

Analysing the Impact on Equalities

Title: “National Perinatal Mental Health Project Report - Perinatal Mental Health of Black and Minority Ethnic Women: A Review of Current Provision in England, Scotland and Wales”

Relevant line in [DH Business Plan 2011-2015](#) :

What are the intended outcomes of this work? *Include outline of objectives and function aims*

The Mental Health Equalities Programme which forms part of the National Mental Health Development Unit commissioned this report, and the studies on which it is based are part of ‘The National Perinatal Mental Health Project’. The remit of this report and related studies is to facilitate better understanding of how and to what extent current and planned perinatal provision is capable of meeting the needs of BME women. This information will support development of a national strategy to improve perinatal mental healthcare via regional managed clinical (care) networks, which will act as mechanisms for planning and delivering more holistic and responsive models of care. It is essential, therefore, that these networks address the needs of all women – including the most vulnerable, where services exclude people or fall short of performing equitably, who are often marginalised and/or deemed ‘hard to reach’. Failure to recognise and address the barriers to accessing care that such women might experience could result in their needs being unrecognised and/or unmet, as a result of service failure and possible breach of human rights.

This report focuses on perinatal mental health and women from BME communities. The purpose of the report is to gather information that will enable national and regional mental health commissioners and service providers to:

- map current/ proposed perinatal mental health provision for BME women
- identify gaps in provision
- identify and share good practice.

Who will be affected? *e.g. staff, patients, service users etc*

The remit of this report and related studies is to facilitate better understanding of how and to what extent current and planned perinatal provision is capable of meeting the needs of BME women. This report draws upon the relationship of perinatal mental health and the impact on the children, fathers as carers, families and communities.

This information will support development of a national strategy to improve perinatal mental healthcare via regional managed clinical (care) networks, which will act as mechanisms for planning and delivering more holistic and responsive models of care. The report discusses issues of need that arise out of the overlapping aspects of ethnicity, culture, language and gender with mental health. This represents a useful approach for influencing commissioning and provision of services. This, in turn, can mean that services are better able to respond to the presenting needs of all women. To underpin this, the report calls for better pre- and post-

registration training in order to strengthen the understanding and skills of practitioners. It also highlights the importance of a stronger evidence base in terms of clinical as well as service evaluation.

Evidence *The Government's commitment to transparency requires public bodies to be open about the information on which they base their decisions and the results. You must understand your responsibilities under the transparency agenda before completing this section of the assessment. For more information, see the current [DH Transparency Plan](#).*

What evidence have you considered? *List the main sources of data, research and other sources of evidence (including full references) reviewed to determine impact on each equality group (protected characteristic). This can include national research, surveys, reports, research interviews, focus groups, pilot activity evaluations etc. If there are gaps in evidence, state what you will do to close them in the Action Plan on the last page of this template.*

Methods

The evidence for this report is extensive. The evidence has been taken from a large range of sources including formal research, government policy and service user consultation. Below is a list of the strategies used to gather information compiled for this report: A number of strategies were used to collect relevant information.

1 A review of the literature was undertaken throughout the period of data collection and report writing (August 2009–June 2010). The purpose of the literature review was to ensure that findings about effective provision of perinatal mental healthcare were placed within the context of what is currently known nationally and internationally about BME women and perinatal mental health.

2 A survey was undertaken using a questionnaire developed with input from practitioners and academics with expertise in perinatal mental healthcare (Appendix 1). The questionnaire, which was distributed nationally via existing regional and other networks, was designed to collect data to:

- facilitate mapping of current and proposed provision for BME women
- provide insight into how participants' definition of 'BME' relates to service delivery
- provide information about the extent to which service providers and commissioners believe BME-specific services (where they exist) meet the needs of women for whom they are designed
- enable practitioners to report on the extent to which services for BME women are integrated into the perinatal and mental health services more generally – both in terms of current provision and planned service development
- encourage regional and local representatives to share good practice.

Participants were stakeholders in the provision of perinatal mental healthcare, such as members of regional networks and mental health commissioners. Adopting a snowball sampling approach, participants were asked to pass the questionnaire to colleagues and relevant members of their networks. It was anticipated that this strategy would ensure that the questionnaire reached all levels of service provision.

