Birmingham & Solihull United Maternity & Newborn Partnership (BUMP)
BME perinatal mental health focus group

Summary Report

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A Focus group took place at a Children's Centre in Birmingham on 5th of May 2017. Three mums participated. The local community is largely Pakistani in origin. Two of the mums speak very little English so the focus group was supported by an interpreter. The group was co-facilitated by the Deputy FSW Manager and an Acacia Locality Manager.

Participants:

All participant mums originate from Pakistan. All three mums have experienced perinatal mental health problems within the past three years.

Mums were encouraged to lead the conversation to facilitate a good, open, conversational flow of information. Hence, the questions were not posed and answered in a systematic fashion. All questions were presented, to set the scene, as part of an introduction to the session. Women were then free to respond and to talk freely about their experiences in relation to their perinatal period and their mental health. Further questions were posed to help clarify barriers and difficulties. One of the mums acted as an interpreter. Notes were taken and form the basis of this overview report.

Introductory questions for the session were as follows:

What was your experience like with the midwifery service in Birmingham with regards to your mental Health?

1: Were your mental health needs recognized?

2: How easy was it to access mental health services?

3: How culturally appropriate were the services?

4: Did they meet your needs?

5: How could this be improved for other mums with a BME background?

6: What changes specifically do you think are needed to make it easier for you to be able to access mental health services in Birmingham?

Conversation

Mum 1:

Mum 1 is presently pregnant with her second child. Mum described her first pregnancy and service via Birmingham Maternity Services and felt that this was not as supportive as her present pregnancy.

Mum discussed that her initial onset of poor mental health had been a result of abusive experiences in her maternal family and her previous relationships prior to her becoming pregnant.

She discussed that whilst she was aware that these relationships had affected her, she would not have been able to identify these feelings as poor mental health. Mum now recognized looking back that, as her first pregnancy progressed and during the latter stages, she experienced what she now knows to be anxiety/depression. She experienced flashbacks and memory of the previous abuse (she didn't realize at the time that this was actually abuse). This was not addressed during her first pregnancy but she was prescribed anti-depressant tablets at some point following the birth of her first child.

Mum 1 remembered that at her first appointment for her second pregnancy the midwife was aware of her history in relation to mental health. At this first appointment the midwifery service provided another person who spoke her language. At this appointment Mum was asked whether she required any counselling Mum said no. Mum 1 said that at her next appointments language support was not present throughout but was sought only if Mum indicated that she did not understand or that she was concerned about something. Mum 1 said that on one occasion a lady who was doing the bloods was asked to provide language support. The staff member was known to Mum 1's community.

Mum 1 cannot read English so was unable to familiarize herself with her pregnancy notes and her birth plan. Mum usually takes her pregnancy notes in to the Children's Centre for a member of staff to go through with her. Mum said that many of the terms used by midwives were unknown to her. An example is the use of the term 5ths to describe baby's head being engaged. Mum had no idea what this meant.

Mum 2

Mum 2 was referred to the Children's Centre, being new to area. Family Support engaged with the mum and made an original referral to ACACIA in 2011 when ACACIA operated their original drop-in service model for the community.

Mum 2 returned to the Children's Centre recently as a self-referral for low well-being and new pregnancy. Mum did not re-engage with ACACIA at this time.

Mum 2 was the first Mum to access the ACACIA/Children's Centre BME Community Engagement Project recently piloted. Following disclosures Mum was referred to specialist midwifery services and has been able to access further appropriate services to address her historical trauma's and mental health, thus she feels the maternity service for the latter part of this pregnancy has improved. However, had she not been identified as needing specific mental health midwifery services and been referred it is uncertain whether she would have been offered this service.

Mum 2 disclosed that she had an arranged marriage which was abusive and had been sent over to the UK from Pakistan. After she had been in England for just a few months her husband's family felt that there was something wrong with her and had sent her back to Pakistan. They told her parents that she had been possessed by the JIN evil, black magic. Mum also disclosed that she had been taken to the family doctor by her mother in law (the doctor was a family friend). Mum said that the doctor had said to her mother in law "Treat her like your daughter and send her back to Pakistan."

On arriving in Pakistan Mum discovered that she was pregnant. She was quickly returned to her husband and his family in England. Her sister in law went along with her to all her antenatal appointments to support her with language. This arrangement meant that Mum was inhibited from speaking openly during appointments and was unable to recognize or access her need for mental health services. The sister in law answered many questions directly without giving Mum an opportunity to speak for herself. Mum recognized that on several occasions the sister in law gave different answers to what the mum had said. When she quizzed the sister in law her reply was that "You do not tell these people this kind of thing." Mum discussed there was never an opportunity for her to speak to anyone alone.

