Understanding the current needs of women in Sheffield related to their mental health and wellbeing needs, to develop more tailored services locally.

A rapid qualitative research report identifying the current mental health challenges and needs of women in Sheffield, using local health data and short semi-structured interview, with a focus on inequalities and intersectionality.
Exploring the impact of the Covid-19 pandemic on these women.

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Abstract

The nature of this research was to identify the current mental health challenges and needs of women in Sheffield, by using local health data and short semi-structured interviews, while exploring the impact of Covid-19 on the mental health of these participants. Research conducted by Healthwatch Sheffield (2020) found patients lacked a choice of health treatments, yet some treatments proved to be more effective for certain individuals than others, thus patients needed to be consulted regarding their preference for the type of support they received. This was corroborated by the Department of Health and Social Care's (2018) research which revealed women felt they needed greater control over decisions made within the mental health services. From previous research it was hypothesised that one of the main needs of women in Sheffield would be that they would want greater control and input of the service they receive and will desire more concise and direct communication. Participants (N= 17), were selected for interviews through a combination of volunteer and opportunity sampling, all participants identified as women, of which 7 were mothers. Data was analysed using thematic analysis (Braun and Clarke 2006), which found themes such as accessibility, the impact of Covid-19, current services, GP services, support networks, inequalities and developments to services, all to occur frequently throughout the interview data. Findings highlighted descriptions of a generally negative impact of Covid-19 on mental health, due to issues such as accessibility to online services and feelings of isolation. Further conclusions regarding inequalities derived the lack of recognition for the role of a mother to play a part in individuals' mental health, additionally services were depicted to lack resources and thus, have reduced accessibility for BAME individuals. Implications of this research suggest that mental health services in Sheffield, need to adapt the support they offer to equate for minority groups, increase accessibility and improve the experience of the first point of access to support individuals have.

Introduction

Mental health problems in recent years have significantly been on the incline, making an increasing issue within society which needs to be addressed. Henceforth mental health services need to improve and update their practices and approaches to supporting individuals. McManus, Bebbington, Jenkins and Brugha (2016), reported one in six adults were subject to a mental health problem: specifically, around one in five women. As of the 2019 Covid-19 pandemic, an ongoing study by Sheridan Rains, Johnson, Barnett, et al. (2021) for University College London (UCL), have been producing rapid research aiming to investigate the impact of Covid-19 on mental health care in the U.K and any innovations that have arisen as a result of these impacts. Further current research conducted by the Mental Health Foundation (2020) during the Covid-19 pandemic, found that as of December 2020, over half (54%) of the U.K adult population, reported feeling anxious or worried due to the impact of the pandemic. Additional research, such as Davies (2020) investigated the repercussions of Covid-19, recognising that between June 2019 and March 2020, 10% of adults were experiencing moderate to severe symptoms of depression, by June 2020 this had almost doubled to 19%; these highlight how mental health services are of paramount importance due to the evidently urgent need for them with an increasing national mental health crisis. Statistics provided by Sheffield City Council (2019), indicated that 62% of adult social care service users do not have as much social contact as they like, thus implying that Covid-19 has had an adverse effect on individuals' feelings of loneliness, a state which has been shown countless times to negatively affect mental health. Therefore, advice for services on how to adapt to individuals' current needs is essential in the current climate.

Drawing upon the impact of Covid-19 on individuals' mental health, specific research into women's health such as that conducted by Tryl (2021), revealed 42% of women said they felt more worried about their mental health as a result of Covid-19, in comparison to 32% of men. Further, the study found 49% of women said in the last year that they have been worried about their mental health, yet in contrast only 34% of men agreed with this. This highlights the gender difference in concerns regarding mental health, implying that women's mental health has been affected by Covid-19 to a greater extent. Previous research into women's mental health has scrutinised those suffering with depression, Brown and Harris (1978), identified four vulnerability factors which were shown to increase the likeliness of women developing depression, in the presence of a stressful life event. One factor of key relevance was identified as the lack of full or part-time employment. This is further reiterated by the work of Aneshensel (1986), who found women have lower odds of being depressed if they are working. Additionally, the World Health Organisation (WHO) (2000), aligned with these findings, recognising unemployment to be interlinked with poor mental health. Low income and loss of income were further shown to be predictors of anxiety and depression (Shevlin et al., 2020). This highlights employment to be one of the key factors in susceptibility to poor mental health, as employment is crucial to individuals' financial situation. Sheffield City Council (2019) found 17.3% of the local population to experience deprivation relating to low income, further 4% of residents in Sheffield, are estimated to have an unsecured debt, greater than £15,000. Gorgievski-Duijvesteijn, Bakker, Schaufeli and Van der Heijden, (2005), supported the impact of financial stress being detrimental to mental health, finding increased levels of financial problems, temporarily increased psychological distress. Henceforth, these findings directly relate to the impact of the Covid-19 pandemic, meaning many individuals have lost their jobs, have been placed on furlough or have had to transition to working from home. Following this, an abundance of research has been conducted into mental health services and the way in which they should support individuals. Research regarding mothers' mental health, support and social care needs, by Tischler, Rademeyer and Vostanis (2007), revealed that services should encourage mothers to maintain contact with their support network and thus, services should provide more formal peer support systems. A supplementary study (Augsberger, Yeung, Dougher, & Hahm, 2015) looking at how services can improve for Asian American women with depression, recommended offering culturally sensitive services and raising mental health awareness in the local community. A number of pieces of research have identified that one predominant factor which seems to be frequent in literature questioning improvements to services, is the service users' control over the support they receive. The Department of Health and Social Care (2018) found a more personalised approach to support to be preferred, as women felt they needed a louder voice and greater control over the decisions made regarding them. Healthwatch Sheffield (2020) further stated that individuals weren't always offered a choice of treatments, despite some treatments being more effective for some individuals, hence finding the receiver of support should always be consulted about their care. These studies provide the basis upon which improvements to mental health services should be implemented.

The current research will investigate specifically into the Sheffield area, aiming to gain greater insight into the needs of women in this region, regarding their mental health and wellbeing.

Sheffield City Council (2019) expressed statistics stating that approximately 9% of people living in Sheffield are clinically depressed, highlighting a significant need for mental health services in the area. This report aims to listen to and understand the experiences of women in Sheffield who live with mental health problems; it further will discuss how to create and develop mental health services for said women; and finally, shall explore the impact of the Covid-19 pandemic on mental health. Based upon the research discussed above, this study hypotheses that one of the main needs of women in Sheffield will be that they want greater control and input in the service they receive and will desire more concise and direct communication.

Method

Participants

Participants were selected for the research, using the method of volunteer and opportunity sampling, in which emails requesting female service users for participants, were sent out to mental health organisations in Sheffield. Seventeen participants, aged between 18-64 years, were recruited for the research, all participants identified as female and of this, seven were mothers.

Procedure

Participants were initially provided with an information sheet (found Appendix A), which detailed the aims and objectives of the study. Participants then provided signed informed consent (see Appendix B), providing evidence that they understood their participation in the research. Confidentiality was addressed through providing participants with unique identifiers and anonymising any names or places mentioned in the interviews, replacing them with pseudonyms. Participants were reminded of their right to withdraw their data up until 1st March 2021. The research was checked for any potential risks, to ensure participants were protected from harm; any potentially hazardous items were addressed in the debrief, following participation. Participants completed a thirty-minute semi-structured interview, using Zoom video call software, which was recorded. The interview consisted of initially a short sociodemographic questionnaire (Appendix C), followed by a series of questions regarding their experience of mental health services. Upon completion of the interviews, participants were thanked for their time and sent both a debrief sheet (Appendix D) and shopping voucher. The interviews were then transcribed and coded for thematic analysis, which identified a number of key themes relevant to the research.

Analytic approach

Data was collected from semi-structured interviews and was selected for Thematic Analysis. This consisted of a number of accounts from participants, discussing their views and experiences of mental health services; primarily the needs of women. Pre-existing literature has found a lack of tailored services to address individuals' needs. Henceforth, the data analysed in this report shall aim to identify the needs of service users and recognise their personal experiences regarding mental health, in order to suggest future improvements. The following report will analyse data using Thematic Analysis, devised by Braun and Clarke (2006). This process is of paramount importance when conducting and analysing qualitative research, as it allows researchers to condense data into significant themes through a step-by-step process. In order to permit researchers to familiarise themselves with the data, transcripts were read and reread before meaningful items were highlighted and coded. Following this, any recurring points in the data were collated from codes into specific themes, which were then refined and defined. Through using this method, we were able to recognise seven themes such as accessibility, the impact of Covid-19, current services, GP services, support networks, inequalities and developments to services. Accessibility consisted of codes such as practical difficulties; severity of mental health; awareness of services; and also, long waiting lists for support. Another theme was the impact of the Covid-19, this was made up of accessibility to technology, the shift from in-person to online support services and the impact of loneliness. Current services consisted of accounts discussing both positive and negative aspects of the current services. Despite GP services being recognised as many patients first point of access to support, many described bad experiences. The theme support networks mainly consisted of ideas of support being based around community and friendship. Inequalities for minority groups, considered gender, motherhood, ethnicity, wealth and disabilities. Our final theme was developments to services to be made, and was composed of statements regarding signposting, control and other suggestions for change. The themes identified above, allowed for a greater analysis of the data, using particular extracts from interviews as evidence to support analysis in these subsections.

