# A scoping study of the provision, access and uptake of health visiting postnatal depression services for minority ethnic women.

## Palo Almond

### Abstract

**Aim:** This paper reports a service review exploring concerns health visitors had in providing equitable postnatal depression care to minority ethnic women.

**Background:** Postnatal depression is a global public health concern. It is thought to be higher in minority ethnic women, yet research has shown that this population's health needs are not adequately met. Little has been reported on culturally competent care in the field of perinatal mental health.

**Methods:** A project drawing on qualitative research principles was conducted with 28 participants, from a range of nursing disciplines, community development workers and education. Information was content analysed to elicit the key factors causing difficulty.

**Findings:** Over 60% of the participating health visitors' caseloads were minority ethnic clients. They had not received specific training in detecting and treating postnatal depression in minority ethnic women. Health visiting teams were overwhelmed with the general volume of work and complexity of their caseloads. Cultural knowledge was largely gained through word of mouth or was self-taught. Community nurses rather than health visitors were the key providers of postnatal depression care.

**Conclusion:** Whilst attempts were made to provide some level of postnatal depression services these were recognised as wholly inadequate. Health care training needs to include cultural competency, knowledge, and skills. Research into community nurses' role in postnatal depression assessment is needed.

### Introduction

This paper reports a project conducted in a Primary Care Trust in England. The study investigated health visitors' expressed concerns about their difficulties in assessing and treating minority ethnic women with postnatal depression. Health visitors are nurses who have had additional training in public health (Almond and Lathlean 2011). Their main role is to prevent ill health and promote the health of families with children under five years of age.

Postnatal depression can strike women at anytime during the first year following childbirth. It is like most other depressions but its incidence is higher postnatally (Deitz et al 2007). It is a psychiatric condition and consequently its treatment is predominantly pharmacological (Hoffbrand et al 2001). However, talking therapies, and cognitive behavioural therapies have shown to be effective (Appleby et al 2003, Morrell et al 2009). Social factors may trigger postnatal depression and treatments such as support groups combine social and therapeutic components (Pope et al 2000, Parvin et al 2004, Rahman et al 2003).

Research has established not only the global incidence and prevalence of postnatal depression but that all women regardless of social class, socio-economic status, ethnicity, culture, race, religion, country of birth or residence are vulnerable to postnatal depression (Ghubash et al 1997, Najman et al 2000, Yoshida et al 2001, Irfan et al 2003, Onozawa et al 2003, Templeton et al 2003, Munk-Olsen et al 2006).

The health literature is relatively devoid of what cultural competence means to health professionals and their clients and how to teach or learn it. The literature is at a conceptual level and is yet to tackle outcomes of culturally competent care delivery (Anderson et al 2003). This is unsurprising since there seems to be a lack of consensus on the meaning of cultural competence. Papadopoulos and Lees' (2002) somewhat lengthy descriptions can be summarised to define cultural competence as:

*A requirement of a practitioner:*

*To have culturally relevant knowledge, skills, and attitudes when working with diverse populations.*

*To have an attitude of respect and openness to learn and provide effective health care which takes account of people's cultural beliefs, needs and behaviours*

This paper presents the project methods and findings. It focuses on postnatal depression and cultural competence. It considers whether cultural competence is a fundamental requirement for achieving equity in perinatal mental health services for women whose first language is not English (or the majority language of the country in which they live). It ends with recommendations.

**Author details**
**Dr Palo Almond**
**Academic Consultant**
**Palo.almond@gmail.com**

**Key Words**
**Health visiting, postnatal depression, equity, ethnicity, cultural competence, public health**

### POSTNATAL DEPRESSION

Health visitors are the key health professionals in the early detection and treatment of mild to moderate cases of postnatal depression (Holden et al 1989, Appleby et al 2003, Morrell et al 2009). More severe cases are referred to the GP and adult mental health services for pharmacological treatment or psychiatric therapies (Hoffbrand et al 2001).

Postnatal depression is a major public health problem for a number of important reasons (Almond 2009). It can have a debilitating effect on the mother's emotional and mental health; it can delay the baby's cognitive development (Carro et al 1993, Ramchandani et al 2005) and its physical health (Harpham et al 2005, Stewart 2007); and can have an adverse affects on the partners' mental health (Webster 2002).

