon the foregoing studies by exploring similar questions but concentrating on a UK context. It explores the general experiences of women from non-English speaking communities when undertaking mental health screening during and after pregnancy, focusing specifically on their perceptions of the effectiveness of mental health screening tools and the barriers, facilitators, and strategies related to the effective use of the tools.

2.1 Development of research questions and methods

2.1.1: Public forum and co-production activity

This research project is part of the Family Hubs and Start for Life programme in Sandwell. The project was initiated following a Family Hubs meeting, which identified the need to get a better understanding of the effectiveness of the current standardised tools for identifying mental health issues in the perinatal and postnatal periods within the different communities in Sandwell, particularly where English is not the first language. A wellbeing engagement event was hosted at a Family Hub (Barnardo's) in Smethwick to provide opportunities for the public to give feedback and input on the research topic, its methodology, and the development of questions.

The event took place on the 4th of May 2023 and involved health professionals from various organisations, as well as women and children who use services at the centre. A total of 10 women with their children attended the event and provided valuable insight and feedback regarding the research topic and how they would like to engage in the research.

The women said they were interested in the research topic and the following points were made:

Data collection methods:

- The women preferred group sessions as this would provide opportunities to meet and socialise with other women.
- Group sessions should provide childcare facilities.
- The women said they would like to be involved in all aspects of the research and would prefer using similar settings (The Family Hub) for data collection, as the event.

What is important in terms of maternal mental health, the women emphasised:

- The impact of finance and wider determinant of health on maternal mental health and wellbeing, which professionals don't consider when administering mental health assessment tools.
- Communication barriers and facilitators – impact.
- Being isolated in a new country with little support and how to address (or identify) this using mental health assessment tools.
- That the mental health screening tools do not explore the "Why" but only the "what" and don't provide action or what "now".

Figure 5: Feedback from Patient and Public Involvement and Engagement (PPIE) event

3. 1 Evaluation aim, objectives, and research questions

3.1.1 AIM

Building on the insight from literature and the health and wellbeing event (see Appendix I), the following overarching aim was proposed for this study: **To understand how expectant and new mothers from non-English speaking backgrounds in Sandwell perceive the effectiveness of the screening tools for identifying mental health issues in the perinatal and postnatal periods.**

3.1.2 Objective

To achieve the stated aim of this study, this research proposed the following objectives:

1. Capture and describe women's experiences of mental health screening tools used during the perinatal and postnatal periods.
2. Explore women's perceptions of the effectiveness of the screening tools used during and after pregnancy for identifying mental health issues.
3. Identify the barriers and facilitators that affect the use of mental health screening tools amongst expectant and new mothers from non-English speaking backgrounds.
4. Develop recommendations to support policymakers and health practitioners address the barriers and facilitators identified above.

3.1.3 Research questions

Building on the above objectives, this research addressed the following research questions:

1. What are the experiences of mental health screening tools among women from non-English speaking communities in Sandwell?

2. How do women from non-English speaking communities in Sandwell perceive the effectiveness of mental health screening tools used during the perinatal and postnatal periods?

3. What are the barriers and facilitators affecting the effective use of the mental health screening tools used for expectant and new mothers from non-English speaking communities?

4. What are the strategies and recommendations for addressing the barriers and facilitators identified above?

4.1 Methods

This methods section was written in accordance with the Standards for Reporting Qualitative Research (SRQR) reporting checklist for qualitative studies (O'Brien *et al.*, 2014).

4.1.1 Study design

Based on feedback from the public forum and co-production activity, this qualitative study used semi-structured interviews and a focus group to explore women's experiences and opinions of the effectiveness of mental health screening tools used during and after pregnancy.

4.1.2 Data Collection

Data collection was in person at the Family Hub between the 20th and 25th of June 2024 apart from one online interview via Microsoft Teams. In several cases, women were interviewed with their children, and one participant had her husband present. An interview guide was developed (see Appendix II) and piloted. The interview guide allowed the use of prompts to elicit further clarification based on participants' responses and the research aim. During the interview, a brief questionnaire was administered to collect participants' sociodemographic data.

The women described their experiences of being asked questions about their mental health during pregnancy and after the birth of their babies, their views on the effectiveness of the screening tools, and the barriers and facilitators to disclosing mental health issues. Participants were also asked to comment on the Whooley questions (Whooley *et al*., 1997), GAD-7 (Spitzer *et al*., 2006; Swinson, 2006), and the EPDS (Cox, Holden and Sagovsky, 1987) in terms of understanding and sensitivity of words on the scale and if they felt comfortable answering the questions truthfully. These tools were chosen because they were identified by the Patient and Public Involvement and Engagement (PPIE) members as commonly used by health care professionals in Sandwell.

