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.

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,
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 do not provide specific guidance on culturally appropriate assessment and treatment of women who do not have English as a first language. This was a matter of concern to assist health visitors in this field of work especially as reports indicated that whilst health visitors were increasingly 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. (Carroll and Sallah 2002) 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 development of health inequalities and avoidable suffering (Whitehead 1988, Wilkinson 1996, Almond 2002, 2008b). 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 2005). Additionally, legislative action such as, The Race Relations (Amendment) Act 2000 has also placed a general duty on specified public authorities.

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 health visiting practice. 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 community-based experience (Sczepura et al 2005:5) ensuing from changing patterns in migration to the UK.

Participants were asked to provide a list of family members, friends and colleagues and then invited to contact them on their behalf. A further meeting was held with the members of the community and friends and then finally with the participants. Given the cultural differences in 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 only in one health visiting practice, the population largely under discussion were Asian families living in localities with high ethnic populations in or near South Asian towns. It can be noted 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.

Participants were asked with a large majority of the sample were female. The majority drew welfare and unemployment benefits, experienced high levels of alcoholism, drug taking, forced marital sex and lived in overcrowded homes. Due to immigration laws, some husbands faced difficulties in getting back into England which caused considerable stress. 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 their extended family, then from the extended family, and then from the community and friends, and then finally from what they saw as ‘white run services’.

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. A 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 only in one health visiting practice, the population largely under discussion were Asian families living in localities with high ethnic populations in or near South Asian towns. It can be noted 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.

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Communication

Participants said that on the face of it men and women were equal in the household, and could speak English, she was always accompanied. Participants said this was because of fear they may say something that would be considered offensive. 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 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 also. Health visitors said they could not do their work if it were not for the family members acting as interpreters.

Family Support Worker

Participants explained that due to their family’s working hours there was a concomitantly a high non-attitude and missed appointment rate. Community health workers, who were preferred home visitors, were community workers from the local community and were provided if the mother was depressed. Concerns were also 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 CPHA picture booklets were available but again it was reported they had limited usage.

Postnatal depression

The Primary Care Trust’s policy directed that all women should be assessed for postnatal depression at 5-6 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 those who were depressed as it was postnatal depression 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 universal screening. Most participants who reported 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 other 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 if it all seemed overly well, this was sometimes accepted without further investigation.

Table 2: Postnatal depression assessment questions

<table>
<thead>
<tr>
<th>Are you happy?</th>
<th>Do you cry?</th>
<th>Are you coping?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you in a good mood?</td>
<td>Do you want to sleep all the time?</td>
<td>What is your mood like?</td>
</tr>
<tr>
<td>Are you enjoying your baby?</td>
<td>Are you going out at all?</td>
<td>Are you fearful?</td>
</tr>
<tr>
<td>Have you managed to go out at all?</td>
<td>What support do you have?</td>
<td>What support do you have?</td>
</tr>
<tr>
<td>Are you coping with the older children?</td>
<td>Are you eating?</td>
<td>Are you eating?</td>
</tr>
<tr>
<td>Have you tried/low/have you ever been like this in the past?</td>
<td>Have you had any treatment or been to the doctor when you have felt like this?</td>
<td>Have you had any treatment or been to the doctor when you have felt like this?</td>
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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 draining, 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 Mental Health Therapy but most said they did not have the time resources to provide it. Severely depressed women were seen by the personal health team. Participants said that Polish women were said to use hot flame therapy and conventional medicine to treat postnatal depression. Women with depression were adapting and doing their best in an area where services are scarce.

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 with the interpreter in the room, participants felt the interpreter was not overtly well, this was sometimes accepted without further investigation.

Studies of advocacy and empowerment in minority ethnic communities have highlighted how Western constructs and values of health and illness have limited cultural knowledge and that many patients 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 seek help as they could not trust the workers and felt they would not understand their culture and language. Furthermore, it was noted 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 that 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 screening tool, but other authors have found if they sampled minority ethnic women. Effective communication is reliant on working in partnership with patients. Almond and Cowley (2008) provide

Cultural Competence and Equity in Postnatal Depression

During the focus group discussions, participants consistently said that in their cultural and religious beliefs, the role of non-white women. Studies of advocacy and empowerment in minority ethnic communities have highlighted how Western constructs and values of health and illness have limited cultural knowledge and that many patients 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 seek help as they could not trust the workers and felt they would not understand their culture and language. Furthermore, it was noted 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 that 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 screening tool, but other authors have found if they sampled minority ethnic women. Effective communication is reliant on working in partnership with patients. Almond and Cowley (2008) provide...
a skill typology for working in partnership with patients and their carers 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 cultural concern, 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 may be a way forward this alone may not improve access. Cultural competency models mainly focus on cultural competence 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 able to 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

<table>
<thead>
<tr>
<th>Resource</th>
<th>Description</th>
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<tbody>
<tr>
<td><a href="http://www.diversitytv.org/html/MAOS&amp;8.htm">http://www.diversitytv.org/html/MAOS&amp;8.htm</a></td>
<td>Listed one of this one has two patient-centred guides</td>
</tr>
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Webster A. 2002. The forgotten father: the effect on men when partners have PND. Community Practitioner. 75. (10), 390-393