Perinatal mental health and especially postnatal depression has received considerable interest from the research community and until recently this was mostly from western high income countries such as the UK, USA, and Australia. The focus was and continues to be primarily on samples that speak English or the primary language of the country within which the research is being conducted. Perhaps as an unintended consequence of this and the bias noted generally in research (Persaud and Sallah 2002) the myth that postnatal depression is a western phenomena and construct has been perpetuated. However, the notion that postnatal depression is not known and experienced in all cultures has been exploded, largely through the popularity of a screening tool, the Edinburgh Postnatal Depression Scale (EPDS Cox et al 1987). The EPDS is a self-administered questionnaire designed to use in primary care. Validations of this 10 item self-report questionnaire have been undertaken in numerous countries across the globe (Gibson et al 2009). Most studies have reported positive results in its ability to detect postnatal depression with a good degree of accuracy following no or very minor adaptations to increase cultural relevance and acceptance (Areias et al 1996, Ghubash et al 1997, Gusia et al 2007, Gibson et al 2009).

Due in part to the popularity of EPDS, England's National Screening Committee (NSC) scrutinised its properties to determine its value as a national screening instrument, particularly as other countries such as Scotland and Australia were using it as their tool of choice in their national screening programmes (Buist et al 2002, Scottish Intercollegiate Guidelines Network 2005). However, the NSC concluded that the tool failed to meet requirements for a national screening instrument (National Screening Committee 2001).

The long awaited national guidance on the assessment and treatment of postnatal depression in England and Wales came at the end of 2007 with publication of the National Institute for Health and Clinical Excellence (NICE), Antenatal and Postnatal Mental Health Guidelines. These however failed to provide specific guidance on culturally appropriate assessment and treatment of women who do not have English as a first language. This was a missed opportunity to assist health visitors in this field of work especially as reports indicated that whilst health visitors were increasingly becoming involved in the detection and treatment of postnatal depression, minority ethnic women were largely invisible in these statistics (Shakespeare 2002).

The Community Practitioner Health Visitors' Association (CPHVA, the professional body for health visitors and school nurses), sponsored the publication of picture booklets (CPHVA 2003) to assist assessment of women whose first language is not English. Downe et al (2007) conducted a systematic review of screening tools to detect depressed mood in the postnatal period in South Asian women. They conclude,

> *'The biggest problem with regard to PND in the Asian communities might not be the detection of the condition, but in integrating women into the support mechanisms that health services can provide' (Downe et al 2007:581)*

## Equity in Healthcare

Lack of provision and access to health care is known to play a key part in the causes of health inequalities and avoidable suffering (Whitehead 1988, Wilkinson 1996, Almond 2002, 20081). Research has revealed many examples of inequalities in health care and a few also report inequalities in the detection and treatment of postnatal depression (Shakespeare 2002, Templeton 2003, Edge et al 2004). In England the government has tackled unjust health care provision through a number of key policies (DH 1999, DH 2000, DH 2002, DH 2003, DH 2005).

Additionally, legislative action such as, *The Race Relations (Amendment) Act 2000* has also placed a general duty on specified public authorities:

*a) To eliminate unlawful racial discrimination*
*b) To promote equality of opportunity between persons of different racial groups*
*c) To promote good relations between persons of different racial groups*

Furthermore, section 2.14 of the *Impact Assessment of the Race Equality Bill* (Government Equalities Office 2009) states that authorities should have measures in place that protect individuals against discrimination and harassment that extends not only to members of a particular racial group, but also to people who may be wrongly perceived to be members of that racial group.

The *Self Reported Experience of Patients from Black and Minority Ethnic Groups* (DH and Office of National Statistics 2009) report examined variations in the views of NHS ethnic patients. It presents data from 2008/09 adult inpatient, 2008/09 emergency department, 2007/08 primary care services and 2007/08 community mental health patient surveys. Also included are data from the National Patient Survey programme, led by the Care Quality Commission. Results indicate unacceptable variations between black and minority ethnic groups and white British patients. This was particularly marked in Asians (in the UK this relates to people from India and their descendents) and Chinese groups.

Robinson (2002) appraised 134 studies related to communication and provides evidence of the part that communication plays in creating barriers to providing quality health care or access to health care by patients who do not have English as their first language. Szczepura et al (2005) also examined research evidence relating to ethnicity and communication in healthcare. They remarked on the challenges that the NHS faces with a 'constantly changing picture of language needs' (Szczepura et al 2005:8), ensuing from changing patterns in migrations to the UK.

## STUDY AIMS AND OBJECTIVES

The study aims and objectives were agreed following discussions with the senior managers of family and children's services and were specifically generated to address local concerns of health visiting teams. Health visiting teams comprise of health visitors (nurses with a health visiting qualification) and community

nurses (nurses without a health visiting qualification).

### Aims:

To scope provision, access and uptake of health visiting postnatal depression services for minority ethnic women.