Findings

Accessibility

Through analysis of interview data, a number of participants alluded to the matter of accessibility to mental health services. This recognised issues such as service users' awareness of mental health support available, touching on which specific services participants frequently seemed to be familiar with and those they weren't. Further, practical difficulties, which considered aspects such as patients' distance to travel to services and the use of transport to get there. Accessibility also recognised that the severity of the patients' mental health, played a role in how easy it was for them to get support. Additionally, long waiting lists were highlighted to be a barrier to accessing services, as no instant support was made available to those in need.

Evidence of service users' awareness of mental health support was illustrated by numerous accounts from participants of organisations such as "Mind"; "IAPT"; 'Light Peer Support" and "No Panic Sheffield". This highlights that these services are more accessible than some smaller organisations, as public awareness of them is evidently greater. Awareness is undoubtedly essential to accessibility, as without being aware of what support is locally available to an individual, they will lack the means to acquire support from a service which best suits their needs. When asked what services are involved in mental health support, one participant stated "a lot and I think that's the main thing is (.) I don't think many people have that (1.0) knowledge", this emphasises that services need to increase public awareness of their organisations, as the majority of people lack knowledge about mental health support. This statement is further supported by a separate account from another interviewee, who claimed it was "easy to access them [services] once you know about them". The participants' emphasis of the word "once" stresses how individuals' lack of awareness negatively impacts accessibility to support services, as prior knowledge of support is essential.

Additional accounts referred to practical difficulties, identifying them as a barrier to accessing mental health support. One participant commented “when you're in (1.0) crisis or you’re in (.) bad mental health even a 10-minute bus ride can be overwhelming”, this highlights how some individuals have to rely on public transport to access support, when in reality, travelling on busy buses etc. may worsen their symptoms of their condition and result in them being discouraged from attending support sessions. This point is further corroborated by another individual stating “I do have to take a taxi cause normally it's quite triggering and I get quite wiped out so actually having to get the bus and noise and stuff like that is is quite difficult for me”, this again reiterates how the physical journey to support is not acknowledged to be a distressing experience to patients, and as an auxiliary account illustrates “I think a lot of mental health conditions you don’t particularly want to be travelling on public transport”.

A third key aspect of issues regarding accessibility was the severity of patients’ mental health. Various interviewees discussed how the support they received and the speed in which they received help depended on how close to crisis they appeared. One individual claimed “I felt like almost like I had to prove (.) I had to prove how bad I felt to get the treatment I possibly needed”, while another stated “you’re in and you’re out like you have to be really ill to get in”, both these accounts accentuate how support was only offered to them once they had demonstrated the severity of their mental health problems and how support was a matter of urgency. Drawing upon this, a service user alluded to services only providing access to support when the individual fit the specific criteria of a crisis, this is reinforced by one interviewee saying “thought I’d be able to get bereavement counselling through the NHS but because I have anxiety not depression (.) because I don't take medication, I'm not entitled to bereavement counselling”. This emphasises the need to ‘tick a box’ to be eligible for treatment. Further, another participant stated “just because I’m managing, doesn’t mean to say that I’m coping”, which underpins the reality of a lot of mental health conditions, highlighting that just because one individual is at crisis point, it doesn't mean all other individuals who are still suffering but not at crisis, are not as entitled to being worthy of support. Henceforth the severity of mental health is evidently a factor in accessibility of support.

A final factor which had evident effect on accessibility was the length of waiting list times to access services. Two separate participants discussed how when accessing services, they appealed for help as they needed it at that moment in time, however due to waiting lists this was not possible. One interviewee clarified “mine was put through as an urgent request and I was given an appointment six weeks”; the emphasis of ‘urgent’ highlights how despite her condition being of a pressing matter, she still received no instant access to support. The second participant backs this up, stating; “you’re already [at] a point where you’re past needing help (.) and then you've got to wait another six months maybe a bit longer for the services”. Additionally, other service users expressed how when “you're waiting at least 6 months. When you want to access that myself, I'm poorly then (.) you know and 6 months is just yeah”, this extract from an interview again, supports claims that waiting times negatively impact accessibility to mental health support, as individuals can’t access services when they really need them. A further account stated having “been told I have to wait another year” this emphasises the length of waiting to receive support and a when patients have to wait such an extended period of time, situations can change and support is not accessed when it is needed; as one interviewee stated when discussing the topic of waiting times, “I’ve just felt discouraged”. This statement sums up the feeling service users are left with after being informed of the time they must wait to access any help or support.

Impact of the COVID-19 pandemic

Following on from the theme of accessibility, the impact of the Covid-19 pandemic proved to be a prominent topic in the data. Covid-19 was depicted to have a negative impact on individuals' accessibility to the services, as it meant service users had to rely on technology and Wi-Fi connection to get support. One interviewee referred to the impact of Covid-19 by disclosing how "it's just the whole digital inclusion thing really, so a lot of people living with mental health conditions don't use Facebook, they don't have smart phones for a reason", this alludes to how changes to services, as a result of the pandemic, meant support depended on individuals having access to technology, yet this naively didn't consider the wellbeing of some individuals whose mental health is better off without using smartphones and social media. Further this participant continued on to highlight "even if people have got a smartphone, they er often haven't gotten a Wi-Fi package", which further isolates them from being involved in digital inclusion, which was vital for support during the pandemic.

Another account discussed the changes to services from being in-person to online, stating "when I have spoken to therapists or whatever it's all had to be online which for me personally is like, I find it hard to build a connection with someone through video screen". This implies despite alternatives being offered to in-person support, patients haven't found it to be equivalent to the care they were receiving prior to the pandemic. Further, as the participant claims she finds it "hard to build a connection" online, it could be divulged that she may not open up and be as candid, as she would in person with her therapist, thus the support she receives may not be as beneficial to her mental health. A supplementary interview reported how "I haven't really been going since they've been online, just cause I struggle with that kind of stuff", this calls attention to how the change in services, due to Covid-19, has interfered with patients' willingness and motivation to receive support. This is an extreme side effect of the pandemic, as not only has it been shown to increase mental health problems, but it is also evidently reducing individuals' willingness to seek help when services are online. However, not all participants criticised the shift from in-person to online services, for those individuals that found travelling to receive support particularly difficult, using online support reduced this stress for them, and as one participant stated regarding accessing services "through Covid where we can realise you can actually do it from the safety of your own home".

An additional factor of the Covid-19 pandemic, which stood out in the data, was the effect of loneliness and social isolation on individuals. Many participants discussed how working from home left them feeling cut-off and lacking social support. One interviewee stated "there's nobody really around so like socially you don't have the people there to speak to, so I think like you don't have people to bounce off and support (.) you're very isolated in the job", this insinuates how individuals rely on colleagues and workplace banter to ease stress and provide a social network of support in a working environment. Further, as well as socialising to break up the work day, one interviewee highlights the exhausting nature of working from home, saying initially "it was great because [you] didn't have to travel to meetings (.) so that was wonderful so liberating but then you realised that there wasn't that gap in your day (.) but you were just having back-to-back meetings (1.0) and more meetings (.) you had more work you end up with and also just exhausting". Hence expressing how changes to working life caused the participant more stress as they struggled to separate their work and home life and take breaks throughout the day.

Current services

A third theme identified within the data, was the concept of current services and thus, both positive and negative aspects of them. The majority of participants discussed negative experiences with the services, for things such as having a lack of choice and involvement in the decision making regarding their mental health. One interviewee's account described how there wasn't "a selection of different options to choose, a menu if you will, erm of things you can look at and think actually yes that will be helpful to me, (.) you're kind of told what your given", this emphasises patients' lack of choice regarding their care and the lack of a partnership approach, between staff and service users, leaving patients unsure of what their alternatives are. This is further backed up by another individual depicting how service users are uninformed, stating "because they don't have the knowledge to know that there is more than one therapy that you can access so they'll say for example try CBT and say Oh well therapy don't work for me so I must be broken or erm this must be wrong but (.) there is a lot of different other therapies and services out there and I don't think that's (.) said enough (.) I don't think that's explained to people". This stresses the importance of patients being aware of what's available to them, as the interviewee states individuals have thought "I must be broken" when their first attempt at a particular kind of therapy doesn't go well. Further another participant corroborated this, "there's a lot of different therapies but you know like it's so simple but they don't say that to you and you go away feeling broken like you know there might be a lot people (.) I know a lot of people that have been to breaking point of like suicide...because it hasn't worked for them that's it". Hence it is vital service users are made aware they have a wide range of options, in case one form support doesn't address their needs sufficiently. Again, this point was facilitated by a different interviewee illustrating the services as "fast food mental health", going on to say "it feels very much you stand there with your hands open waiting for what your given and then (.) if you're not given the thing you wanted your still sort of go off with it and try and figure it out", this adds weight to the argument that there is a lack of choice and service users are left feeling unsatisfied with the support they have received. One participant exemplified their lack of choice with support, where the treatment offered didn't seem to benefit them, instead causing them more stress "I got offered CBT like fifteen times (.) and every time I went, I hated it and I felt like I had got homework to do...when you're in a bad mental state the last thing you want to do is sit down and do work".