3 An electronic data collection sheet was used to survey mother and baby units (MBUs) in England, Scotland and Wales about the ethnic backgrounds of the women using their services a) at the time of the survey and b) in the previous 12 months.

Data analysis

Simple descriptive statistics have been used to report quantitative findings. Qualitative data have been reported using direct quotation from transcripts and questionnaires. They have been used primarily to illuminate quantitative findings. To protect respondents' identity, quotations are reported using the numbers assigned to completed questionnaires

Disability *Consider and detail (including the source of any evidence) on attitudinal, physical and social barriers.*

This report deals with mental illness which in itself is a disability. The Mental Health Equalities Programme is currently undertaking some work on deaf people and mental health.

www.mentalhealthequalities.org.uk

Gender *Consider and detail (including the source of any evidence) on men and women (potential to link to carers below).*

This report increases the evidence base to more effectively address needs of women from BME communities and perinatal mental health. It focuses primarily on BME women as it is a review of literature and service provision in perinatal mental health, since the publication of 'Into the Mainstream' (DH, 2002) and 'Mainstreaming Gender Equality and Women's Mental Health' (DH, 2003) which relates purely to women's mental health. The Department of Health published a consultation strategy 'Into the Mainstream' in September 2002. This set out the case for a focus on women's mental health: Understanding the nature and causes of mental ill health in women, and how these differ from those in men, is essential to the development of mental health care that is responsive to women's needs. Whilst there are a number of risk factors linked to mental health, research into the impact of factors that give protection against mental ill health is in its infancy. However the role of family ties, positive parenting experiences, social networks and good housing are all likely to play a part. Risk factors that impact particularly on women are:

- socio-economic factors eg poverty, 'work in the family';
- physiological factors eg hormonal and reproductive changes;
- psychological factors eg life events, social isolation;

The Gender Equality and Women's Mental Health Programme has been reviewing progress 5 years on from the prior publication of Into the Mainstream (2002) and Mainstreaming Gender and Women's Mental Health: Implementation Guidance (2003). The progress report [Working towards Women's Well Being](#) was published and launched in 2010.

Working towards Women's Well-being reflects and contributes to the government-wide

commitment to ensure fairness and equity for all women, of all ages and all backgrounds.

Department of Health (2003): *Mainstreaming Gender and Women's Mental Health: Implementation Guidance*. London: Department of Health.

Department of Health (2002): *Women's Mental Health: into the mainstream. Strategic Development of Mental Health Care for Women*. London: Department of Health.

National Mental Health Development Unit (2010): *Working towards women's wellbeing: unfinished business*. National Health Equalities Programme. London: Department of Health. www.mentalhealthequalities.org.uk

The Mental Health Equalities Programme has commissioned further reports which mention the needs of men as fathers. *Untold Problems: a review of the essential issues in the mental health of men and boys* was published in February 2010. The review was commissioned by the National Mental Health Development Unit (NMHDU) from the Men's Health Forum.

Delivering Male: Effective Practice in the mental health of men and boys was published in January 2011. This guidance was commissioned by the NMHDU from the Men's Health Forum.

Race Consider and detail (including the source of any evidence) on difference ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers.

This report will have a positive effect on this area as clearly sets out the needs of this group and areas for further improvement for issues relating to black and minority ethnic women and perinatal mental health directly address within this report. In summary, these findings, together with previous research, suggest that proposals to improve perinatal mental health provision by developing more holistic care pathways are timely. An important part of this work is facilitating development of models of care that incorporate all levels of service provision so that the full spectrum of perinatal mental health need can be addressed. Ensuring that BME and hidden minority women such as travellers and English-speaking non-White women do not continue to fall through the net is integral to the success of these strategic developments.

This report is a welcome addition to the knowledge base regarding the position of women from Black and minority ethnic (BME) communities. Increasing national and international evidence about the potentially deleterious consequences of perinatal mental illness for some women's long-term mental health and the close inter-relationship between maternal and child health suggests that urgent action is required to develop/improve care pathways and interventions. Its importance also lies in the light it sheds more broadly on the perinatal needs of all women. The report discusses issues of need that arise out of the overlapping aspects of ethnicity, culture, language and gender with mental health. This represents a useful approach for influencing commissioning and provision of services.