### Objectives:

1. Collect information about the provision of health visiting antenatal and postnatal mental health services provided for minority ethnic women living within the boundaries of the primary care trust.
2. Collect information about antenatal and postnatal mental health visitor team practice in relation to minority ethnic women.
3. Determine what the challenges are in providing culturally sensitive and appropriate health visiting antenatal and postnatal mental health services to minority ethnic women.

This was a service development project and therefore research ethical approval was not necessary. Ethical principles of anonymity and confidentiality were respected throughout and participants who contributed to the project did so on an informed voluntary basis.

## METHODS

### Information Collection

Face to face or telephone conversations with participants (team leaders, health visitors, school nurses, community nurses, community children nurses, community development workers and primary school teacher, and Sure Start) were undertaken individually, in pairs, or in groups. Sure Start is a government funded initiative that invests resources into communities that experience socio-economic disadvantage in order to equalise opportunities for health and education for families with children. Community nurses are registered nurses in adult health, and community children's nurses are registered in child health.

Information was collected through informal conversations rather than interviews. This enabled the free exchange of information in a relaxed and non-threatening manner which allowed participants to describe freely their own views and experiences of detecting and treating postnatal depression in minority ethnic women. The length of conversations were determined by participants themselves. Generally these lasted between 30-90 minutes.

### Information analysis

Notes were taken during conversations. These were typed and analysed using the principles of qualitative content analysis to identify recurring themes, factors that hindered assessment and treatment and examples of culturally competent good practice. Consequently little interpretation was undertaken.

## FINDINGS

The main findings related to Training in the detection and treatment of postnatal depression describing postnatal depression and its detection, the various ways of treating it (mainly counselling and group based support), the role of the family support worker, and descriptions of communication processes.

The term woman/mother in most instances refers to the health visitors' client that was the mother. Other women are referred to by their relationship to the mother, for example, mother in law. A narrative reporting style has been used (O'Dea 2006, Clandinin 2007).

Whilst participants involved in the project worked across the primary care trust, the population largely under discussion were Asian families living in localities with high ethnic populations in or near the city centre. They came from Punjab, Dehli, and Ludhiana districts of India and made up 80% of the population. For the most part they were Sikhs and Muslims. Though participants described issues relating to Asian communities, many discussed how they faced similar issues with Polish women and other ethnicities. The ethnic composition of health visitors' caseload was typically described as, 30% White British, 30% Asian and 30% others for example, Iraqi, Afghanistani, Middle Eastern, Eastern European, and Polish. In a local school, over 40 different languages were spoken.

Participants said they worked with a *'very closed'* community in which a large majority drew welfare and unemployment benefits, experienced high levels of alcoholism, drug taking, forced marital sex, rape, domestic violence and lived in overcrowd homes. Due to immigration laws, some husbands faced difficulties in getting back into England which caused women to become depressed. There were large pockets of emergency and temporary accommodation and about 20% of the community were transient.

Participants explained that if a family member became ill the initial recourse for help was not to go to the GP. Rather in the first instance they sought solutions from the immediate family, then from the extended family, then from the community and friends, and then finally from what they saw as *'white run services'*. Assimilated and integrated families were thought to take a shorter route to '*white health, social or educational services*', but it still took a huge cultural leap for them to approach and utilise such services. These services were only used in extreme situations such as suicide ideation or actual attempts, and if the marriage was threatening to collapse which may lead to public humiliation and ostracisation. The only other instances where main stream healthcare might be used was if there were problems with the children, particularly if these affected their ability to make the most of their education such as dyslexia, autism and asbergers.

One participant said that none of the children in one of the local primary schools was white British and added that the education system itself created insurmountable barriers to any degree of integration and missed opportunities to raise awareness of the value of local health and social services. This had led to an unconscious inhibition to refer families to services as it was anticipated that they would not follow through with the referral. An example of this was given from an analysis of referrals to children's mental health services which had only dealt with one Pakistani child.

### Table 1: Participants Details

| **Participants (n-28)** | **Ethnicity:** | **Gender:** |
|---|---|---|
| Health Professionals (n=25) Sure Start (n=2) Education (n=1) | Asian (n=2)<br>Caribbean (n=1)<br>white British (n= 25) | **All but one female** |

### Communication

Participants said that on the face of it most families appear engaging and depict a supportive and well presented household. However cultural norms meant that even if the mother could speak English, she was always accompanied. Participants said this was because out of fear she may say something to bring shame to the family. The husband or a family member often acted as interpreters. This was believed to limit disclosures to health visitors.

Faith in the accuracy of interpretation was limited. Participants said the mother might say a great deal, but it was translated back in only a few English words leaving the health professionals in doubt of what was actually said. Children were sometimes kept from going to school so they could act as interpreters if a home visit was planned. Participants preferred husbands to be the interpreter as they were deemed to be their clients too. Health visitors said they could not do their work if it were not for the family members acting as interpreters.