4.1.3 Researcher characteristics and reflexivity

The research team considered their own perspective and experiences on maternal mental health and how it may influence the research. To identify biases and other factors that may influence how data were analysed and interpreted, reflective and reflexive practices were employed throughout the data analysis phase (Holland, 1999). The lead researcher (NJH) also considered seriously the influence of her role as a female researcher from an ethnic minority background and how this may impact data analysis. Accordingly, no relationship was developed with the research participants prior to the commencement of the study. Members of the research team agreed on the developed coding framework before its application to all transcripts. Data analysis was initially conducted by the principal investigator from Sandwell Council (NJH). Findings and themes were refined in triangulation meetings with the co-investigator (LK) in the second stage (Carroll and Booth, 2015).

4.1.4 Participants and sampling

Eligible participants met the following inclusion criteria: (1) aged 18 years or older; (2) experience of being screened for mental health concerns during or after pregnancy; (3) belonging to an ethnic minority or non-English speaking background in Sandwell; (4) being pregnant or having recently given birth; and (5) willing to take part in the study.

To ensure diversity of participants and experiences (e.g migration, ethnicity, and women who do not speak English, as they are often excluded from research studies), a non-probability purposive sampling strategy (Palinkas *et al*., 2015) was employed to recruit eligible participants from Barnardo's – Smethwick Family Hub in Sandwell.

Staff from Barnardo's Family Hub (SS) supported participant recruitment by identifying potential participants, approaching them, and obtaining consent to provide the research team with their contact details.

Participants were recruited via the distribution of advertising flyers (Appendix III), publicising on the Family Hub website and social media sites and oral announcements during women's maternal classes at the Family Hubs. All women were from non-English-speaking communities. All participants received a £15 shopping voucher honorarium for taking part and reimbursement for travel expenses. In total, the final sample consisted of 15 participants. An expected sample size of 10-12 individual participants was initially estimated based on prior research (Conneely *et al*., 2023). However, recruitment continued until no new information or themes were identified and thematic saturation was achieved (Guest, Namey and Chen, 2020). One additional participant who was invited decided not to proceed with the study and did not give a reason.

4.1.5 Patient and Public Involvement and Engagement (PPIE)

PPIE was embedded into the study to inform the recruitment of participants and the development of the research aim, questions, and topic guide. The research team also worked with Sandwell's Perinatal Mental Health & Parent-Infant Relationship Workstream group on all aspects of the development of the study outputs. The group comprised nine members, including health professionals, public health officers, patients, and the public and served as the project's advisory board.

4.1.6 Data analysis

Interviews and focus group discussions were audio-recorded, transcribed verbatim, read and sense-checked against the audio recordings. Transcribed interviews were anonymised and analysed using framework analysis (Furber, 2010). All transcripts were read several times to facilitate data familiarisation. Data was initially colour-coded to identify emerging themes from the transcript and a coding framework based on prior concepts from the interview schedule and emerging themes was then developed. Following Tobin and Begley's (2004) guide, the research team met and agreed on the developed coding framework before its systematic application to all transcripts and adapted as new codes emerged (indexing). Finally, data was summarised in a matrix in an Excel worksheet, where each participant was allocated a row, and each theme and subtheme were allocated a column (charting). Researcher triangulation meetings were held to review and shape the analyses.

4.1.7 Ethics and informed consent

This study was approved by the University of Birmingham Science, Technology, Engineering and Mathematics Ethical Review Committee (ERN_23-1041) and Barnardo's Research Ethics Committee (BREC). All participants were provided with participants information sheets and signed a written informed consent form before any data collection activity commenced.

5.1 Findings

5.1.1 Participants characteristics

Out of 16 women invited to this study, 15 were interviewed – 12 women took part in one-to-one interviews and three in a focus group discussion. Of these, 12 spoke English fluently and three (n = 3) were interviewed with the help of a Punjabi interpreter. Interviews lasted between 30 to 45 minutes whereas the focus group discussion lasted for 54 minutes.

The majority of participants in the study were of Indian descent, residing in Smethwick, and aged between 25 and 34 years. The remainder of the participants represented diverse backgrounds, including African, Bangladeshi, Pakistani, Caribbean, and Afghan communities.

5.1.2 Overview: focus group and interview findings

The key overall themes are shown in Figure 6. These are *feelings* (in the context of experiences of being asked about emotional well-being, having a supportive family network, and relationship issues), *Formality* (in the context of having informal and causal chat with little information provided), *Familiarity* (of the process of screening and the results), *Fear* (due to lack of information and privacy, of the consequences of disclosure, cultural norms, and understanding and communicating in English), *Follow-ups* (the lack of) and *Focus* (of the time, attention, and social connection provided and facilitated). The quotes in the subsequent section are accompanied by participant's interview and focus group codes to provide context.