To underpin this, the report calls for better pre- and post-registration training in order to strengthen the understanding and skills of practitioners. From the national survey of current perinatal mental health provision was undertaken using a questionnaire developed for this study, a number of respondents raised concerns about their ability to manage the range and complexity

of mental health needs of some BME women. This was especially so in respect of refugees and asylum-seeking women. Practitioners felt that neither pre- nor post-registration training had equipped them to deal with the impact and consequences of these women's experiences. This suggests that greater emphasis on equipping healthcare professionals to work with an increasingly diverse patient/client population is required in initial training.

It also highlights the importance of a stronger evidence base in terms of clinical as well as service evaluation. Critically, it underscores the requirement to develop and improve care pathways in primary care and in non-statutory provision, as part of an overall framework for improvement. The confluence of structural factors, such as unavailability of BME therapists and lack of 'culturally-sensitive' care pathways, with personal and cultural factors, such as attitudes and beliefs about mental health and illness might represent significant (sometimes insurmountable) barriers to accessing care for BME women. Further research is needed to understand the complex relationships between these issues and to devise effective strategies for reducing the inequalities in access, care and treatment experienced by some communities.

Baker-Henningham H, Powell C, Walker S, Grantham-McGregor S. *Mothers of undernourished Jamaican children have poorer psychosocial functioning and this is associated with stimulation provided in the home*. European Journal of Clinical Nutrition 2003; 57: 786-792

Rahman A, Iqbal Z, Bunn J, Lovel H, Harrington R. *Impact of maternal depression on infant nutritional status and illness: a cohort study*. Archives of General Psychiatry 2004; 61: 946-952

Cinnirella M, Loewenthal KM. *Religious and ethnic group influences in beliefs about mental illness: a qualitative interview study*. British Journal of Medical Psychology 1999; 72: 505-524

Brown JSL, Casey SJ, Bishop AJ, Prytys M, Whittinger N, Weinman J. *How black African and white British women perceive depression and help-seeking: a pilot vignette study*. International Journal of Social Psychiatry, 2010; OnlineFirst, published on March 2, 2010 as doi:10.1177/0020764009357400

27 Edge D, Mackian S. *Ethnicity and mental health encounters in primary care: help-seeking and help-giving for perinatal depression among Black Caribbean women in the UK*. Ethnicity & Health 2010; 15: 93-111

Age Consider and detail (including the source of any evidence) across age ranges on old and younger people. This can include safeguarding, consent and child welfare.

The focus of the research within this report is on women of child bearing age and seeks to improve their access to appropriate services. Age is not specifically considered within this report, but it is touched upon in relation to perinatal mental health and family needs therefore covering the needs of children. Younger people are being addressed more widely by the Children and Adolescent Mental Health Programme which forms part of the Children and Families Department of Health work stream. Older women form part of the Later Life Mental Health programme of the Mental Health Equalities National Programme. Age also forms part of the new National Mental Health Policy work with both younger years and older adults needs being specifically mentioned. Web: www.mentalhealthequalities.org.uk.

Gender reassignment

The needs of transgendered individuals whilst not considered within this report are being addressed by the wider work of the Gender Equality Mental Health programme.

www.mentalhealthequalities.org.uk

The Department of Health has also published a report relating to how to provide appropriate and effective services for Transgendered people, 'Trans: A practical Guide for the NHS' (DH, 2008). This document gives practical best practice advice for NHS organisations to address their responsibilities relating to trans employment and healthcare delivery.

Sexual orientation *Consider and detail (including the source of any evidence) on heterosexual people as well as lesbian, gay and bi-sexual people.*

It is not appropriate to address sexual orientation in this report and therefore does not have a negative impact on this area. However as a result of plans to extend their focus to all strands of equality, there is better coverage of this issue within the Mental Health Equality National programme.

Stonewall carried out a piece of research on Lesbian and Bisexual women, clearly detailing the level of discrimination these women experience published in 'Prescription for Change: Lesbian and bisexual women's health check 2008' (Stonewall, 2008).