### Communication via Professional Interpreters

Professional interpreters were available through a local public organisation. The majority of interpreters were recruited locally. Interpreters were however, thought to have inadequate training, and so lacked the knowledge and skills to translate accurately on mental health issues.

It was reported that as the discussion of a woman's emotions and feelings was undertaken via an interpreter and generally the communication of this kind was difficult, health visitors expressed grave doubts as to whether their clients were actually honest about how they felt. Participants said that due to the community's extreme fears about breakages of confidentiality, women did not reveal anything to health professionals via interpreters. They said women tended to keep everything within the family, even if she were depressed. It was thought that women, who could speak English, probably understood more than was immediately obvious, but they were not allowed to communicate with outsiders. Sometimes the need for privacy was so important to the family that participants said they felt intimidated and threatened.

### Family Support Worker

Participants explained that due to their client's husbands' long working hours there was a consequently a high non-attendance and missed appointment rate. Clients also preferred home visits. Family support workers were recruited from the local community and were provided if the mother was depressed. Concerns however were expressed that their personal safety might be put at risk as they knew families too well and were taken into their confidence. Efforts were made to link mothers to other mothers who spoke the same language. Family support workers also assisted by driving the mother to appointments and acted as interpreters. Additionally, they helped with older children and offered practical help.

They did not have access to health education materials such as leaflets on postnatal depression as these were not available in languages other than English, furthermore it was reported that translated versions of the EPDS were not used. The CPHVA picture booklets were available but again it was reported they had limited usage.

### Postnatal depression

The Primary Care Trusts' policy directs that all women should be assessed for postnatal depression at 5-8 weeks postnatally. However non-health visiting participants felt health visitors were extraordinarily busy and not clear about what they should be doing in this area of work. Community nurses in some teams did much of the work relating to postnatal depression. Participants said it was easier to identify the percentage of their caseloads that were not depressed as depression was endemic in the localities. Poor housing, poverty, high unemployment, low educational achievement, high crime rates, poor local environment, and poor health were noted as factors that contributed to the depression epidemic.

### Detection of Postnatal Depression

Guidance as recommended by the National Institute for Health and Clinical Excellence (2007) were not being followed. Community nurses engaged in the targeted use of the EPDS rather than universally. Most participants felt that there was little point screening with the EPDS if the mother did not speak English. They said that since the EPDS uses British idiom it was difficult to translate into some of the Asian languages. They said that interpreters found the EPDS too complex to interpret and added that assessing feelings through an interpreter was difficult. Women also became anxious at being asked such questions. However some participants had managed to overcome these obstacles and described how they were able to rephrase the questions in the EPDS (see Table 2).

Other aspects of assessment for postnatal depression involved observing the mothers' interaction with the baby. However in some instances this was difficult as the mother-in-law cared for the baby during the home visit. Observing non-verbal cues, interactions with the baby and other children and assessing the state of the house were all part of the assessment. Participants felt that sometimes the mother said it was the child that was ill as a ruse to get help for herself. They added that unfortunately due to time pressures if the women did not engage in the assessment for postnatal depression or if all seemed overtly well, this was sometimes accepted without further investigation.

**Table 2: Postnatal depression assessment questions**

*Are you happy?*
*Do you cry?*
*Are you coping?*
*What is your mood like?*
*Do you want to sleep all the time?*
*Are you enjoying your baby?*
*Have you managed to go out at all?*
*Are you tearful?*
*What support do you have?*
*How are you feeling?*
*How are you coping with the older children?*
*Are you eating?*
*You look tired/low have you ever been like this in the past?*
*Have you had any treatment or been to the doctor when you have felt like this?*

### Treatment of Postnatal Depression

Participants elaborated on experiences of how difficult it was to provide treatment and care for women who were postnatally depressed when they could not speak their language. Improvements were difficult to measure and at times it felt like they were just going round in circles despite a lot of effort being made. Some community nurses said they were not trained in counselling and were largely self-taught.

Due to lack of time they said it was convenient to refer women to support groups rather than provide home based counselling. However it was also reported that the women did not actually attend groups due to family demands. Some however, received one hour long home visits once a week if they were very depressed. Community nurses found this work d*raining, time consuming and frustrating.* Such visits were planned early in the day so they had the rest of the day to deal with emerging issues but there was always the *pressure of time bearing down on them.*

Women with depression did have support from the health visitor, but as reported earlier much of this work undertaken by community nurses. Some health visitors were trained in Cognitive Behavioural Therapy but most said they did not have the time resources to provide it. Severely depressed women were seen by the perinatal mental health team.