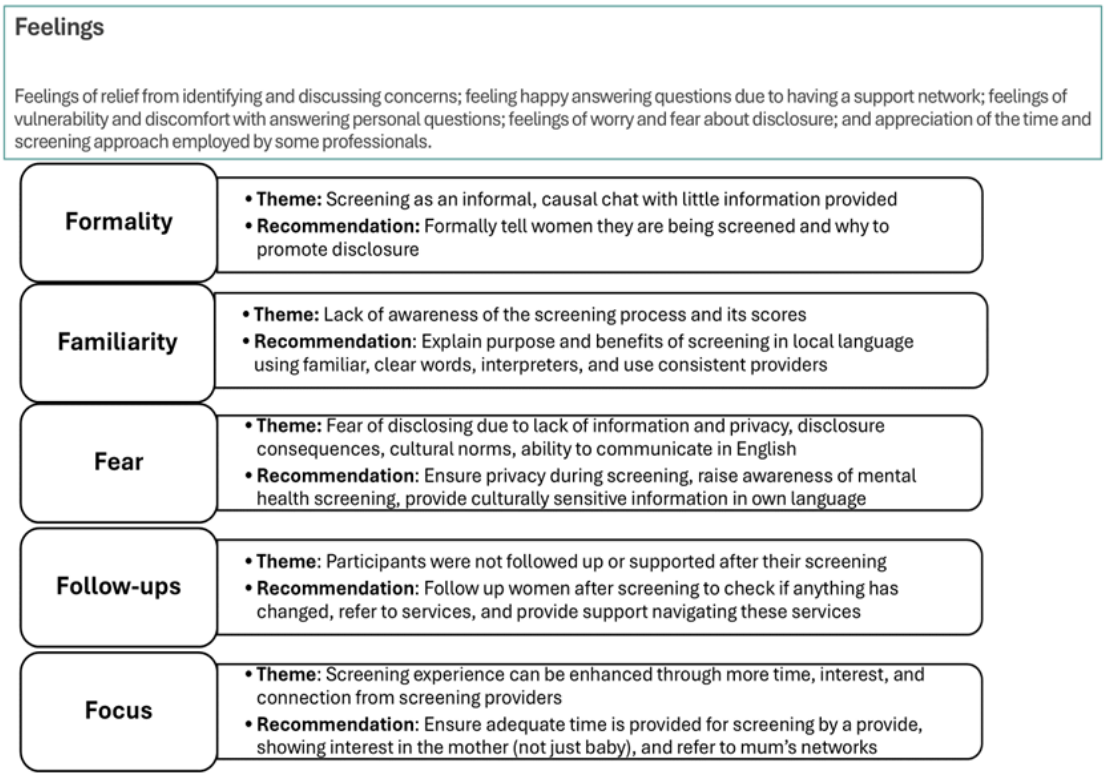

Figure 6: The Six Fs of Maternal Mental Health Screening Tools' application

5.1.3 Theme one: Feelings

An important theme that emerged across all other interrelated key themes and highlighted the experiences of the women was feelings. Generally, when participants were asked about

their experiences with mental health screening, they reported a range of emotions. These included feelings of relief from identifying and discussing their concerns, happiness from answering questions due to having a supportive network, vulnerability and discomfort when responding to personal questions, worry and fear about disclosing their issues, and appreciation for the time and care taken by some professionals during the screening process.

"When she [midwife] was asked the question, I was in a happy place… I had the support network [family support] in place.

So, I was happy to answer that question" (INP 1).

"I think there were two miscarriages…. and there was constant [counselling]…. the counselling was really, really, helpful" (INP 3).

Like your trust in talking to that person..... how they're going to share it or who they're going to share it with. I think it'd [feeling of worry] be with how the information is shared, like what would happen with it once if you did say something? Would they pass it on to like family or would it go through to like a doctor?" (INT 11).

These emotions are further illustrated through other key themes: formality, familiarity, fear, follow-up, and focus.

5.1.4 Theme two: Formality

The women also described their screening experience as being informal: having a casual chat or routine conversation where they were asked generally about their emotions and family network. Interestingly, they felt that there was no need to give their feedback on the questions posed, nor was there any requirement to disclose prenatal mental health issues. They thought that screening process could be improved if more information about it was provided:

"So, I feel it's like a normal chat and that feedback is not needed as such, it's felt like a general chat……Normally a chat. It's just a casual chat really. They didn't say this is the reason why we ask. No reason for asking those questions" (INP 1).

"It was just routine questioning. So, they just said, like, you know, how you how? Are you feeling? Any stress? Any depression? So, they asked just a routine questions ...." (INT 10).

"Yeah, you know, like they .... they, will ask you know, how is everything at home and you know the routine, the routine stuff" (FGP 3).

One woman from the focus group additionally noted she felt like she was answering a scripted question:

"It was just like a chat…. It didn't feel like something that was just like a tick box. He [The general practitioner] *screened me by looking at my mannerisms, like how, how I sat down and how I was talking…..And then he wanted to watch how I would talk to him, how I would see the baby, and he did go through, like, a scripted question on the computer*" (FGP 2).

One of the ways to improve mental health screening related to its formality was the need to explain the process more obviously:

"I think it [screening tool] *is effective, but they can do more as in talking though, like obviously explaining about it"* (INP 5).

"I think the questions that my doctor asked was.... were good because they really, like, pinpointed it" (FGP 1).

Although the informality of the process could potentially support with disclosure of mental health challenges through enhancing rapport, it is also a weakness because women did not have enough information to understand they were experiencing screening. To address this, women need more explanation about screening. Transitioning the screening process from an informal to a formal setting may help women understand the importance of disclosing mental health concerns to their healthcare professionals, although the formality of the process could also inhibit disclosure, too.