Issues relating to sexual orientation are being addressed in other arenas. The Department of Health published 'Sexual orientation: A practical guide for the NHS' (DH, 2009) to help the NHS provide response and effective services for Lesbian, Gay and Bisexual people.

CSIP/NIMHE published 'Mental disorders, suicide, and deliberate self harm in lesbian, gay and bisexual people – a systematic review' (CSIP/NIMHE, 2007) recognising the higher rates of self harm and suicidal ideation in this group of individuals. In 2009 the Department of Health and the National Mental Health Development Unit commenced a piece of work aimed to address this issue. They commissioned a piece of work that will scope out how to best provide support to these individuals and meet their needs.

Stonewall's 'Prescription for Change' research of lesbian and bisexual women found high rates of mental health problems compared to the general female population.

'Sexual Orientation: A practical guide for the NHS' provides advice and guidance to enable NHS organisations to meet their responsibilities relating to sexual orientation service delivery and employment practice.

NIMHE (2007) Mental disorders, suicide and deliberate self-harm in lesbian, gay and bisexual people London: NIMHE

<http://www.nmhd.org.uk/silo/files/mental-disorders-suicide-and-deliberate-selfharm-in-lesbian-gay-and-bisexual-people.pdf>

Religion or belief *Consider and detail (including the source of any evidence) on people with different*

religions, beliefs or no belief.

Religion and belief are referred to but are not addressed directly in this report, the Mental Health Equalities Programme has done some work on religion or belief. Please see website address below and list of policy drivers below around spirituality and religious belief.

www.mentalhealthequalities.org.uk

There are an increasing number of policy drivers around Spirituality and Religious faith. As a legal and policy framework around equalities develops, and the cultural make-up of British society grows ever more diverse, there are a significant number of major policy imperatives set by Government, and also expressed needs set out by people who use mental health services:

- Personalisation, through the White Paper: *Our Health Our Care, Our Say* (2006), the 2007 Commissioning Framework for Health and Well-being, and *Putting People First* (December, 2007), the Government concordat to transform adult social care.
- The need to create greater social cohesion and community well-being, as set forward in: *Our Shared Future* (2007).
- The Equalities legislative and policy agenda ('Delivering Race Equality' now placed within a broader Equalities agenda, which includes 'Religion and Belief')
- The accent on promoting a healthier social and economic community, as promoted by Lord Layard.
- The need to meet the aspirations recorded by service users and carers in surveys, research and through inspection reports.
- The 2001 revised patient's Charter states that: NHS staff will respect your privacy and dignity. "They will be sensitive to and respect your religious, spiritual and cultural needs at all times" (p29).
- The clear evidence from research that membership of Faith communities can improve physical and mental health.
- The importance of ethnicity and of faith in individual and group identity. NB: The recent Leeds University research (July, 2010) indicates a rise of ethnic diversity from 8% in 2010 to 20% in 2051. There will also be changes in where people live.
- Increased cost benefit analysis achieved through working with the motivations of individual service users, carers and community groups.
- The social inclusion agenda in which Spirituality has an important role to play.
- The Recovery approach, as set out in eg the CSIP/RCPsych/SCIE document of 2007.
- The need for Health and Social Care to be sensitive to user, carer and staff belief systems [*Religion or Belief: A practical guide for the NHS*, DH, January, 2009]. Links across to Scottish guidance.
- *New Horizons* (DH, November, 2009) accent on prevention and early intervention
- The NHS contract.
- The March 2009 WHO Europe report by Dr Lynne Friedli, emphasises the challenge of social inequality to the mental health of the nation.
- The developing public health and mental health policy framework eg *New Horizons: Confident Communities, Brighter Futures - A framework for developing well-being*, March, 2010.
- The 'Total Place' approach to partnership and service delivery.
- DH White Paper (July, 2010): *Equity and Excellence: liberating the NHS*, speaks of a "genuinely patient-centred approach"- "Nothing about me without me".
- The 'Big Society' concept of the incoming Government, with its accent on

community organisations taking a lead, and 'subsidiarity'.