Another point regarding the current services that participants drew attention to was the offer of only short-term support, which expected them to be 'fixed' following their brief encounter with the services, when in reality what they may have needed was something more long term. "It's not gunna get changed in one like 12 week block erm (.) but I felt like there wasn't really the option for any more" this expresses how there was quite an abrupt end to the support she was receiving, another participant again reiterated this: "you've got 12 sessions and then that's it, you kind of (.) like I know I'm not fully sorted (.) I don't feel anywhere near as depressed as I was but (.) all you like the underlying issues that led to that I think are still (.) they're still there in some form erm (.) so I wouldn't rule it out having to (.) to go back". Both of these accounts express the same view that services offer individuals a limited period of time to get support and at the end of this period it is expected the patient will be recovered, however this generally doesn't match the feelings of the patient. Henceforth the services are evidently not user-focused and lack taking into account the needs, wants and feelings of the patient.

Further criticisms of current services discussed the lack of instant support, as despite individuals receiving a quick initial assessment, the majority experienced long periods to wait before they received any formal support, during this time, one individual described it as "you're in limbo there's nothing in between". This emphasises how individuals aren't provided with support when they need it most, are expected to be complicit waiting alone with no mental health aid. This period of waiting has even been depicted to cause desolation as one interviewee referred to it as "even more distressing cause it's like no please help me, ohh well you'll have to wait in the queue I'm sorry, so it's sort of the options your given is sort of wait in line". This refers back to the previous point of having a lack of choice and how patients' suffering is increased by an absence of instant support. Considering this, Sheffield specifically has been identified as particularly poor when it comes to providing prompt support services, with another interviewee stating "compared to when I have (.) conversations with err friends in other parts of the country, it seems to be quite slow to get services in this city". Therefore, it should be recognised that this is inadequate for Sheffield, as if other areas of the country are able to meet service users' needs in a shorter response time, this city should be able to too.

Current services have again been faulted due to their lack of consistency with supplying service users with the same staff members. This was highlighted to be a prominent issue as a service user reported "you have to constantly explain yourself over and over again to a new person every time": not only is this providing inconsistent support for service users, but it is also a clear example of not utilising resources and staff to the most productive extent and an inability to organise services to their full potential. Another account reiterated this point saying "because you got different people each time and often there was a little bit of a different approach" the emphasis on both "constantly" and "different approach", stresses the service users' frustration with the lack of fluidity between transitions of staff members.

Moreover, a number of interviews referred to having been almost turned away from support services, after having not met the specific criteria, with one participant disclosing "I got told by IAPT in Sheffield if I was to go there, they didn't help people like me with trauma related issues" and another stating "I was told I wasn't suitable for it (.) for whatever reason, (.) but how do they know unless they start treating you". Both of these accounts highlight how they were not only disregarded by services, but they were also not signposted or advised on alternative services where they could seek help and support. This suggests that their mental health needs were not met, despite attempting to access help, henceforth Sheffield's mental health services neglected individuals in need.

However, despite all these criticisms, some interviewees disclosed positive experiences with support services. Some of these pragmatic points were specific to one service in particular: Survivors of Depression in Transition; this service was seen to address criticisms of other services who lacked providing support during the waiting period between an initial assessment and formal support. One account referred to this saying "they have like a holding (.) place so you not just left for (.) six months or more waiting for the service, you actually have somebody who can speak to in the meantime", this addresses the need for instant support and despite the informal care offered during the waiting period, it still provides essential and valuable help to those who need it. As most services don't tend to offer this, one participant described it as being “such a surprise and such a WELCOME that there was someone to talk to a little bit before a counsellor”. The individual’s emphasis on it being a ‘surprise’ and ‘welcome’, implies how much this care meant to her.

Another service user described services taking her opinions into account and involving her in the decision making regarding her care; “they listen to my opinions and how I'm feeling and I can kinda (1.5) choose what sort of support I need”, she further goes on to describe how “there's been a lot of times where they've actually contacted me and said oh, I've got this really good idea and I think it would be great for you, what do you think”. This evidently alludes to the idea, that not all services disregard the patient’s wants and that some services do focus on a more person-centred approach to care.

GP services

The topic of GP services was frequently brought up by numerous participants during interviews, it was widely acknowledged by most individuals that their GP would be their first point of access to support. One account from an interviewee stated “I’d probably speak to my GP first and then go from there in terms of what they suggest”, an individual corroborated this with “GP services which is the first place you go coz (.) erm especially when people are really confused about their mental health and they don't really know as much they will go to the GP”. These two accounts both imply that individuals in need of support, approach their GP initially as their first point of call for support, as they are already familiar with this service. Thus, without the knowledge of what other services are available, this is the easiest option, “cause that’s the usual route”.

However, despite the GP being most peoples’ first point of call for support, many participants discussed having had bad experiences with their GP. One account disclosed “I wouldn't probably go to the doctor to be honest”, thus alluding to having a previously negative encounter, another individual voiced “when it comes to the doctors, I found there were barriers”. This again supports the argument that GP services were not providing patients with adequate support and thus, were discouraging them from returning to the service. Following on from this, a third interviewee went on to say “from GPs I’ve had some absolutely horrendous interactions with GPs, one recently in fact 2 weeks ago that I had to make a complaint about them”, this emphasises the extent to which services provided such poor support, that the patient felt so strongly about her experience, she had to resort to making a complaint.

A further point made regarding GP services, highlighted how patients felt the options available to them weren’t explained “I didn't feel I had much of an option when (.) I’m going through the GP”. This was an important factor to consider, as with GPs being most peoples’ first point of access, it was implied by participants that GPs should be the ones informing and signposting them to other options and information. “The GP needs to really sit down and say to people look this is one thing that we can try but if it isn’t for you we can try something else there is a lot of different therapies out there and it it's not gunna be for everybody because everybody is different”, this interviewee expresses their view of the GP services, drawing attention to the fact that their GP didn’t provide them with alternatives, and as another participant claimed “if you go to a GP they just give you medication”, hence strongly insinuating GPs don’t always provide support tailored to the patient. Moreover, a separate account remarked “GP's are always really reluctant to (.) you know, take that step and so it's always (.) it's the wrong time of the year or let's leave it until summer that's a better time to take you off medication and then I think there is a general fear so I'm asking for one thing but (1.5) not necessarily getting it", this heavily infers how the individual felt they had no control over the choices their GP made about them, and how their GP seemed to almost make excuses as to why the patient couldn't have a say in their care "it's the wrong time of the year…". This could be considered to be a reason as to why many participants described GP services in a poor light.

Support networks

The interview data further revealed the importance of individuals having a support network to help them through their mental health problems. Numerous participants described support networks as being a key, essential feature of mental health support, proposing services consisting of a "collection of everybody working together". Interviewees referred to "speaking to other people in the group that are also in the similar position to me" to provide comfort to them, as relating to others' experiences seemed to assure them that they were not alone. Many people discussed the strengths of peer support, stating "you get something from sharing your experiences with people", thus indicating that this form of support was felt to be extremely beneficial to service users, consoling them in a way in which other forms of individual therapy could not. Further, drawing upon the idea of social support, one account disclosed how "when I'm really really anxious... I don't hide away, I like to be with people, (.) I want to be connected with people and that distracts me and just makes me more comfortable", this highlights how often, those with mental health issues experience feelings of isolation, yet social support seems to reduce this, providing individuals with a community, who understand what they're going through.