Participants said that Polish women were said to use hot flame therapy and conventional medicine to treat postnatal depression whilst Sikh, Muslim and Hindu women tended to turn to religion.

### Support Groups for Postnatally Depressed Women

Support groups were thought to be a *peculiarity of the English for English clients.* Health visiting teams valued them highly because they took up less time than one to one home visiting. However, group work was said to be very difficult with transient communities. Participants consistently said *most minority ethnic women did not like groups*. According to the findings, the reasons for this were understood to be that women would not go to a group where they could not communicate with others in their own language and equally white women tended not go to a group with a majority of non-white women. Nevertheless, within in the locality there were some groups that were attended by minority ethnic women. These groups were run by community development workers and Sure Start. These focussed on practical advice that would help the mother in her role and childhood issues, and only indirectly or occasionally dealt with postnatal depression. They were therefore seen to be *acceptable* by the community as they were viewed as primarily benefitting the child.

### Training in the detection and treatment of postnatal depression

Health visitors had received training in the detection and treatment of postnatal depression but most community nurses had not. However time was generally not available for health visitors to put this knowledge into practice. Training in cultural competence in health care had not been provided, though some had received training from Sure Start on how to work with interpreters. Knowledge about working with minority ethnic families was largely self-taught or learnt from those who had had longer experience of working with minority ethnic communities.

## DISCUSSION

This project illuminated a range of participants' very honest and open perspectives on providing health care to an ethnically diverse population. The narrative style of reporting has been used to fully capitalise on participants' honesty and strength of feeling. Participants were aggrieved and saddened that they were not able to provide the same level of care and quality care to minority ethnic women as they did for British women and those who could speak fluent English. Nevertheless it is reported that many patients (including minority ethnic patients) are very satisfied with the care they receive (DH and Office of National Statistics 2009).

The value of skill mix was very evident and without this it is possible that greater problems with providing equitable health care to minority ethnic women may have existed. Community nurses were clearly of immense value to busy health visitors, with some undertaking most of the postnatal depression related work. This is a novel finding as most of the perinatal mental health research and development literature focuses on health visitors (Holden 1989, Seeley et al 1996, Shakespeare 2002, Appleby et al 2003, Morrell et al 2009).

Another interesting finding was an almost complete reliance on the health visiting teams' knowledge generated from their personal working experience. They had received very little cultural education or training, either in their initial nursing or health visitor training or through continuous professional training programmes. A drawback of internally derived cultural knowledge is that it may lead to stereotyping and institutionally-based belief systems. On the other hand it appears that health visiting teams were adapting and doing their best in an environment where cultural resources were scarce.

### Cultural Competence and Equity in Postnatal Depression Healthcare.

Studies of advocacy and empowerment in minority ethnic communities have highlighted how Western constructs and values do not sit well in some cultures. Rai-Atkins et al (2002) and Fazil et al (2004) explored advocacy in African, Caribbean and South Asian communities, and argue that acquiring power and positioning the needs of the self over those of the family can lead to conflict. In such cultures 'the self' is of less value and important than the family and the community. They too found that women could not find the time to attend groups.

The lack of engagement by minority ethnic women has been previously reported. Bowl (2007) studied the experiences of South Asian people's use of mental health services. They were very reluctant to share information because they could not trust the workers and felt they would not understand their needs. Rhodes et al (2003) indicates that trust seemed to develop more quickly between health professionals and 'white' clients than it did with minority ethnic clients. The principal reason for this was because the client and health worker were on first name terms, and it was this that helped to build rapport which led to trust being developed. A systematic review of assessment of women for postnatal depression (Hewitt et al 2009) suggests that the EPDS is an acceptable tool but it is uncertain from the report if they sampled minority ethnic women.

Effective communication is reliant on working in partnership with patients. Almond and Cowley (20082) provide a skill typology for working in partnership with patients and clients and many of these relate to culturally competent communication. In middle to high income countries, barriers to accessing health care are more often related to difficulties in communication than geography. (Gerrish et al 1996). Szczepura et al (2005:9) suggest from their review of the research literature concerning communication, that

> *'despite substantial evidence in favour of providing proper language support, and demonstration of adverse effects linked to its absence, there is a lack of consistent, universal provision or adequate resourcing of such services in the UK.'*

Though cultural competency training maybe a way forward this alone may not improve access. Cultural competency models mainly focus on culture and fail to capture the complexity of health inequalities. Additionally they fail to capture the significance of structural factors that cause barriers and create health inequalities. Communication services that are designed to manage language diversity need to developed in a less ad hoc fashion and research is needed to evaluate their effectiveness (Szczepura et al 2005). Bilingual therapists and practitioners are needed to provide individualised care.
Nevertheless, culturally competent health professionals may be more successful in providing culturally appropriate care that is more acceptable to minority ethnic women, and in doing so may be achieve greater engagement. It is therefore unclear whether or not cultural competence can ameliorate inequity in health care or prevent it and research is necessary to determine this.
The following recommendations arise from the findings.