Pregnancy and maternity Consider and detail (including the source of any evidence) on working arrangements, part-time working, infant caring responsibilities.

This report focuses on the mental ill health during pregnancy and early motherhood, or 'perinatal mental illness', is a serious public health issue with potentially deleterious consequences for women's life-long mental health and the health and wellbeing of their children and families from BME communities. The Mental Health Equalities Programme has a list of resources on perinatal mental health, please see website address below.

www.mentalhealthequalities.org.uk

Carers Consider and detail (including the source of any evidence) on part-time working, shift-patterns, general caring responsibilities.

This report references statistics and research into how perinatal mental health impacts on other family members, children and fathers.

See reference list below from report:

Ballard CG, Davis R, Cullen PC, Mohan RN, Dean C. *Prevalence of postnatal psychiatric morbidity in mothers and fathers*. British Journal of Psychiatry 1994; 164: 782-788

Baker-Henningham H, Powell C, Walker S, Grantham-McGregor S. *Mothers of undernourished Jamaican children have poorer psychosocial functioning and this is associated with stimulation provided in the home*. European Journal of Clinical Nutrition 2003; 57: 786-792

Rahman A, Bunn JEG, Lovel H, Creed F. *Maternal depression increases infant risk of diarrhoeal illness – a cohort study*. Archives of Diseases in Childhood 2006; 92: 24-28

Weissman M, Feder A, Pilowsky D, Olfson M, Fuentes M, Blanco C, Lantigua R, Gameroff M, Shea S. *Depressed mothers coming to primary care: maternal reports of problems with their children*. Journal of Affective Disorders 2004; 78: 93-100(8)

Patel V, Prince M. *Maternal psychological morbidity and low birth weight in India*. British Journal of Psychiatry 2006; 188: 284-285

Lees M. *Gender, ethnicity and vulnerability in young women in local authority care*. British Journal of Social Work 2002; 32: 907-922

Righetti-Veltema M, Bousequet A, Manzano J. *Impact of postpartum depressive symptoms on mother and her 18-month-old infant*. European Child & Adolescent Psychiatry 2003; 12: 75-83

Oates MR. *Adverse effects of maternal antenatal anxiety on children: causal effect or*

developmental continuum? British Journal of Psychiatry

The Mental Health Equalities Programme commissioned further reports which mention the needs of men as fathers. *Untold Problems: a review of the essential issues in the mental health of men and boys* was published in February 2010. The review was commissioned by the National Mental Health Development Unit (NMH DU) from the Men's Health Forum.

Delivering Male: Effective Practice in the mental health of men and boys was published in January 2011. This guidance was commissioned by the NMH DU from the Men's Health Forum.

Please see website address for links: www.mentalhealthequalities.org.uk

Other identified groups Consider and detail and include the source of any evidence on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access.

Issues relating to BME women and families and the impact of socio-economic groups are addressed within this report. The report will have a positive effect on this area as clearly sets out the needs of this group and areas for further improvement. This report gathers research information, and identifies issues on how services can engage more effectively with BME communities alongside the principles stated in the Social Care White Paper: A Vision for Adult Social Care: Capable Communities and Active Citizens .

Self A, Zealey L. *Social trends*. London: Office of National Statistics, 2007

Amin K, Oppenheim C. *Poverty in Black and White: deprivation and ethnic minorities*. London: Child Poverty Action Group/Runnymede Trust, 1992

Engagement and involvement

Was this work subject to the requirements of the cross-government [Code of Practice on Consultation](#) No

How have you engaged stakeholders in gathering evidence or testing the evidence available?

A number of strategies were used to engage stakeholders in gathering evidence for this report:

1 A review of the literature (August 2009–June 2010) was completed to place the studies in the context of what is known nationally and internationally about ethnicity and perinatal mental illness.

2 A national survey of current perinatal mental health provision was undertaken using a questionnaire developed for this study. Data was collected between September 2009 and March 2010.

3 Mother and baby units in England, Scotland, and Wales were surveyed about the ethnic backgrounds of women using their services between May and July 2010 and in the previous 12 months.