5.1.5 Theme three: Familiarity

An important theme that emerged from the interviews was familiarity, which is related to the following sub-themes: awareness, language, consistency in care and trust. Interviewees conveyed that they were unfamiliar with mental health screening tools and their scores and had not received information about these before. For example:

"To me, this is the first time am hearing about maternal mental health screening tool. This is the first time" (INP 4).

"I was never told what the score means to me. Do you know what I mean? No, never explain the purpose to say..... we'll just go through the questions, and at the end, he [Doctor] *didn't say the score means this"* (INP 6).

One woman emphasised the need for clear information about the purpose and benefits of maternal mental health screening, especially when provided in their local languages. This change could empower women to disclose mental health issues, seek help, and improve their mental well-being during and after pregnancy.

> *"I think they* [women from the Asian community] *need to be aware of it in their language. You know whether it is, you know, whether it's Punjabi, Urdu or Polish, it doesn't matter"* (INP 3).

One interesting finding is that many women spoke about needing explanations for screening questions and expressed that the use of elaborate words in screening tools is unnecessary. They noted this as a challenge to understanding the questions and two women highlighted this concern by discussing the challenges words such as "*edge*" and "*anxious"*, both from the Generalized Anxiety Disorder Questionnaire (GAD-7), presents:

> *"...depends if they* [Bangladeshi women] *have an interpreter, do they know what on edge means? Because on edge, it's like a phrase, isn't it? So, does that translate back to what you mean it to mean? I don't think there's a word for anxiety because am Bangladeshi"* (INP 2).
>
> "*Anxiety I can relate to, I know what that means, but words like "edgy" wouldn't mean anything….. anxiety, depression I know, I don't know [edgy]. Anxious, not sure about that, nervous I know*" (INP 7).

Being on edge is a 'polysemous' phrase with multiple meanings. Moreover, participants felt that the simplicity of questions affected their responses to the Whooley questions and EPDS.

> *"I think that they're quite easy. So, I think some questions are fine because they are very straightforward, but those ones that have multiple words and multiple meanings they can be more difficult"* (INP 2).
>
> *"The questions are quite straightforward because it's just like how you felt recently, and you felt like harming yourself?"* (INP 6).

All interviewees, irrespective of their ethnic background or English proficiency, acknowledged the critical role of an interpreter when applying screening tools for women from non-English speaking communities. One interviewee stated:

> "*I went to every appointment with her and then when the health visitor came, she always had a Punjabi interpreter*" (INP 10)

This understanding highlights the necessity of effective communication to ensure that all individuals receive the support they need. Others highlighted the importance of having a consistent health professional to foster a trusting relationship:

> "*I think it's ideal to see the same person* [health professional] *because they know your history, or they know...*" (INP 3).
>
> "*The midwife I saw was like sort of straight after I had given birth to him* [baby]. *She* [midwife] *asked me those questions, but she was a stranger to me, and I guess, yeah, I didn't feel comfortable to…*" (INP 2).
>
> "*Having the same midwife made me feel comfortable. Can't share my personal things to another person*" (INP 12).

These comments highlight important oversight in women's care that deserves attention and underscores a gap in maternal mental health care that may need to be addressed. Providing women with information about mental health screening tools, including their processes and purposes, eradicating polysemous words and phrases, avoiding the use of complex words, and building a trusting professional relationship with health care providers by maintaining consistency in who provides care could improve detection rates in ethnically diverse groups and non-English speaking communities.

5.1.6 Theme four: Fear

Another important theme that emerged from the interviews was fear, and this included fear due to lack of information and privacy, fear of disclosure consequences or outcomes, cultural norms, and inability to understand and communicate in English (*language barriers*). Interviewees felt that lack of information about maternal mental health screening and its purpose can result in worry about revealing mental health issues during the screening process.

One interviewee referenced a question from the Edinburgh Postnatal Depression Scale (EPDS) that exemplified this concern:

> *"…. there are questions when you ask and then it leads to another thing. Why will you blame yourself? Is it going to affect your children? …..So, there are questions that are better not to be answered, not to even think about it"* (INP 8).

One FG participant highlighted the importance of mental health screening awareness by sharing her experience of fearing the disclosure of her emotional pain due to its implications.

> *"There needs to be more awareness and they're having a tick box thing, but I don't think it's effective because even when I had my break down, they said to me has there been any social services involvement and straight away I was like, oh, great, that's it and I'll just kind of put up a wall"* (FG 3).

Others felt that they would require *information* about the implications of disclosing mental health concerns before answering questions on the tools:

> *"……so, there wasn't anything negative to feedback to her. I think if there was maybe I might have asked a bit more from her, like, what will you do if I tell you or…"* (INP 11).

Fear and worry about answering sensitive questions can be reduced by screening in the women's own language. For instance, interviewees expressed the significance of answering the screening questions in their local *language***,** through the help of an *interpreter*, suggesting it facilitated easy understanding of the questions and enable truthful answers.