## RECOMMENDATIONS

1. Research into the contribution community nurses make in relation to postnatal depression.
2. Training in cultural competence and cultural awareness. (Table 3 provides lists of a few potential sources).
3. The value of peer support for postnatal depression needs to be examined.

### Table 3: Cultural Competence Resources

http://www.diversityrx.org/htmL/MOASSB.htm

http://www.omhrc.gov/templates/browse.aspx?lvl=1&lvlID=3

http://www.thinkculturalhealth.org/ccnm/ this one relates to nursing

http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15 Office of minority health standards for linguistic services, US

http://www.omhrc.gov/templates/content.aspx?ID=4375&lvl=2&lvlID=107 this one has two patient-centred guides

*Transcultural Health and Social Care: Development of culturally competent practitioners (Papadopoulos. 2006).*
*Postnatal depression and maternal mental health in a multicultural society: challenges and solutions (CPHVA 2003).*
*Partnerships for Public Health: Professional Involvement to Improve Health and Wellbeing. (Almond, Cowley. 2008)*
*Communication. (Almond P, Yardley. 2009)*
*Ethnicity and Healthcare Practice. (Culley, Dyson. 2009).*
*Marginalized Reproduction: Ethnicity, Infertility and Reproductive Technologies.(Culley, Hudson, van Rooij) .*
*Cultural Competence in Health Care: a practice guide. (Rundle, Carvalho, Robinson. 1999).*
*Culture and Health: A Critical Perspective Towards Global Health. (MacLachlan. 2006).*
*Primary Healthcare and South Asian Populations: Meeting the Challenges. (Shahid , Atkin . 2004).*
*Mental Health in a Multi-ethnic Society: A Multidisciplinary Handbook. (Fernando. 1995)*
*Culture, Religion, and Patient Care in Multiethnic Society: A Handbook for Professionals. (Henley, Schott. 1999).*

## References

Almond P, Lathlean J. 2011. A Study of Equity in Provision and Access to Health Visiting Postnatal Depression Services. Journal of Advanced Nursing. 67 (11) 2350-2362

Almond P. 2002. An analysis of the concept of equity in health services and its application to health visiting. Journal of Advanced Nursing. 37 (6). 598-606.

Almond P, Cowley S. 2008. Partnerships for Public Health: Professional Involvement to Improve Health and Wellbeing. In Coles L, Porter L. Public Health Skills: A Practical Guide for Nurses and Public Health Practitioners. Blackwell Scientific. Oxford.

Almond P, Yardley J. Communication. 2009. In Marjoram BA, Coles LM, Childs L. Essential Skills Clusters for Nurses: Theory and Practice. Wiley-Blackwell. Oxford.

Almond P. 2009. Postnatal depression: A global public health perspective. Perspectives in Public Health. 129:221-227

Anderson L, Scrimshaw S, Fullilove M, Fielding J, Normand J. 2003. Culturally competent healthcare systems. American Journal of Medicine. 24. Supplement. 68-79

Appleby L, Hirst E, Marshall S, Keeling F, Brind J, Butterworth T, Lole J., 2003. The treatment of postnatal depression by health visitors: impact of brief training on skills and clinical practice. Journal of Affective Disorders. 77 (3), 261-266

Areias ME., Kumar R., Barros H, Figueiredo E. 1996. Comparative incidence of depression in women and men during pregnancy and after childbirth. Validation of the Edinburgh Postnatal Depression Scale in Portuguese mothers. British Journal of Psychiatry. 169 (1), 30-35

Bowl R. 2007. The need for change in UK mental health services: South Asian service user's views. Ethnic Health. 12. (1). 1-19

Buist AE, Barnett BEW, Milgrom J, Pope S, Condon JT, Ellwood DA, Boyce PM, Austin MP, Hayes BA. 2002. To screen or not to screen – That is the question in perinatal depression. SO Medical Journal of Australia. 177. s101-s105

Carro M , Grant K, Gotlib I, 1993. Postpartum depression and child development: An investigation of mothers and fathers as sources of risk and resilience. Development of Psychopathology. 5, 567-579

Clandinin DJ. 2007. Handbook of Narrative Inquiry. Sage. London.

Community Practitioners and Health Visitors Association. 2003. Postnatal depression and maternal mental health in a multicultural society: challenges and solutions. CPHVA. London.