Due to the sample size, quantitative data was analysed using only simple descriptive statistics. A limited amount of qualitative data was collected from questionnaires and follow-up telephone conversations with consenting participants. Their qualitative responses have been used to illustrate the quantitative findings. To protect respondents' identity, their quotes are reported using the numbers assigned to the completed survey questionnaires.

Please see appendices in report for copies of surveys. See findings of surveys listed in next section for full information regarding stakeholders.

How have you engaged stakeholders in testing the policy or programme proposals?

The survey was undertaken using a questionnaire developed with input from practitioners and academics with expertise in perinatal mental healthcare. The questionnaire, which was distributed nationally via existing regional and other networks, was designed to collect data to facilitate mapping of current and proposed provision for BME women, and encourage regional and local representatives to share good practice. Participants were stakeholders in the provision of perinatal mental healthcare, such as members of regional networks and mental health commissioners. **Please see appendices in report for copies of surveys.**

Key findings:

Survey 1: Review of current provision

- Of the 45 completed questionnaires received, 31 (69%) were returned by secondary care professionals. Only 20% (n=9) were completed by primary care practitioners. Consultant psychiatrists (n=15) were most likely to return questionnaires.
- Altogether, 27 different professional groups were named as members of perinatal mental health teams. Specialist nurses (n=16) and doctors (n=17) were the additional team members most commonly cited by participants. With the exception of specialist health visitors (n=11) and social care staff (n=11), primary care practitioners were not mentioned.
- More than half the respondents (53%, n=24) stated that they currently had no services specifically for BME women, although 13% (n=6) had plans to develop services in the future.
- Some respondents stated that they adopted an overtly 'inclusive'/'universalist' philosophy of care. This means that they actively encouraged BME women to integrate while working to provide individualised care. These services emphasised the important role of community-based, voluntary sector provision for ensuring that women's cultural needs were met.
- While acknowledging that the needs of BME women were often unmet, some respondents pointed out that this was also the case for white women. In this context, perinatal services were described by a number of respondents as 'patchy' or 'poor' for the majority of women, irrespective of ethnic background.

An electronic data collection sheet was used to survey mother and baby units (MBUs) in England, Scotland and Wales about the ethnic backgrounds of the women currently using

their services, and over the last 12 months.

Survey 2: Survey of mother and baby units (preliminary findings)

In May 2010, questionnaires/data collection sheets were distributed via email to managers of the mother and baby units (MBU) in England, Scotland and Wales. To date, 13 have been returned – one of which is incomplete.

As these are preliminary findings from an ongoing study, they should be interpreted with caution. However, findings from this survey (the first of its kind) raise important issues about MBUs in general and their accessibility to BME women in particular.

Preliminary findings

- The 13 participating units provide a total of 91 beds. This is 76% of the national total of MBU beds (n=120) available in England, Scotland and Wales to women with severe perinatal mental illness. At the time of the survey, 71 women were inpatients within the participating services. While this represents 79% bed occupancy, there was a wide range of occupancy rates, with some units operating at or under 50% capacity.
- Two thirds of the women (66%, n=47) in MBUs in May 2010 were white British. The next largest ethnic group were Eastern European women (n=6), of whom four were classified as recent migrants.
- According to respondents, a total of 380 women had occupied the 91 available beds in the previous 12 month period. This suggests a high throughput, with each bed having been used by four women in a 12 month period.
- Over 12 months, occupancy rate by ethnicity was similar to that recorded by cross-sectional data. However, occupancy levels for white British and Irish women were even higher (75%) than in the cross-sectional survey. South Asian (n=36) and African (n=20) women were the biggest ethnic minority groups. Among South Asians, Pakistani women (n=9) were the largest sub-group. Apparently no Chinese or Middle Eastern women had been admitted to any of these MBUs during the 12 month period covered by the survey.

For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:

The report reviews a wide range of literature, research and evidence. The results of the surveys are discussed in the report. As part of the National Perinatal Mental Health Project, there has been national stakeholder's event to engage regional stakeholders in this work and also for dissemination when published. The national project also developed links with the good practice examples sited in the report, as well as attending regional events with stakeholders in perinatal and infant mental health.