> "*The fact that they was explaining to her what they were asking through the interpreter, that made it easy*" (INP 10)
>
> "*Possibly it could be having somebody like a translator or someone in the room that could speak the language of the lady who's there, rather than just in English, and then the lady might just assume she can only say yes. If you had someone there that could speak her language, she might feel a bit more comfortable with opening up*" (INP 11).

Lack of privacy was also raised as a barrier to the effective use of these screening tools because participants feared the consequences of disclosure to others.

One woman recognised the advantage of having a healthcare professional who spoke the language of immigrant women, as it promoted *privacy* and fostered more honest responses when answering screening questions, while another elaborated on her experience of being screened in the presence of her partner.

> *"…. they need the doctors and midwives like that who can speak in their own language then is make more easy for them"* (INP 9).
>
> *"….and my partner was there, and this health visitor ask... I couldn't speak up because I'm scared that he is there, and I can't tell the truth*" (INT 4).

As reported by interviewees and focus group participants, another barrier to the effective use of the screening tools was cultural norms. One interviewee described the cultural expectations of the African community in discussing sensitive family or emotional problems and how this may affect responding to questions from the screening tools. This is demonstrated in the quote below:

> *"We are Africans anyway, when it comes to family things, problems, issues, is not something you can just go out and start opening up, you need to sort it out homely"* (INP 8).

These comments imply that the themes of "fear" and "familiarity" are interconnected (See Figure 6) and present among the study participants. Again, this highlights the importance of ensuring privacy during screening and the need to raise awareness of maternal mental health screening.

It is crucial to provide women with culturally sensitive information regarding mental health screening tools, particularly in their own language, to ensure their effective use.

5.1.7 Theme five: Follow-up

The follow-up theme is underpinned by three interrelated sub-themes: delayed intervention, access to hidden services, and referrals. Interviewees advocated for follow-ups and support services to encourage women to disclose mental health concerns during screening. They spoke frankly on how *follow-ups* can help build trust and elicit truthful responses from women, even after unsuccessful initial screenings.

> *"I think if I did get a phone call or something to say…. Yeah. Any follow-up to kind of say ohh, you know, you were feeling upset at this appointment, how are you feeling now? Yeah, I think that would have been appreciated at the time"* (INP 2)
>
> *"I would have appreciated a call back at least to say…. if not an appointment just if am still feeling the same, do you need support or are you in a good place?"* (INP 7).

Interestingly, interviewees said that women from non-English communities are not familiar with the UK health system and therefore, educating women on how to navigate the system and access *hidden services* was necessary for timely disclosure. One woman described the experiences of women in her community, while another verbalised her struggles in accessing maternal services.

> *"Because a lot of people and a lot of women don't know, don't have a clue, they don't know that they can get help from so and so person"* (INP 5).
>
> *"I contemplated the idea of speaking to somebody about my mental health, but because I didn't know what to do, I didn't know how to go about it, I never did"* (INP 7).

Most women believed that screening should occur early in pregnancy as they were often concerned about their pregnancy and that they should have access to healthcare professionals as soon as possible. They shared their experiences of having to wait to be seen by a healthcare provider.

> *"I couldn't even get hold of anyone to talk to in the first place and my scan came much more later…..I was surprised that there's kind of until your first scan, there's no contact with anyone ….I feel like that's the moment when you're most vulnerable"* (INP 2).

> *"... I think I was four weeks [pregnant] and I contact them [health care provider], they have to wait till eight weeks before I get appointment for the first scan. I was so stressed"* (INP 4).

One interviewee interestingly suggested conducting screenings during each trimester, as circumstances can change at different stages of pregnancy.

> *"…. whatever month you are a woman still goes through like a hormonal change. I feel like even then they should ask* [screen]*. I'm talking about personal experience towards the end of my pregnancy, my hormones were all over the place"* (INT 5).

5.1.8 Theme six: Focus

The focus theme is about the time, interest, and social connection that screening providers give to and facilitate for women. Women were clear that there is a need for an adequate amount of time to be allocated for maternal mental health screening as it felt rushed:

> *"Oh! Yeah, this appointment is ending now ……there's a whole waiting room full of people…..yeah, it felt probably a bit rushed"* (INP 2).
>
> *"…. if the people like midwives and the doctors and everybody, if they can give more time to the ladies who are pregnant and stuff to like, make the appointment and see them and then discuss with them … like few hours to spend with them to ask the problems and to ask how you feel in the home"* (INP 9).

Surprisingly, lack of *interest* was cited as a barrier to effective maternal mental health screening. As a result, some argued that maternal mental health screening appointments should prioritise women's mental health rather than focusing primarily on their babies and the progress of their pregnancies. This is supported by the comment below:

> *"I felt like he* [Doctor] *was asking the right questions, but not in the right sense, like here my questions was based on the newborn…It was all about the baby, baby, baby"* (INP 6).

A focus group participant emphasised the importance of allowing adequate *time* for formal screening while sharing her experience of being examined for postnatal depression.

> *"…… and he did go through, like, a scripted question on the computer. And I felt a bit of a relief that he took time out and did it bit more professionally than I could logically think in my brain*" (FGP 2).