Additionally, many individuals stressed the significance and value of having a support network, claiming "I built a community around me (.) that saved me". This indicates how having social support is indispensable to those severely suffering from mental health problems, and the consequences of an absence of this form of support could be costly. Further, one individual described clearly not having a strong support network around her, referring to how "everyone's like way too busy to like be bothered at the minute that's how it (.) that's (.) and I don't think people mean that at all (.) but I just think that's how it comes across (.) I always feel like I'm a problem", this infers how the individual experiences feelings of loneliness, believing she can't express her feelings to others as they're "too busy" to care. This emphasises the need for mental health services to provide users with a community, where users can talk about their problems, open up, and as one interviewee commented, having someone who "listens... understands… advises", thus, providing an essential type of support. Another account referred to the need of having social support outside of the mental health services, suggesting the importance of "family support...because it's <u>there</u> when you need it, but professional support is 9 'til 5", indicating that informal care is of great value to individuals as it provides them with more intimate, personal reassurance, which can't be offered by formal services. Thus, implying that for those who don't have that family support, mental health services need to help increase users' opportunities to meet others outside of formal support, in order to strengthen their social support networks.

Inequalities for minority groups

From the data it was found that inequalities were a common theme explored by interviewees, touching on topics such as; gender, motherhood, ethnicity, class and disability. When examining the subject of gender, many participants seemed to find a clear difference in the treatment of different genders. When discussing access to mental health services, one participant described finding “loads of barriers, to access and especially as a woman (.) I experience moments of (.) dismissive like ohh your hormones ohh it's maybe, (.) you know never associated with (.) I’m not feeling well this has being going on for a long time something is happening like (.) even from other women that were doctors I was really shocked (.) you know I was surprised (1.0) everything was my womanly it nothing was nothing to do with er (.) a particular health issue er, I found that very frustrating”, this infers the dismissive nature of service staff towards female patients. The interviewee recollects how upon accessing services, her problems seemed to be dismissed and not taken seriously, as professionals brushed aside symptoms classing them as simply down to female biology. Further, as the individual emphasises the attitudes from ‘other women’, it is implied that this is evidently not only an issue within institutions, but within society itself, as the participant implies expecting female staff to relate to female issues, and thus, not have her problems disregarded so abruptly. This account is corroborated by another individual who voiced “it's very hard for women in particular because er we always get (.) dismissed more than men”, this again brings to light the contrast in the treatment of different genders within the services, emphasising how women’s’ opinions are readily more disregarded. A supplementary account deliberates gender differences further, saying “I do wonder how many (.) care coordinators would consider (1.0) the menopause affecting erm (1.0) medication that people are prescribed for mental health conditions”, this indicates both services’ lack of consideration for specifically female needs and how since the patient is evidently not aware of staff recognising this issue: the topic of the menopause is clearly not addressed as much as it should be. Another participant inferred sexist attitudes within the services, stating “they had what they called the lady doctor patronisingly she’s not just a normal doctor, she’s a lady doctor”, this emphasises the gravity of the gender divide, and the difference not only between service users but between staffs’ behaviour towards those of the female gender. This participant then went to on to discuss the need for an option to have a preference regarding staff members’ gender “I always feel better seeing a female (.) person practitioner or whatever because I just think they understand things ((laughs)) like periods and hormones and autism and you know it sometimes (.) like the old man aspect makes me think ahh I don't think they really understand what I'm on about”. This infers how service users should be given a choice over the staff member they see, as if patients feel a staff member of a certain gender is less likely to understand their problems, the individual is more likely to refrain from disclosing their true thoughts and feelings. Another account expressed the need for having choice over staff gender, as she contrastingly preferred seeing a male staff member, stating “I don't respond well to female therapists I think a lot of my my histories is trauma related to females in a sort of position of authority”, thus alluding to gender related trauma, a matter which should be taken into account when providing individuals with mental health services. Moreover, when considering other genders, one interviewee reported having “a non-binary person in our group who who had expressed real challenges accessing support and factoring in things like use of their pronoun and things like that has been really difficult for them”, this implies services having a lack of awareness and respect for those who identify as LGBTQ+ and not taking into account the additional needs and problems faced by these people.

Drawing upon the concept of gender, motherhood was frequently mentioned by participants, as having a significant impact on their mental health. One service user described her role as a parent being “where my mental health [problems] began”, going on to say “it's just so much pressure”, hence implying the extent to which being a parent impacts her mental health. A separate account referred to the experience of motherhood, discussing how “women just get on with it around giving birth really and (.) you know [post-natal] depression isn't the baby blues it's (.) it's a mental health condition”, this infers the expectations of women when becoming a mother and the presumption that this huge life change does not require the need for additional support. This account further alludes to how some mental health conditions are only experienced by mothers; thus, the needs of this group should be given greater recognition by mental health services. When referring to her son, one mother disclosed “I don't want him listening to my struggles... if they could provide like childcare so when we do run our groups, we have a separate like a volunteer to play with the children so that the mums can talk openly and safe without the fear of the children listening”, this alludes to the struggle for mothers to gain access to services, while maintaining their role as a parent, without causing their child worry or stress about their health. This highlights the impact of motherhood adding to mental health problems and creating more issues regarding both access to mental health services and receiving support from them. In light of this, a different participant disclosed how when with her child “I'm like more short tempered, everything feels more stressful, the responsibility, having to deal with him and his needs and cope with my own stressors I do find it more relaxing and easier to cope with my own life when he's at his dads”, this insinuates the pressure of the responsibilities mothers face and how even when they’re struggling they have to put their child’s needs before their own, a situation which can have a hugely detrimental impact on their own mental health.

Further inequalities identified within the data, touched on the impact of ethnicity within mental health services. It was highlighted by one interviewee that services seem “very tailored to sort of (1.0) I don't know White British”, this implies the lack of cultural awareness from mental health services. The participant continues on, to state of her support group; “three maybe four members including myself… that are from an ethnic minority erm the rest are predominantly you know White British… I mean you’ll know about looking at Black African and Black Caribbean erm sort of erm (.) mental health statistics erm that's it's quite surprising that we <u>don't</u> have any in that group so it obviously shows that ways that, that marketed or perceived isn't working”. This directly criticises services’ approach to inclusivity regarding patients’ ethnicity and how the BAME community lacks representation within support services. Further, as the patient refers to the way in which mental health support is ‘marketed’ and ‘perceived’, claiming it ‘isn’t working’, it suggests there is an evident need for change and a shift in attitudes to meet ethnic minority groups’ needs to a greater extent. Another account shared how “as a foreigner (.) I don't understand how the system works”, implying that services don't make the way in which they operate clear to those from different cultures, hence change is evidently necessary. Drawing upon this, an additional interviewee referred to conception of services as being “much harder for people with (.) English as a second language… if it's your first language (.) it can ease the stress levels and anxiety levels because you know you understand [services]”, this infers the extra barriers faced by those from minority ethnicity backgrounds, as accessing services outside of one’s native language can cause greater stress and add to one’s mental health issues. Considering this, another participant commented “I feel that maybe someone that understands the culture and the language is very important” when services are providing patients’ with support, as a shared understanding and ability to relate may allow the patient to feel more comfortable opening up; as the participant continues on to summarise if “someone trained actually comes from the same ethnic background, [this] may be useful”. A separate interviewee recognised the lack of acknowledgement for different cultures, stating “I don't remember receiving any written information in my language”, thus alluding to both the absence of materials in alternative languages and the missed opportunity for the patient to be offered any options for support in her own language. However, another participant suggested using an “interpreter” to address this issue. Considering this, an additional interviewee discussed the lack of signposting in languages other than English, “a lot of the posters you see aren't in other languages”, this undeniably will create barriers to accessing mental health support to those from other cultures.

Furthermore, inequalities were addressed when regarding class, with one participant stating support was offered more to those who were “middle class and White”, this alludes to both class and race having an impact on accessibility to support services. Additionally, class was seen to have an influence on accessibility to support services, as when public services failed to meet the needs of one individual, she discussed how her only alternative was to use private services, however this depended entirely on whether she had the financial means to access it. She stated “I probably can't afford to do a specialist psychotherapy”, thus highlighting how services need to be meeting mental health needs, so individuals are not forced to strain their financial situation to address health problems which should be supported through public services. Moreover, this interviewee further disclosed how if she had chosen to access private care, she was told “support erm (.) from the NHS” would cease, thus alluding to how services seemed to lack compassion and understanding that financial situations may change, hence public support should always be available.

A final point made regarding inequalities was consideration of individuals’ disabilities. It was highlighted by a participant that support materials were of inadequate quality, as she expressed having “dyslexia and dyspraxia”, both of which affected her ability to read and understand resources, meaning she had to adapt the materials on offer, changing “the background colour so it's easier for me to process the information”. Additionally, she discussed how “if I see a leaflet with loads of information even if it’s about a service, I don’t read it through”, the emphasis of “I don't” stresses the extent to which the lack of inclusivity for individuals with disabilities, can result in users disengaging completely with support. This implies more services need to offer alternative resources to increase inclusivity for those with disabilities, as otherwise individuals may not be able to access help.