Cox JL, Holden JM, Sagovsky R. 1987. Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. British Journal of Psychiatry. 150. 782-786

Culley, L & Dyson, S. (2009a). Ethnicity and Healthcare Practice . Quay Books.

Culley, L, Hudson, N & van Rooij, F. eds (2009) Marginalized Reproduction: Ethnicity, Infertility and Reproductive Technologies. Earthscan Books London. ISBN 978-84407-576-8

Department of Health. 1999. National Service Framework for Mental Health: Modern Standards and Service Modules. The Stationery Office. London

Department of Health. 2000. Race Equality Scheme. The Stationery Office. London

Department of Health. 2002. Women's Mental Health: Into the Mainstream Strategic Development of Mental Health Care for Women. The Stationery Office. London

Department of Health. 2003. Improving Mental Health Services for Black and Minority Ethnic Communities in England: Inside Outside. The Stationery Office. London

Department of Health. 2005. Delivering Race Equality in Mental Health. The Stationery Office. London Department of Health and Office of National Statistics. 2009.The Self Reported Experience of Patients from Black and Minority Ethnic Groups . HMSO. London.

Dietz PM, William SB, Callaghan WM, Bachman DJ. Whitlock EP., Hornbrook MC., 2007. Clinically Identified maternal depression before, during and after pregnancies ending in live births. American Journal of Psychiatry. 164, 1515-1520

Downe S, Butler E, Hinder S. 2007. Screening tools for depressed mood after childbirth in UK-based South Asian women: as systematic review. Journal of Advanced Nursing. 57. (6). 565-583

Edge D, Baker D, Rogers A. 2004. Perinatal depression among black Caribbean women. Health and Social Care in the Community. 12. (5). 430-438

Fazil Q, Wallace L, Singh G, Ali Z, Bywaters P. 2004. Empowerment and advocacy: reflections on action research with Bangladeshi and Pakistani families who have children with severe disabilities. Health and Social Care in the Community. 12. (5). 389-397.

Fernando S. 1995. Mental Health in a Multi-ethnic Society: A Multidisciplinary Handbook. Routledge. London.

Gausia K, Fisher C, Algin S, Oosthuizen J. 2007. Validation of the Bangla version of the Edinburgh Postnatal Depression Scale for a Bangladeshi sample. Journal of Reproductive and Infant Psychology. 25 (4) 308-315

Gerrish K, Husband C, Mackenzie J. 1996. Nursing for a Multiethnic Society. Open University Press. Buckingham.

Ghubash R, Abou-Saleh MT, Daradkeh TK. 1997. The validity of the Arabic Edinburgh Postnatal Depression Scale. Social Psychiatry and Psychiatric Epidemiology. 32. (8), 474-476

Gibson J, McKenzie-McHarg K, Shakespeare J, Price J, Gray R. 2009. A systematic review of studies validating the Edinburgh Postnatal Depression Scale in antepartum and postpartum women. Acta Psychiatrica Scandaniva. 119. 350-364

Government Equalities Office. (2009). Equality Bill – Equality Impact Assessment. HMSO. London

Harpham T, Huttly S, DeSilva MJ, Abramsky T. 2005. Maternal mental health and child nutritional status in four developing countries. Journal of Epidemiological and Community Health. 59. 1060-1064

Henley A, Schott J. 1999. Culture, Religion, and Patient Care in Multiethnic Society: A Handbook for Professionals. Age Concern. London.

Hewitt CE, Gilbody SM, Brealey S, Paulden M, Palmer S, Mann R. et al. 2009. Methods to identify postnatal depression in primary care: an integrated evidence synthesis and value of information analysis. Health Technology Assessment. 13 (36).

Hoffbrand S, Howard L, Crawley H. 2001. Antidepressant drug treatment for postnatal depression. Cochrane Database of Systematic Reviews. 2. CD002018

Holden JM, Sagovsky R, Cox JL. 1989. Counselling in a general practice setting: controlled study of health visitor intervention in treatment of postnatal depression. British Medical Journal. 298. (6668), 223-226

Irfan N., Badar A., 2003. Determinants and pattern of postpartum psychological disorders in Hazara division of Pakistan. Journal of Ayub Medical College Abbottabad. 15 (3) 19-23

*MacLachlan M. 2006. 2nd Ed. Culture and Health: A Critical Perspective Towards Global Health. Wiley and Sons Ltd. Chichester.