However, another interviewee alluded that she did not disclose her postnatal mental health concerns due to a lack of interest and attention from a healthcare provider.

> "*I didn't feel like telling them* [health professional] *because they'll just ask a question and then they'll just leave it and carry on with like looking at the baby and stuff*" (INP 5).

Others advocated for social connection with peers to facilitate information sharing.

> *"…maybe some kind of network for like all mums, I don't know if that exists, but something a bit more casual like informal*" (INP 2).

These comments emphasised the importance of dedicating enough time and attention to maternal mental health to effectively utilise its screening tools and encourage honest disclosure of perinatal and postnatal mental health problems.

6.1 Discussion

Literature on women with non-white ethnicities' experiences and views of perinatal and postnatal mental health screening tools is mainly Canada and Australia-based. To the best of our knowledge, this is the first qualitative study to explore how expectant and new mothers from non-English speaking backgrounds in the UK perceive screening tools for identifying mental health issues during the perinatal and postnatal periods.

Findings from this study propose a conceptual framework (Figure 6) describing women's perceptions, barriers, and facilitators to the effective use of these mental health assessment tools. The framework presents six key elements that influence the effective use of perinatal and postnatal mental health assessment tools – feelings, formality, familiarity, fear, follow-up, and focus. It also reflects the experiences and perspectives of immigrant women regarding mental health screening tools, thereby providing a deeper understanding of the phenomenon under investigation.

Findings from this study reveal that perinatal and postnatal screening tools such as the EPDS and GAD-7 are acceptable and perceived to be effective by women in this study. This finding reflects the perceptions of mental health screening by women from non-English speaking backgrounds as reported elsewhere (Kingston *et al*., 2015; Willey *et al*., 2020). This implies that women from non-English speaking communities felt comfortable answering the questions on the tools and were happy to discuss their mental health. However, they stressed the importance of providing information regarding the purpose of screening and sharing screening results. Similarly, immigrant women in Champaign County, Illinois, perceived mental health screening as ineffective because providers didn't explain the purpose and uses of screening tools, nor did they disclose the results or scores of screenings (Hsieh *et al*., 2021).

Surprisingly, the women in this study indicated they felt happy answering the questions from the tools and described their experiences of being screened for mental health issues as having a causal chat with health professionals about their *feelings* and the availability of a '*supportive family*'. Nevertheless, women reported that they did not feel obligated to disclose mental health concerns, as responding to the questions felt more like having a "*routine discussion"* about their emotional well-being and support than undergoing a screening process. This finding illustrates a shared understanding among women from non-English speaking communities and ethnic minority backgrounds about not being truthful regarding their emotional pain as reported elsewhere (Shannon *et al*., 2015; Willey *et al*., 2020).

Consistent with the literature (Kingston *et al*. 2015; Willey *et al*., 2020), it is important to note that women in this study reported the screening tools as clear and easy to answer. However, the approach in which these tools were implemented prevented women from disclosing their mental health concerns. Overall, the women reported no clear preference for any specific tool; however, they highlighted significant challenges in comprehending certain terms used in the GAD-7. To exemplify, the women in this study highlighted the difficulty of translating specific words such as "*edge"* into other languages, which often leads to losing the meaning and essence of the original text. This reflects the importance of effective communication and language sensitivity when designing measures for women of migrant background (Willey *et al*., 2020; Miteva *et al*., 2022).

The implication of this is that there is a need to engage interpreters who are trained in mental health to help facilitate effective screening (Willey *et al*., 2020). Interpreters can act as community champions to facilitate effective communication and build trust between immigrant women and health professionals.

Community Champions programmes have been reported to facilitate trust-building between community groups and health providers (Subramanian *et al*., 2023; Gilburt *et al*., 2024). It is essential to have more ethnic representation among healthcare staff, as this could potentially enhance trust. Additionally, the women in this study voiced concerns about responding to sensitive EPDS regarding self-harm, particularly without adequate information about the potential consequences of disclosing such personal issues. This highlights the need for healthcare professionals to ensure confidentiality and build trust when using mental health screening tools with this group of women. The provision of adequate information around the outcomes of disclosing mental health concerns and availability of immediate support are extremely important in ensuring effective perinatal and postnatal mental health screening (Bayrampour *et al*., 2017; Hsieh *et al*., 2021).

As reported in previous studies (Bayrampour *et al*., 2017; Forder *et al*., 2020), lack of awareness of mental health screening, privacy, fear of disclosure consequences and language difficulties (Willey *et al*., 2020) are barriers to communicating mental health problems. This is an important finding which reemphasises the importance of public awareness campaigns of maternal mental health screening, access to confidential care and advocacy through the provision of trained interpreters to improve maternal mental outcomes.

As with results from previous research (Shannon *et al*., 2015; Anderson *et al*., 2017), the women in this study agreed that conducting screening in a formal setting (formality), providing information on perinatal and postnatal mental health, screening, immediate social support, and ensuring a consistent health professional to foster a trusting relationship (familiarity), including follow-up services (follow-up) and allocating sufficient time, resources and interest (focus) for ongoing management of mental health conditions would better address barriers (**fear** of disclosure) to the effective use of screening tools.