Developments to services

The final subject which had a recurring presence within the data, was the topic of services users’ ideas for developments to the mental health services. One matter which was frequently brought to light was the comparison between physical and mental health, with multiple participants expressing the view that mental health problems needed to be seen “as more of an equal to like physical health”. One of the interview accounts speculated of mental health, that “because they can't measure [it] very easily at the minute, like cause if you break your leg… you know it's fixed… but like you can't really measure it fully with mental health”: this alludes to the key distinction between physical and mental health problems, postulating as to why mental health doesn’t seem to be taken as seriously as physical health. Drawing upon this, another account stated “everyone goes to the GP from year zero with physical health things, so why should it really be any different to mental health", this reinforces the argument that mental health needs to be treated equally to physical health, the participant then went on to say; "it's just (.) people feel stigmatised and they're discriminated against". This can be considered as a fundamental explanation as to why many people feel they can't reach out for help, as it is implied, if it were the same as having a physical problem the patient would be given the respect and attention they deserve. A key comparison between mental health and physical health services, such as the GP, considered how mental health services "need to keep people on the books... like a GP (.) has you on the books (.) so you don't always have to go (.) you might have months or years without going but you know you can if you need to". This highlights how mental health services seem to view support as short term, with the idea that once formal support has ended, the problem is solved, whereas in reality this is not the case for many mental health conditions and as this is not the belief regarding physical health conditions, why should mental health be treated any differently.

Another aspect of development to services which participants repeatedly mentioned, was having support in the form of counselling and talking therapies. When talking about what individuals wanted from their support, numerous participants suggested "just offering general support, (.) somebody to talk to", as they thought this would be "<u>really</u> helpful". The emphasis on 'really', alludes to strong feelings that this form of support would benefit them more than others, another interviewee endorses this, providing reasoning as to why this type of support is preferred "having someone to listen… just to say that [your condition] it's <u>normal</u>". An additional extract from the interviews, reinforced this point of wanting to talk through issues and gain the assurance that their condition was natural, divulging that services should "explain what's happening to you and, [that] this is normal". This can be interpreted as service users wanting more information and comfort regarding their recovery.

Signposting was identified by many participants as an area in need of development, with interviewees claiming "there doesn't seem to be ANY form of signposting" and "<u>REALLY</u> GPs should be signposting people to these kinds of sessions, psychotherapists should be signposting people...you're sort of left to fend for yourself in a large way". Both these accounts stress how strongly they feel regarding the lack of direction they were given when trying to access different types of support, this was especially evident with the emphasis on 'any' and 'really', which gave weight to the strain this had put on their emotions. Further, the comment of being "left to fend for yourself" illustrates how individuals felt increasingly isolated when accessing support, yet this is the opposite of how services should have made them feel. A supplementary point regarding signposting, suggested that "clear information, easily accessible information for people to understand (.) not jargon language", was described as being really important for when patients were provided with further guidance, as this alludes to the idea that previously signposting materials were not clear with the information they contained. A key suggestion made by a participant stated "places need to have (.) kinda like a list of things for people whatever that is like (.) help with money or help with (.) sexuality or anything else that kinda is needed, like for me it would be (.) to do with like weight and all the things that come with being a woman of er (.) you know equality...maybe have like a referral sheet for different things say to people like this is one type of therapy but there's a lot of different others and there's a lot of different avenues we can try… they could even write it on a slip of like you know, some numbers you can have for a crisis". The point made by this individual, suggesting that signposting should consist of providing people with a list of services they can access to help with specific problems, infers that current services need to change and raise awareness of all the options available for all types of mental health issues.

Further developments that were mentioned explored services' lack of opportunity for feedback, which reiterated the idea that services didn't work as a partnership with users. One interviewee stated "I don't remember getting any feedback_(.) or anything that I can contribute… I don't feel that my opinion matter", henceforth implying that the individual felt she had no voice regarding how services were run, despite clearly having an opinion on the topic. Another interviewee suggested "it would be good like if they could just send you out like questionnaires or even just phone you like once a month, let you know where we are on the list", thus, through the mention of 'questionnaires' upholding the previous accounts' want for an opportunity for feedback, whilst also making the suggesting of services keeping in contact with individuals while they wait for formal support. This infers that services currently lack consideration of users' opinions and further don't attempt to offer contact, regarding the period in which people have to wait to access support.

Moreover, another area for development of services, focused on the use of volunteers. As one interviewee highlighted, services "don't utilise that [there] is a lot of people that will do work for free (.) and can be trained and would love the training and the experience to build up their CV", this implies that mental health services don't make use of all the resources available to them, such as recruitment of volunteers, who could help essential support services. Drawing upon this, another individual commented "they should have a volunteer go for walks or getting you out and about, that could help", which corroborates the previous accounts' argument for using volunteers to develop services. This further alludes as to how volunteers would not only help services, but also service users themselves, hence this would be an area of paramount importance for development.

Discussion

Through the employment of a thematic analysis, semi-structured interview data was analysed to provide an understanding of the mental health needs of women in Sheffield.

Several themes were found through this analysis, which included; accessibility, the impact of covid-19, current services, GP services, support networks, inequalities and developments to services. Through inspection of these themes, an insight into the needs of women was allowed, thus meaning the research could provide potential implications as to how mental health services should change and adapt to maximise their positive impact on individuals.

A dominant theme within the data, which looked at the needs of women's mental health, was the topic of accessibility. This theme highlighted aspects such as; awareness of support, practical difficulties, severity of mental health and long waiting lists. From analysis it was made clear that awareness of support services was crucial to accessibility, thus, it is suggested that services need to promote their work to a more widespread audience. As with this, an increased number of individuals will have their mental health needs met, through being able to access services. Further, it was found that practical difficulties played a role in accessibility, as when service users had to travel on public transport, it was frequently disclosed that this action seemed to increase their negative symptoms. Henceforth, as many interviewees described this as being a reason for them to refrain from attending support sessions, practical difficulties can be seen as a barrier to mental health support, thus, alternatives should be offered. From our analysis of the impact of Covid-19 impact, it was brought to light that some individuals expressed a preference for accessing support in the comfort of their own home, through the use of video call software. This alternative is an appreciable solution to the practical difficulties affecting accessibility. Moreover, the point of accessing support depending on how severe a patients' condition was, meant a lot of service users felt they had to prove how serious their mental state was, as it was revealed to impact the type of support and the speed in which individuals received help. Drawing upon this, individuals were unable to access support services when they really needed them, due to long periods of waiting. It was also mentioned that Sheffield seemed to provide support services at a slower rate, than other areas of the country. Suggestions can be made from this, that services should provide users with a type of informal support, to give people reassurance that they are in the process of receiving formal care. This is backed up by evidence from research such as Reichert and Jacobs (2018), who observed longer waiting times to be significantly associated with a deterioration in patients' mental health, henceforth it gives greater weight to the argument that services need to provide some form of instant support. However, as discussed in our analysis of the current services: SODIT offers individuals opportunities to speak with staff while they are still on the waiting list, this action was highly praised by a service user and thus, if one mental health service can offer this, why cannot all services incorporate this into their process of care, as it helps address the issue of long waiting lists.

A second theme apparent in the interview data, referred to the impact of the Covid-19 pandemic on mental health services how service users' needs had changed as a result of this. Due to the pandemic the majority of support depended on patients having access to technology and the internet, this called attention to the assumption of digital inclusion. However, for those individuals who didn't have access to technology, the option for support services was minimal. Considering this, online support was not deemed to be equivalent to in-person care, thus recommendations could be made for services to offer some form of in-person socially distanced support. Furthermore, feelings of isolation, as a result of Covid-19, were frequent, hence services should increase their communication with patients, especially during this period of time.

When considering current services, it was deemed to be of significant importance that service users were provided with numerous options of the different types of support on offer to them. Despite many individuals expressing negative experiences with services who had given them a lack of choice, the few individuals who felt they had a say in their healthcare and had a wide range of options explained to them, were really positive about their involvement with mental health support. Thus, this signifies the value of patients being provided with greater choice. Acknowledging this, many individuals expressed a want for long-term, continued support, post their formal 12-week block of sessions, however the only support offered was short term and once this ended many felt almost cut off from help. It could be suggested that services consider providing people with on-going, but reduced support in order to create a more person-centred experience, where the patient can have a say in when support ends. A further point highlighted that there was a lack of consistency in providing patients with the same member of staff, this meant service users had to continuously repeat themselves to different staff, meaning the user received alternate approaches to the way their treatment was delivered, which thus, reduced the efficiency of the service. To resolve this issue, it is recommended that services assign patients with one member of staff from their initial assessment, to the end of their treatment.