See links below:

<http://www.nmhdu.org.uk/our-work/mhep/gender/perinatal-mental-health/>

<http://www.nmhdu.org.uk/our-work/mhep/gender/perinatal-mental-health/regional-networks-for-perinatal-mental-health/>

The national event had presentations from a range of networks from across the regions on perinatal and infant mental health networks. Those regions were:

- East Midlands Region [Download presentation](#)
- South Central Region [Download presentation](#)
- North West Region [Download presentation](#)
- Eastern Region [Download presentation](#)

Summary of Analysis *Considering the evidence and engagement activity you listed above, please summarise the impact of your work. Consider whether the evidence shows potential for differential impact, if so state whether adverse or positive and for which groups. How you will mitigate any negative impacts. How you will include certain protected groups in services or expand their participation in public life.*

In summary, these findings, together with previous research, suggest that proposals to improve perinatal mental health provision by developing more holistic care pathways are timely. An important part of this work is facilitating development of models of care that incorporate all levels of service provision so that the full spectrum of perinatal mental health need can be addressed. Ensuring that BME and hidden minority women such as travellers and English-speaking non-White women do not continue to fall through the net is integral to the success of these strategic developments. The aim of the report is to support commissioners, planners and front line staff across health and social care in perinatal mental health service provision to women from BME communities. Overall there will be no adverse impact but there is anticipated positive impact on women from BME groups.

Cinnirella M, Loewenthal KM. *Religious and ethnic group influences in beliefs about mental illness: a qualitative interview study*. British Journal of Medical Psychology 1999; 72: 505-524

Brown JSL, Casey SJ, Bishop AJ, Prytys M, Whittinger N, Weinman J. *How black African and white British women perceive depression and help-seeking: a pilot vignette study*. International Journal of Social Psychiatry, 2010; OnlineFirst, published on March 2, 2010 as doi:10.1177/0020764009357400

27 Edge D, Mackian S. *Ethnicity and mental health encounters in primary care: help-seeking and help-giving for perinatal depression among Black Caribbean women in the UK*. Ethnicity & Health 2010; 15: 93-111

Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups

Eliminate discrimination, harassment and victimisation *Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).*

The report aims to increase evidence base of research for perinatal mental health service provision for women from BME communities. The report addresses this issue, and is evidenced by the provision of examples of how services can be provided to achieve better outcomes for women which are illustrated throughout the report.

In terms of perinatal mental health, the evidence base for BME women in the UK is currently relatively poor. It is therefore difficult to advocate effectively for and/or implement the kind of services that would best meet the needs of BME women on the basis of evidence-based practice. Evaluation of current provision and new research to establish levels of morbidity and unmet need among BME women are urgently required to bridge the evidence gap.

Increasing national and international evidence about the potentially deleterious consequences of perinatal mental illness for some women's long-term mental health and the close inter-relationship between maternal and child health suggests that urgent action is required to develop/improve care pathways and interventions.

Baker-Henningham H, Powell C, Walker S, Grantham-McGregor S. Mothers of undernourished Jamaican children have poorer psychosocial functioning and this is associated with stimulation provided in the home. *European Journal of Clinical Nutrition* 2003; 57: 786-79

Rahman A, Iqbal Z, Bunn J, Lovel H, Harrington R. *Impact of maternal depression on infant nutritional status and illness: a cohort study*. *Archives of General Psychiatry* 2004; 61: 946-952

Advance equality of opportunity *Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).*

This report aims to promote equality of opportunity for women from BME communities. Within mental health and perinatal mental health historically there has been insufficient focus on the mental health needs of BME women. This report provides the information needed to assist organisations identify the areas further progress is needed to develop more effective services for women from BME communities.

Promote good relations between groups *Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).*

The report promotes good community relations in that it encourages service providers to engage with communities in order to develop services that better meets the needs of women and women from black and minority ethnic communities. The whole ethos underpinning the women's mental health and the delivering race equality policy is to engage service users and listen to their express wishes instead of making assumptions regarding needs.