Mum 3

Mum 3 experienced the loss of her child within weeks of the birth. She struggled to cope and this had massive re-percussions in her family life and to her relationship with her partner. She had a good grasp of English language so this was not a significant barrier. However, she didn't feel that anybody recognized or responded to her needs at the time. She didn't know who to talk to or how to talk about it. She developed a reactive postnatal depression and was eventually referred to Acacia by the health visitor. She has since had a further successful pregnancy and birth and has not experienced any further significant PND.

Common Themes

- The use of family and friends as interpreters was counter-productive and in our mums' experiences was inhibitive, and generally a bigger barrier to successful communication than not having them present.

- Suspicion of health professionals and health workers who are known to the family and/or community. There was wide consensus from all three mums that they would be reluctant to share information to any of these health staff, believing that confidentiality would not be maintained and that their information would be fed back to their family. Two of the mums gave specific examples of this happening. One of them concerned a GP. The exception to this rule seemed to be regarding Family Support Workers who were overall seen as very trustworthy.
- All mums felt that insufficient time and space was given for them to build a trusting relationship with their midwives and health professionals. They felt rushed and felt that there were huge communication barriers due to lack of good, independent, empathetic interpreter and cultural barriers.
- There were huge barriers to good communication in the form of two of the mums' ignorance and inability to comprehend mental health problems and PND. Their language doesn't even have a word to describe mental illness apart from the notion of being somehow possessed. This made it difficult to navigate the system due to very low or non-existent baseline knowledge.
- Birth Plans are written in English. This was of no use to one of our mums, who cannot read English and had no access to anyone who could read and interpret for her.
- One of the mums was told that the midwifery service in her region did not do any home visits following hospital discharge. The mother and baby were expected to attend a community clinic. Mums in this culture/community are not allowed to leave the house until after the 40th day following birth.
- Two of the mums felt frustration that they didn't remain with the same midwife but saw several. This was very detrimental to their ability to build trust and/or to feel comfortable and safe enough to disclose mental health issues.

Learning points

1. The use of family and friends for interpretation should not be normal practice and should be avoided if at all possible. Ideally all BME women should be given access to an independent professional interpreter.
2. It is important to develop a mechanism to ensure that family friends/relatives are not involved in delivery of maternity care to these mums as this may inhibit open communication from the mum.
3. All of the mums agreed that insufficient time was given for them to build a level of relationship with their health professional which would allow them to be open and honest about their feelings.
4. The midwifery service needs to be more person centered, particularly in the context of cultural needs. There needs to be more opportunity to discuss and plan for specific cultural needs ie.

Consideration needs to be given to written information/birth Plan and ideas explored to overcome language barriers eg. birth plan could be voice recorded in home language if women cannot read English or their own written script.

5. There is currently a huge gap in the recognition and understanding of mental illness and PND amongst this community. Considerable work needs to be done to raise understanding amongst this client group. In an environment where mental illness is not even a concept, how likely is it that a mum would recognize and report symptoms?
6. Two of the mums identified sexual violence as a significant issue and felt that they would have benefitted if this had been identified sooner and they had been offered a specific pathway to help them to address this. Disclosures of rape or sexual violence should ideally have their own pathway and not simply be categorized as mental health. A specialist midwife for" rape and sexual abuse" would be ideal.

Conclusion

The results of this focus group are not new news to those of us working in the sector, but it has been useful to verify directly with these mums what the main barriers and issues are in relation to perinatal mental health service provision for some BME communities. The key areas identified by this group are:

1. Language
2. Effective relationship building and communication.
3. Lack of confidence in health professionals from own community.
4. Lack of significant culturally appropriate person centered care pathways.
5. Lack of understanding and awareness of mental health and perinatal mental health.

Many of these issues can be addressed with a more purposeful and innovative approach to the needs of the BME community but are likely to involve additional cost.

Note: *All of the mums in the focus group have accessed the drop-in service provided by the Acacia/Children's Centre community engagement pilot project. This provided a safe place with language support to explore issues. The mums found this invaluable, providing a forum and a referral pathway to address most of the identified issues. Unfortunately, this pilot was time limited and has now concluded. It was significantly costly to provide. (Acacia can provide more information on this model if requested).*