GP services were described as being the majority of peoples' first point of access to support, however many participants related having had a negative experience with this service, which resulted in many being discouraged from returning. It was also recognised that GP services lacked the ability to explain options and provide patients with information, before the individual was referred to one specific service. Henceforth, GP services need to make a significant change to the way in which they practice, as they were highly criticised and as being most peoples' first point of call, this is unacceptable. It is thus recommended that GPs receive greater education on mental health conditions and how to be more empathic when helping such patients.

Another theme of particular interest in the data, was support networks. This theme emphasised the impact of how individuals felt social support reduced feelings of loneliness and isolation. The idea of support, for many, was built around the concept of a community and informal care, the majority of members of such a community had a shared understanding and experience of mental health problems. This allowed for a more intimate, reassuring space for individuals to disclose their feelings. Henceforth, it is strongly recommended that services attempt to increase patients' opportunities for meeting other individuals, who have gone through similar experiences, in order to help strengthen service users' social support networks.

Furthermore, inequalities of different minority groups were depicted to be an area in need of significant alteration within the mental health services. The topic of gender revealed a clear divide in the differences of support offered to diverging genders. It generally found that many patients felt their issues were seemingly dismissed and not taken seriously, as a result of them identifying as female. Hence, health conditions specific to females, need to be treated with the same respect as other universal health problems. In addition, parenting was recognised to make mothers feel more reluctant to seek support, as many individuals felt uncomfortable opening up about issues, in front of their children. Thus, it is recommended that an option for childcare within services, is offered so mothers can speak candidly, without fear their child is listening. Further, Tryl (2021) found 62% of women to be more likely to say they felt home-schooling was stressful, in comparison to 41% of men; this emphasises how specifically the role of being a mother is particularly demanding and thus can put greater pressure on mental health. Moreover, the option for having a preference for the gender of a staff member, was frequently discussed, as individuals disclosed having had gender related trauma, meaning they felt more comfortable and could be more honest with staff who were of a certain gender. This point is important for services to consider, when providing support, as service users may not get the most out of their care, without being offered this choice first. Additionally, the need for greater recognition of LGBTQ+ community was highlighted, as services were described as not taking the additional needs of these people into consideration, for instances such as using the correct pronouns and making support more inclusive for these individuals. Another issue regarding inequalities was the ethnicity of service users, as services were described as being tailored to White British patients. Mental health statistics for BAME individuals have been found to be significantly high, as Bhui and McKenzie (2008) revealed suicide rates to be higher among middle aged Black African, Black Caribbean and South Asian women than among their White British counterparts. Yet, despite this, it was brought to light that there were few members of the BAME community in support sessions, suggesting the way in which services are promoted is not of an inclusive enough nature to appeal to individuals from these communities. Further, it was found the support systems were evidently harder to navigate for those from different cultures, as there was an absence of resources in different languages and thus this could be seen as a barrier to accessing support. Hence, it could be endorsed that materials, such as posters etc. are made available, and the option for an interpreter in some cases, is provided. Similar to the work of Alegria, Falgas-Bague and Fong (2020), who conducted research into ethnic minorities, finding when social identities are not shared between client and clinician, it can lead to feelings of unease or distrust. The current research also found service users feel similar ethnic backgrounds may be useful, as it would allow for a shared understanding and greater ability to relate, leading to the participant disclosing more information. Further, class was described to play a role in factoring as to whether individuals would access support services. The data found many participants to criticise public health services for not meeting their needs, which resulted in them seeking private care; however, not all individuals can afford this alternative, thus public health services need to address patients' issues both more thoroughly and at a faster pace, to make good quality mental health support available to those from all social classes. Finally, regarding inequalities for minority groups, for individuals with disabilities, it was found services seemed to lack inclusivity, thus, alternative resources and a more direct approach to this group of people, needs to be offered to create easier accessibility.

The final theme analysed from interview data, was developments to services, this touched on the main suggestion's participants had for change to mental health services. It was discovered that many participants felt there was a clear distinction between physical and mental health and the support that was offered. Mental health was presented to not be taken as seriously as physical health problems, meaning individuals felt they did not receive the same quality of care. This issue is not only a problem within services, but within society too, thus it is necessary for mental health services to initiate change in order to break the stigma surrounding it. Drawing upon this, to make mental health services equal to physical health ones, it is suggested that services keep patients on their books, in order to allow both continued access over a long period of time and easier access for re-referrals. It was further brought to light that many participants expressed a want for greater opportunities to have talking therapies, as many felt this would be beneficial to their treatment, and those who had experienced it highly praised this form of support. Greater developments that were suggested were issues surrounding signposting, as it was evident in the data, that the majority of individuals felt there was a lack of direction and awareness of what types of support and what services were available. Therefore, it is suggested that services could try and provide materials such as an information sheet, with a list of types of support and which services to go to for certain mental health conditions. Considering this, service users communicated a lack of opportunity for feedback and little chance for them to make choices regarding their own support, thus, services need to consider a more service user - centred approach. Moreover, the use of volunteers was discussed to be something that had potential to be a huge asset to services, however it was not utilised enough, as they could not only benefit the service staff members by sharing the workload: which could help reduce waiting times, but the users too, by providing additional support.

When reflecting upon the process of conducting this piece of research into the mental health and wellbeing needs of women in Sheffield, a number of limitations of this study were identified. Through the employment of semi-structured interviews to gather data, the concept of the interviewer effect was recognised to potentially have created a bias, in which interviewees may have responded to questions saying what they believe the interviewer wants to hear, rather than what they actually thought. As Newton (2010) highlighted, this bias could question the validity of interview data, thus, creating a limitation of the research. Newton (2010) further suggested a weakness of semi-structured interviews to be a lack of consistency in results, as participants may discuss topics irrelevant to the research question and thus, also miss subjects that are of key relevance to the research, making comparison of interviews challenging. Additionally, a methodological limitation was noted to be the restriction on time to complete the research, as this was a rapid qualitative study conducted within an eight-week time frame, thus, it would have been unrealistic to use a sample size larger than seventeen, as processes within thematic analysis, such as transcribing, were hugely time consuming. Henceforth the method of gathering participants was restricted to volunteer and opportunity sampling, both of which are not as effective as random or probability sampling, as Byrne (2012) notes, the time involved in qualitative research significantly limits the prospect of using larger samples. A further limitation of the research questioned the skill of the researchers. As the principal investigators for this research were students, they lack professional experience and thus, may have been deficient in the ability to ask prompt questions, therefore causing them to miss valuable data. Kajornboon (2005) recognised this, commenting that inexperienced interviewers may not probe a topic to gather data of greater detail relevant to the research. The video call software Zoom was used to conduct socially distanced interviews, which meant participants were able to answer interview questions from the comfort of their own home, meaning a lot of them may have felt more relaxed and at ease in the interview situation. Yet, due to interviews being conducted in the participants' own homes, interviewees were exposed to a greater number of distractions, as the environment could not be controlled and may not have disclosed as much information in case other household members overheard. However, semi-structured interviews proved to have strengths as the use of open-ended questions allowed for participants to provide a more detailed, in depth account of information to be analysed. Further a strength of the research was that in light of ethical considerations, participants were not deceived regarding what their participation would entail and the aims and purpose of the research at any point during their participation. Thematic Analysis was used as the analytic method to investigate the data; however, this method of speech analysis has been heavily criticised, Terry, Hayfield, Clarke and Braun (2017) critiqued this method as the process simply refers to finding patterns within the data. Braun and Clarke (2006) corroborated this, commenting that Thematic Analysis has limited power beyond description, they suggested a further limitation of this method of analysis, was that unlike Discursive or Conversation Analysis, it does not allow the researcher to make claims about the functionality of talk and language use. Additional limitations of Thematic Analysis identified the flexibility of it to be a point of concern to the researchers as it can make it difficult to decide which aspect of data to focus on. However, flexibility can also be seen as a strength, as it allows for a wide range of points of analysis. Further strengths of Thematic Analysis were recognised by Braun and Clarke (2006), being that this method is easily accessible to qualitative researchers with little experience and results are broadly available to educated members of the public. This method has also been identified to be useful for producing qualitative analyses to guide policy development, a matter which is highly relevant within the current research, as it aimed to provide greater understanding of women's mental health needs to guide the development of creating more tailored services.

In summary of the points made above, it is recognised that to address the current mental health and wellbeing needs of women in Sheffield, services need to make changes to consider areas such as; accessibility, the impact of Covid-19, the support that current services offer, GP services, the opportunity for patients to strengthen support networks, issues regarding inequalities for minority groups within support services and thus, the essential developments that need to be made in order to make the services more user-friendly. The findings of this study supported the hypothesis that: one of the main needs of women in Sheffield would be that they would want greater control and input of the service they receive and will desire more concise and direct communication; as within themes such as current services, GP services and developments to be made, it was repeatedly expressed that participants felt there was an absence of personal choice in the decisions made regarding their support and a lack of signposting to mental health services. The current research provides information as to how mental health services in Sheffield could improve to develop a more tailored approach, however greater research into the key themes found in this analysis, could prove to be of significant use to improve specific areas within support services in the future.