What is the overall impact? *Consider whether there are different levels of access experienced, needs or experiences, whether there are barriers to engagement, are there regional variations and what is the combined impact?*

The report has shown that there is regional variation in the way that services are provided and that the aim of the report is to offer examples of good practice that will enable areas that do not do so well to improve. These findings also suggest that more needs to be done to improve

the links between primary and secondary care and between statutory and voluntary sectors. In light of evidence that BME women currently favour community-based models, perhaps greater emphasis should be placed on creating care pathways in which non-statutory provision is more formally integrated into mainstream services. This will help reduce inequalities that exist for women from BME communities.

Addressing the impact on equalities *Please give an outline of what broad action you or any other bodies are taking to address any inequalities identified through the evidence.*

The report is aimed at addressing the needs of BME women with perinatal mental health issues and improving service provision. Mental illness is a disability and therefore the report aims to promote positive attitudes and improve understanding.

The delivering race equality and the women's mental health agenda is strongly underpinned by the philosophy of service user participation. This report continues to outline the need for this thus encouraging ongoing participation of disabled people.

Issues relating equality and human rights run through the entire of this report. Whilst the individual human rights have not been clearly defined and addressed specifically they are cross cutting themes throughout the report.

The remit of this report and related studies is to facilitate better understanding of how and to what extent current and planned perinatal provision is capable of meeting the needs of BME women. This report forms part of a direct action to improve the inequalities some women experience from BME communities. It is a core function of the report.

Action planning for improvement *Please give an outline of the key actions based on any gaps, challenges and opportunities you have identified. Actions to improve the policy/programmes need to be summarised (An action plan template is appended for specific action planning). Include here any general action to address specific equality issues and data gaps that need to be addressed through consultation or further research.*

Recommendations for the report states that further research is urgently need to:

1. Improve the evidence base on perinatal mental health in BME women, both for producing accurate denominator data in order to assess prevalence and incidence of morbidity and for developing effective interventions. Without better evidence, it is likely that provision will continue to fail to achieve anticipated benefits and that good practice will remain

confined to isolated pockets rather than being shared across all levels of provision.

2. Improve understanding of the factors that might account for low levels of diagnosis and/or engagement with mental health services among BME groups. This is exemplified by the relatively low number of minority women accessing MBUs, despite their disproportionate exposure to known psychosocial risks.

3. Further research is needed to understand the complex relationships between these issues highlighted in this report, and to devise effective strategies for reducing the inequalities in access, care and treatment experienced by some communities.

Please give an outline of your **next steps** based on the challenges and opportunities you have identified.

The next steps include arrangements for the publishing the assessment and ensuring relevant colleagues are informed of the results. Dissemination of this report on BME women and Perinatal Mental Health to National Organisations to national websites ie ChiMat and National Perinatal and Infant Mental Health Network, National CAMH's Programme, Regional/National Perinatal and Infant Mental Health Networks, Parent Mental Health and Child Welfare Network and National BME Organisations. This area of work will be picked up as part of the new mental health strategy.

Include here any or all of the following, based on your assessment

- Plans already under way or in development to address the **challenges** and **priorities** identified.
- Arrangements for continued engagement of stakeholders.
- Arrangements for continued monitoring and evaluating the policy for its impact on different groups as the policy is implemented (or pilot activity progresses)
- Arrangements for embedding findings of the assessment within the wider system, OGDs, other agencies, local service providers and regulatory bodies
- Arrangements for publishing the assessment and ensuring relevant **colleagues** are informed of the results
- Arrangements for making information accessible to staff, patients, service users and the public
- Arrangements to make sure the assessment contributes to reviews of DH strategic equality objectives. •

For the record

Name of person who carried out this assessment: Cathy Freese

Date assessment completed: 25 January 2011

Name of responsible Director/Director General: Melba Wilson

Date assessment was signed:



Action plan template

This template is to help you develop your action plan. You might want to change the categories in the first column to reflect the actions needed for each policy.

Category	Actions	Target date
Involvement and consultation		
Data collection and evidencing		
Analysis of evidence and assessment		
Monitoring, evaluating and reviewing		
Transparency (including publication)		

v0.1

I've said policy or programme, but later we've said activity. Did we agree on what this would be? I think the Duty is function, policy or practice – or it was....

Is this table OTT?