Morrell CJ, Slade P, Warner R, Paley G, Dixon S, Walters SJ, Brugha T, Barkham M, Parry GJ, Nicholl J. 2009. Clinical effectiveness of health visitor training in psychologically informed approaches for depression in postnatal women: pragmatic cluster randomised trial in primary care. http://bmj.com/cgi/content/full/338/jan15_2/a3045

Munk-Olsen T, Laurenson MT, Pedersen CB. 2006. New parents and mental disorders: a population-based register study. Journal of American Medical Association. 296 (21), 2582-2589

Najman JM, Andersen MJ, Bor W, O'Callaghan MJ, Williams GM. 2000. Postnatal depression-myth and reality: maternal depression before and after the birth of a child. Social Psychiatry Epidemiology. 35. (1), 19-27

National Screening Committee. 2001. Screening for Postnatal Depression. National Screening Committee.

National Institute for Clinical Excellence. 2007. Antenatal and Postnatal Health: Clinical Management and Service Guidelines. HMSO. London.

O'Dea JW. 2006. Pursuing truth in narrative research. Journal of Philosophy of Education. 28 (2) 161-172.

Onozawa K, Kumar R., Adams D, Dore C, Glover V. 2003. High EPDS scores in women from ethnic minorities living in London. Archives of Women's Mental Health. 6. (2), 51-55

Papadopoulos I, Lees S. 2002. Developing culturally competent researchers. Journal of Advanced Nursing 37. (3). 258-264

Papadopoulos I. 2006. Transcultural Health and Social Care: Development tioners. Churchill Livingston. London.

Parvin A, Jones C, Hull S. 2004. Experiences and understandings of social and emotional distress in the postnatal period among Bangladeshi women living in Tower Hamlets. Family Practice. 21. (3), 254-260

Persaud A, Sallah D. 2002. National Black and Ethnic Minorities Mental Health Innovations and Research and Development Expert Group. National Institute for Mental Health England. London

Pope S., Watts J, Evans S, McDonald S, Henderson J. 2000. Postnatal Depression: A Systematic Review of Published Scientific Literature to 1999. National Health and Medical Research Council

Race Equality Scheme (2008) http://www.equalities.gov.uk/equality_bill.aspx 17.6.09

Impact Assessment of the Race Equality Bill (2009)

Rahman A, Iqbal Z, Harrington R. 2003. Social environment and depression among pregnant women in urban areas of Pakistan: Importance of social relations. Social Science and Medicine, 63, 1466-1476.

Rai-Atkins A, Jama A, Wright N, Scott S, Perring C, Craig G, Katbamna S. 2002. Best Practice in Mental Health: Advocacy for African, Caribbean and South Asian Communities. The Policy Press, Joseph Rowntree Foundation. London

Ramchandani P, Stein A, Evans J, O'Connor TG. 2005. Paternal depression in the postnatal period and child development: a prospective population study. Lancet. 365. 2210-2205.

Rhodes P, Nocon A, Wright J. 2003. Access to diabetes services: the experiences of Bangladeshi People in Bradford, UK. Ethnicity and Health. 8. (3). 171-188

Robinson M. 2002. Communication and Health in Multi-Ethnic Society. Policy Press. Bristol

Rundle A, Carvalho M, Robinson M. 1999. Cultural Competence in Health Care: a practice guide. Jossey-Bass. San Francisco.

Scottish Intercollegiate Guidelines Network. 2005. Review of SIGN Guideline 60. SIGN. Edinburgh.

Seeley S, Murray L, Cooper P. 1996. Postnatal depression: the outcome for mothers and babies of health visitor intervention. Health Visitor. 69. (135), 138

Shahid A, Atkin K. 2004. Primary Healthcare and South Asian Populations: Meeting the Challenges. Radcliffe Medical Press Ltd. Oxford.

Shakespeare J. 2002. Health visitors screening for PND using the EPDS: a process study. Community Practitioner. 75. (10). 381-384

Stewart RC. 2007. Maternal depression and infant growth- a review of recent evidence. Maternal and Child Nutrition. 3 (2) 94-107

Szczepura A, Johnson M, Gumber A, Jones K, Clay D, Shaw A. 2005. An Overview of the Research Evidence on Ethnicity and Communication in Healthcare. Warwick University. Warwick.

Templeton L, Velleman R, Persaud A, Milner P. 2003. The experience of postnatal depression in women from black and minority ethnic communities in Wiltshire, UK. Ethnicity and Health. 8. (3). 207-221

The Race Relations (Amendment) Act 2000. HMSO. London.

Webster A. 2002. The forgotten father: the effect on men when partners have PND. Community Practitioner. 75. (10), 390-393

Whitehead M. 1988. Inequalities in Health: The Health Divide. Penguin. London

Wilkinson R. 1996. Unhealthy Societies: the Afflictions of Inequality. Routledge. London

Yoshida K, Yamashita H, Ueda M, Tashiro N. 2001. Postnatal depression in Japanese mothers and the reconsideration of 'Satogaeribunben'. Paediatric International. 43. (2), 189-193