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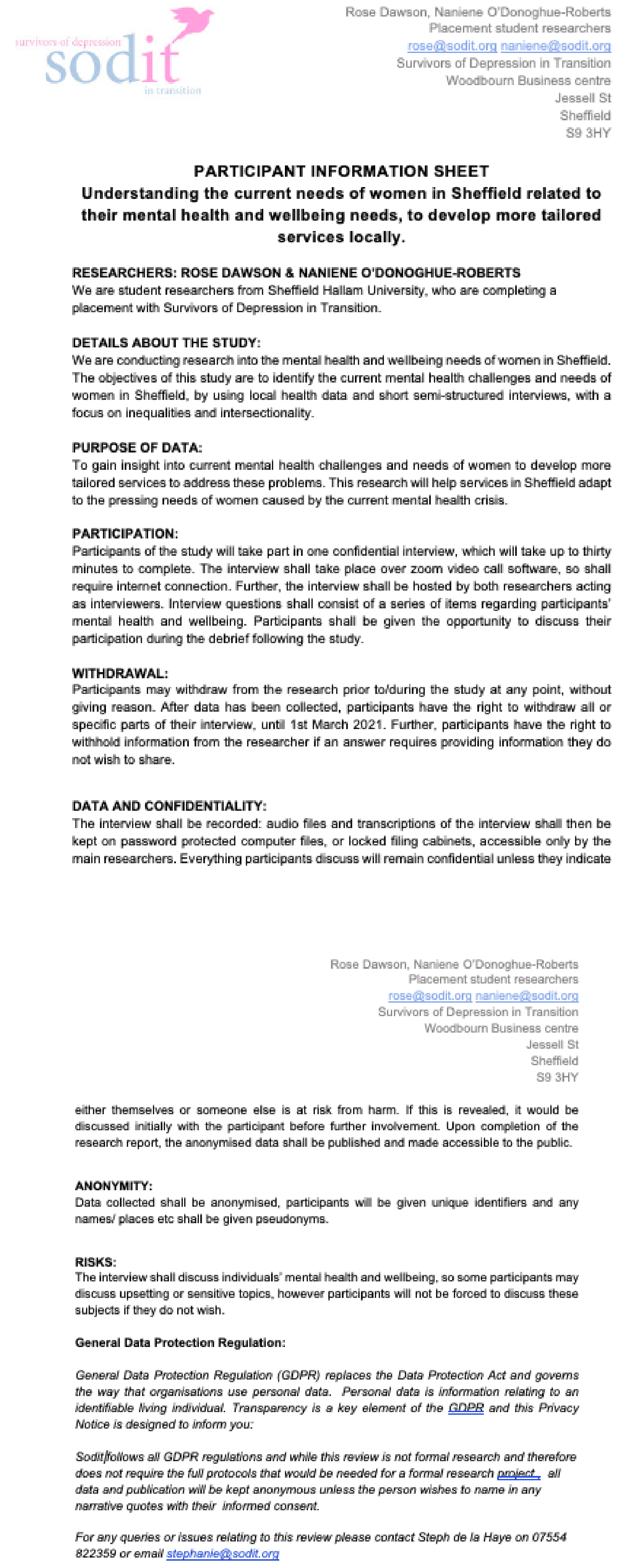
Appendices

Appendix A: Information Sheet



survivors of depression sodit in transition

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PARTICIPANT INFORMATION SHEET
Understanding the current needs of women in Sheffield related to their mental health and wellbeing needs, to develop more tailored services locally.

RESEARCHERS: ROSE DAWSON & NANIENE O'DONOGHUE-ROBERTS
We are student researchers from Sheffield Hallam University, who are completing a placement with Survivors of Depression in Transition.

DETAILS ABOUT THE STUDY:
We are conducting research into the mental health and wellbeing needs of women in Sheffield. The objectives of this study are to identify the current mental health challenges and needs of women in Sheffield, by using local health data and short semi-structured interviews, with a focus on inequalities and intersectionality.

PURPOSE OF DATA:
To gain insight into current mental health challenges and needs of women to develop more tailored services to address these problems. This research will help services in Sheffield adapt to the pressing needs of women caused by the current mental health crisis.

PARTICIPATION:
Participants of the study will take part in one confidential interview, which will take up to thirty minutes to complete. The interview shall take place over zoom video call software, so shall require internet connection. Further, the interview shall be hosted by both researchers acting as interviewers. Interview questions shall consist of a series of items regarding participants' mental health and wellbeing. Participants shall be given the opportunity to discuss their participation during the debrief following the study.

WITHDRAWAL:
Participants may withdraw from the research prior to/during the study at any point, without giving reason. After data has been collected, participants have the right to withdraw all or specific parts of their interview, until 1st March 2021. Further, participants have the right to withhold information from the researcher if an answer requires providing information they do not wish to share.

DATA AND CONFIDENTIALITY:
The interview shall be recorded: audio files and transcriptions of the interview shall then be kept on password protected computer files, or locked filing cabinets, accessible only by the main researchers. Everything participants discuss will remain confidential unless they indicate either themselves or someone else is at risk from harm. If this is revealed, it would be discussed initially with the participant before further involvement. Upon completion of the research report, the anonymised data shall be published and made accessible to the public.

ANONYMITY:
Data collected shall be anonymised, participants will be given unique identifiers and any names/ places etc shall be given pseudonyms.

RISKS:
The interview shall discuss individuals' mental health and wellbeing, so some participants may discuss upsetting or sensitive topics, however participants will not be forced to discuss these subjects if they do not wish.

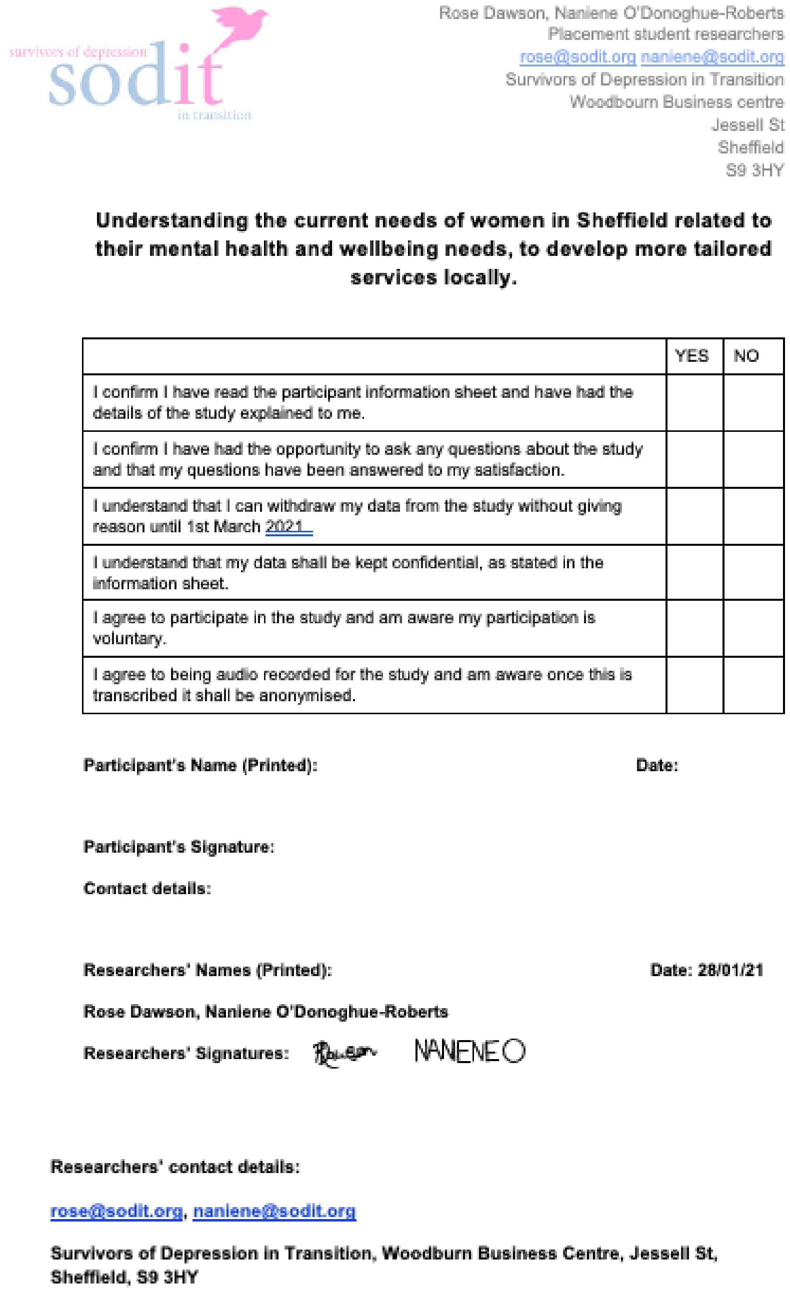
General Data Protection Regulation:

General Data Protection Regulation (GDPR) replaces the Data Protection Act and governs the way that organisations use personal data. Personal data is information relating to an identifiable living individual. Transparency is a key element of the GDPR and this Privacy Notice is designed to inform you:

Sodit follows all GDPR regulations and while this review is not formal research and therefore does not require the full protocols that would be needed for a formal research project, all data and publication will be kept anonymous unless the person wishes to name in any narrative quotes with their informed consent.