7.1 Strengths and Limitations

A significant strength of this study was the recruitment of women from seldom-heard communities, engaging them in a sensitive discussion and providing a platform for the voices of these unique ethnic groups. Their contributions facilitated the development of a conceptual framework that depicts the six key areas (six Fs) to consider when administering maternal mental health screening tools among women from ethnically diverse and non-English speaking communities. However, this study is not without limitations.

The sample for this study was confined to a single geographic area, specifically at the Family Hub in Smethwick, Sandwell. Most of the participants are from Asian backgrounds and educated to at least a secondary level, suggesting that they do not reflect the experiences of all perinatal and postnatal women from non-English speaking communities in Sandwell.

Future research is therefore needed to explore the perceptions of a larger and more ethnically diverse representative study sample to enrich the findings. Additionally, the use of purposive sampling to recruit participants limits the generation of the findings to the study sample. Although interviews were conducted in English and native dialects as required, those who were unable to speak and understand English were underrepresented.

This study should also be replicated among vulnerable women, including those with disability, protected characteristics and are uneducated. Further research could explore the social factors that significantly impact maternal mental health within various communities. Understanding these influences is crucial for developing effective support systems and interventions.

8.1 Conclusion and Recommendations

This qualitative study concludes that women from non-English speaking communities, specifically in Smethwick, Sandwell, hold a variety of perceptions of perinatal and postnatal mental health screening tools. The women reported varied experiences of being screened for mental health concerns, including feelings of relief from identifying and discussing concerns, feeling happy answering questions due to having a family support network, and feelings of vulnerability, worry, and fear about disclosure. Some felt uncomfortable answering personal questions, while others appreciated the time and screening approach employed by some professionals. Some women perceive the screening tools as effective in identifying perinatal and postnatal concerns because the questions are clear and straightforward. However, those who hold alternative views do so because providers do not share screening purposes and results or scores. Based on the findings from this study, the following recommendations are proposed for the improvement of maternal health.

Recommendation 1:

It is important to consider women's feelings, raise awareness and formally inform women about mental health and its screening, specifically among women from underserved communities and immigrant backgrounds to help address cultural barriers. This can be accomplished by providing mental health information booklets during antenatal visits, creating videos about mental health that are translated into various languages, discussing mental health screening topics in maternal classes and Family Hubs, and organising community events to address cultural expectations that hinder the effective use of mental health screening tools.

Recommendation 2:

Mental health professionals should explain the purpose and benefits of screening in local languages using familiar, clear words, and interpreters if required. Women should be engaged in discussions about their results and information about maternal mental health services and how to access them shared with women. Screening tools should be easy and clear to understand, and the use of polysemous words or phrases should be avoided. Additionally, language barriers should be addressed by removing words that are hard to translate into other languages or would lose their original meaning. It is important to maintain a consistent healthcare provider and ensure effective communication with pregnant and new mothers to build a sustainable and trusting relationship. It is essential to have more ethnic representation among healthcare staff, as this could potentially enhance trust.

Recommendation 3:

There is a need to ensure privacy during screening and raise awareness of mental health screening by providing culturally sensitive information in local languages to address cultural norms. Maternal mental health services could consider applying a community champions model by training interpreters as champions in mental health and effective communication to bridge the communication gap and foster trust between women from non-English-speaking communities and healthcare providers. This initiative can build trust and address the issue of fear due to language barriers.

Recommendation 4:

There is a need to follow up with women after screening to check if anything has changed, refer to services if necessary, and provide support with navigating these services. It is also important to improve the accessibility of maternal services in this area, particularly for women from minority ethnic groups. This can be achieved by collaborating with community groups and organisations, faith sectors and charities to promote the use of community services such as the Family Hubs.

Recommendation 5:

It is important to allocate sufficient time during mental health screening appointments to ensure person-centred care. This can be accomplished by maintaining consistency in care delivery, demonstrating a genuine interest in women's mental health, and encouraging the formation of peer support or social groups. These initiatives can significantly enhance information sharing and promote social wellbeing.

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Appendix I: Health and wellbeing event flyer

Sandwell Metropolitan Borough Council

Believe in children Barnardo's

NHS

HEALTH AND WELLBEING: ENGAGING WITH DIVERSE COMMUNITIES

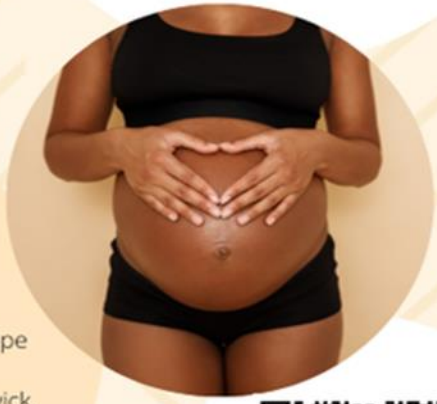
Our services are for you. We need your help to make sure they do what you need them to do.

Join our research group to tell us what you think of the mental health and well-being screening tool which is used during and after pregnancy.
We will use what you say to make improvements to our service.

In particular we would like to hear from individuals who meet any of the following criteria:
Currently pregnant or caring for a child under the age of 3.
From a background of Arab, Indian, Pakistani, Bangladeshi, Chinese, or any other Asian ethnicity.
From a Black or mixed ethnic background, including Black British, Caribbean, African, White and Black Caribbean, White and Black African, White and Asian, or any other multiple ethnic groups.

To book a space, scan the QR code or email:
ayodele_adebisi@sandwell.gov.uk or jane_hemuka@sandwell.gov.uk

Refreshments will be provided on the day.
Arrangements can be made for childcare on the day.



Date: 4 May 2023
Time: 11am - 1pm
Venue: Barnardo's – Cape Hill Children's Centre, Corbett Street, Smethwick, B66 3PX

Appendix II: Interview and focus group topic guide.

This is the preliminary topic guide. The overarching objectives will remain the same, but questions and prompts will be developed as interviews and focus group discussions are undertaken to incorporate any important themes that emerge.

Date of interview	……..
Venue of interview	……
(in person, online, or telephone)	…….
Pseudonym for participant	…….

Instructions:

• Explain Council's policy of how the data will be managed [used only for this research and will not be shared outside of Council team and University of Birmingham assisting with the study – relationship subject to data sharing agreement and confidentiality clauses].

• Ensure participant reads PIS and signed consent form.

• Restate the purpose of the Interview – explore perspective/experiences of prenatal/postpartum mental health screening tools.

• Explain that you are there to understand more about their experiences and views of the effectiveness of the prenatal/postpartum mental health screening tools and that you would also talk about any other issues that are important to them that may not have been covered by the questions in this guide.

• Show participants a copy of the Whooley questions and the 10-item Edinburgh Postnatal Depression Scale (EPDS) to ensure they recall the experience.

• Check if participants have any questions.

•Start audio-recording.

•Begin the interview.

My name is Jane Hemuka and I'm the researcher working on the Maternal Mental Health Screening Tools research. Thank you for taking part in this interview. Can you just confirm for me that you have read the Information Sheet and signed the Consent Form? During the interview, we'll be talking about your experiences during your antenatal and/or postanal mental health screening by a health professional. Shall we begin?

TOPICS TO BE COVERED IN THE INTERVIEW

1. Could you please describe your experience of being screened for emotional and mental health problems (such as depression and anxiety disorders) during and after pregnancy, using one of these (show interviewees the screening tools) mental health screening tools?

2. Did you feel comfortable answering the questions from the screening tools? Yes or No, and why?

3. What do you think worked well during the screening program/session?

4. What do you think didn't work well during the screening program/session?

5. Were you informed of the name of the screening tool that was used? Yes or No. If Yes, what mental health screening tool was used during your screening session?

6. Were you informed of the purpose of the perinatal/postnatal mental health screening tool and process that was used? Yes or No. If yes, could you please explain your experience of how the midwife discussed the purpose of the screening tool and process when you were at your first antenatal/postnatal mental health screening visit?

7. Were you informed of the result of the perinatal/postnatal mental health screening? Yes or No, and how did you feel about that?

8. If you answered Yes to question 7, could you please explain your experience of how the health care professional (example, midwife, health visitor, nurse, doctor) discussed the results of your screening when you were at your first antenatal/ postnatal mental health screening visit?

9. Do you think the screening tool used during and after your pregnancy is effective in identifying mental health problems (such as depression and anxiety disorders) amongst women from non-English ethnic groups? And why do you think so?

10. Did you answer honestly to the question from the screening tool? Yes or No, and why?

11. What do you think are the barriers that hinder the effective use of the mental health screening tools used for expectant and new mothers from non-English speaking communities?

12. What do you think could improve the effective use of the mental health screening tools for expectant and new mothers from non-English speaking communities?

13. Do you think it would be beneficial for expectant and new mothers from non-English communities to take part in a mental health screening during and after pregnancy?

14. Did the midwife refer you to another service after administering the perinatal/postnatal mental health screening tools?

15. Do you have any other comments, doubts, or concerns to make about the screening tool we haven't talked about?

This is the end of the interview. Thank you for taking part.

Appendix III: The maternal mental health screening tools project advertising flyers

The Maternal Mental Health Screening Tool (MMHST) Project

PRESENTED BY SANDWELL METROPOLITAN BOROUGH COUNCIL

Dates: TBC

Time: TBC

Venue: Barnado's – Smethwick Family Hub, Corbett Street, Smethwick. B66 3PX.

Cost: FREE

We are seeking the involvement of women from non-English speaking communities to join our MMHST Project to share their knowledge and opinions about maternal mental health screening tools.

Bring your own knowledge and opinions to the session.

All travel and childcare are covered, and food will be provided on the day.

How to get involved?

If you are happy to take part in an anonymous interview or focus group session to help us gather information about the project, please speak to your service provider who will contact the research team.

How many spaces are available?

10-12