For any queries or issues relating to this review please contact Steph de la Haye on 07554 822359 or email stephanie@sodit.org

Appendix B: Consent Form



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Understanding the current needs of women in Sheffield related to their mental health and wellbeing needs, to develop more tailored services locally.

	YES	NO
I confirm I have read the participant information sheet and have had the details of the study explained to me.		
I confirm I have had the opportunity to ask any questions about the study and that my questions have been answered to my satisfaction.		
I understand that I can withdraw my data from the study without giving reason until 1st March 2021		
I understand that my data shall be kept confidential, as stated in the information sheet.		
I agree to participate in the study and am aware my participation is voluntary.		
I agree to being audio recorded for the study and am aware once this is transcribed it shall be anonymised.		

Participant's Name (Printed): **Date:**

Participant's Signature:

Contact details:

Researchers' Names (Printed): **Date: 28/01/21**

Rose Dawson, Naniene O'Donoghue-Roberts

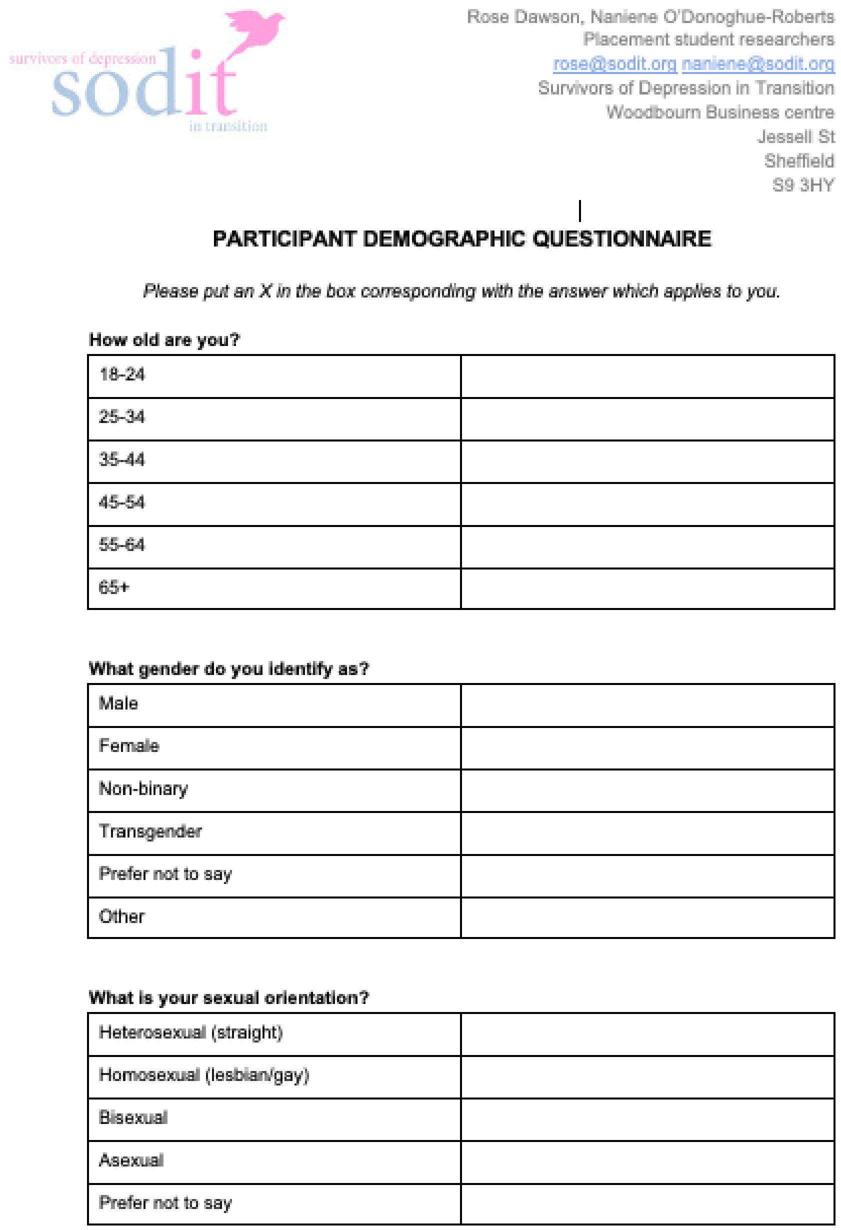
Researchers' Signatures: NANENE O

Researchers' contact details:

rose@sodit.org, naniene@sodit.org

Survivors of Depression in Transition, Woodburn Business Centre, Jessell St, Sheffield, S9 3HY

Appendix C: Demographic Questionnaire



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PARTICIPANT DEMOGRAPHIC QUESTIONNAIRE

Please put an X in the box corresponding with the answer which applies to you.

How old are you?

18-24	
25-34	
35-44	
45-54	
55-64	
65+	

What gender do you identify as?

Male	
Female	
Non-binary	
Transgender	
Prefer not to say	
Other	

What is your sexual orientation?

Heterosexual (straight)	
Homosexual (lesbian/gay)	
Bisexual	
Asexual	
Prefer not to say	

Other	

Which of the following best describes your ethnic background?

White	
Black, African, Black British or Caribbean	
Asian or Asian British	
Mixed or multiple ethnic groups	
Other	
Prefer not to say	

Are you a British citizen?

Yes	
No: please specify	
Prefer not to say	

What is your employment status?

Employed	
Unemployed	
Self-employed	
Retired	
Unable to work	
Prefer not to say	

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What is your living situation?

Live in my own home	
Live in a household with other people	
Live in a residential facility	
Live in a facility (such as a nursing home)	
Temporarily staying with a relative or friend	
Temporarily staying in a shelter	
Homeless	

What area of Sheffield do you reside in?

Do you have a condition or illness that may affect you in any of the following areas?

Vision (for example blindness or partial sight)	
Hearing (for example deafness or partial hearing)	
Mobility (for example walking short distances or climbing stairs)	
Dexterity (for example lifting or carrying objects, using a keyboard)	
Learning or understanding or concentrating	
Memory	
Mental health	
Stamina or breathing or fatigue	

Socially or behaviourally (for example associated with autism, attention deficit disorder or Aspergers' syndrome)	
Other (please specify)	
None of the above	

What is your marital status?

Married	
Single	
Divorced	
Widowed	
Separated	

How many children do you have?

None	
One	
Two	
Three	
Four or more (please specify)	

What is your highest level of education?

GCSEs/ O Levels	
A Levels	
Apprenticeship	

Undergraduate degree	
Masters/ professional/ doctorate degree	
Other: please specify	

Please create a six-digit number to be used as your unique identifier to ensure your anonymity in the research:

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Appendix D: Debrief Sheet

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PARTICIPANT DEBRIEF SHEET

Understanding the current needs of women in Sheffield related to their mental health and wellbeing needs, to develop more tailored services locally.

Principal investigators: Rose Dawson and Naniene O'Donoghue-Roberts

What was the purpose of the experiment?
To understand the current needs of women in Sheffield related to their mental health and wellbeing, to develop more tailored services locally, through using semi-structured interviews to gather data.

How will I find out about the results?
If you would like to know the outcome of this piece of research, you can contact the principal investigators after April 2021, and they will be happy to provide you with a summary of the findings.

Have I been deceived in any way during the research?
No, you have not been deceived at any part during this research, we have only withheld and anonymised participants names and the names of people and places, mentioned in interviews.

If I change my mind and wish to withdraw the information I have provided, how can I do this?
If you make the decision you want to withdraw your information and the data you have provided for this research, you are able to do this by contacting the principal investigators (details included at the top of this sheet) before 1st March 2021, by providing your unique identifier. The researchers shall then destroy all data and information related to your participation, before publication. If you contact the researchers any later than 1st March 2021, it may not be possible to withdraw your data from the research, as your results will have been written up for the report and due to be published. However, all data is anonymised, so your individual data will not be identifiable in any way.

If you have any questions, concerns or adverse effects as a result of participation, please contact the principal investigators:
Rose Dawson: rose@sodit.org
Naniene O'Donoghue-Roberts: naniene@sodit.org