

# Do Specialist Community Public Health Nurses Assess Risk Factors for Depression, Suicide, and Self-Harm Among South Asian Mothers Living in London?

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**ABSTRACT** Evidence indicates that suicide rates are higher in South Asian women in the United Kingdom compared with other ethnic groups, suggesting increased vulnerability to attempted suicide and mental distress in these women. Specialist Community Public Health Nurses (SCPHNs, including health visitors) are in an ideal position to assess such risk. The objectives are to determine whether SCPHNs assess known risk factors for depression, self-harm, and suicide during initial contact with South Asian mothers in London; the extent to which these risk factors are documented in the nursing records; and whether their assessments of South Asian women differ from those of other ethnic groups. Structured content analysis of semistructured interviews with 8 SCPHNs and analysis of 60 matched pairs of SCPHN records were carried out in an inner London community. The results revealed that SCPHNs assessed general risk factors for postnatal depression and some culture-specific factors when assessing South Asian mothers. Documentation of risk factors was under-represented in the SCPHN records and there was a significant difference between the documented risk factors for South Asian women and women from other ethnic groups. While SCPHNs understood some aspects of South Asian culture, service improvements must be made to ensure better care provision.

Key words: depression, health visitors/SCPHNs, self-harm, South Asian mothers, suicide.

In the United Kingdom, suicide is the leading cause of maternal death in the year following child birth (Confidential Enquiries into Maternal and Child Health, 2004). Research indicates that South Asian women in the United Kingdom suffer increased rates of attempted self-harm and mental distress. The term

South Asian here refers to individuals whose ethnicity originates from countries of the Indian subcontinent: India, Pakistan, Bangladesh, Sri Lanka, Nepal, and Bhutan.

Studies have found that suicide rates are higher for British South Asian women compared with other ethnic groups (Bhugra, Desai, & Baldwin, 1999; Cooper et al., 2006; McKenzie, Serfaty, & Crawford, 2003; Neelam & Wessely, 1999; Patel & Gaw, 1996; Raleigh, 1996). South Asian women have the highest overall suicide rate: 1.6 times that of Caucasian women (Bhugra, Desai, & Baldwin, 1999). For younger women (under 30 years), the rate is even higher: 2.5 times that of Caucasians (Bhugra, Desai, & Baldwin, 1999; Cooper et al., 2006). The problem is often exacerbated in the postnatal period, when there is significant risk of postnatal depression in new mothers from diverse

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cultures (Oates et al., 2004). Although there are varying rates of prevalence (between 10% and 15%), a meta-analysis of 59 studies reported it affects 13% of all mothers in Western societies (O'Hara & Swain, 1996). Risk factors associated with postnatal depression include lack of close confiding relationships, poor marital relationships, low social support, history of mental illness and history of suicide or self-harm (Coggill, Caplan, Alexandra, Robson, & Kumar, 1986; Dennis, 2005; Merrill & Owens, 1986; Seeley, Murray, & Cooper, 1996; Scottish Intercollegiate Guidelines Network [SIGN], 2002). South Asian mothers present a group where two already high-risk groups overlap creating a group that is at even more significant risk. South Asians make up 4% of the total UK population and 50% of the ethnic minority population (ONS, 2002). Therefore, this is a major public health issue for all public health professionals, in both commissioning and provider services.

In the United Kingdom, SCPHNs, more commonly known as health visitors, provide a service designed to offer proactive support to families particularly in the postnatal period. Unlike most health and social professionals, these SCPHNs have routine access to all mothers following birth, through referrals from maternity services. The first contact between SCPHNs and new mothers after childbirth is referred to as the "new birth visit." The aim of this visit is to undertake a comprehensive assessment of the family situation, including maternal well-being and assessment of the newborn baby, and relationship building with the mother in order to plan the most appropriate care pathway. Through these contacts SCPHNs identify needs or problems with a view to improving health (Luker & Chalmers, 1990), placing them in an ideal position to assess risk of depression, suicide, and self-harm in new mothers.

Recent clinical guidelines by the National Institute of Clinical Excellence (NICE, 2007), suggest that during a woman's first contact both antenatally and postnatally, healthcare professionals should investigate any past or present mental illness, and assess her mental health in the postnatal period by asking specific questions (Fig. 1). In the UK Primary Care Trusts (PCTs) control 80% of the National Health Service (NHS) budget and provide frontline healthcare services to its community, including the services provided by SCPHNs. Clinical recommendations for best practice also suggest that PCTs should have clear protocols and care pathways for the assessment and

The National Institute of Clinical Excellence (2007) recommends that "at a woman's first contact with primary care, healthcare professionals (including midwives, obstetricians, health visitors and GPs) should ask two questions to identify possible depression:

- During the past month, have you often been bothered by feeling down, depressed or hopeless?
- During the past month, have you often been bothered by having little interest or pleasure in doing things?

A third question should be considered if the woman answers 'yes' to both of the initial questions.

- Is this something you feel you need or want help with?"

(NICE, 2007)

**Figure 1. Clinical Management and Service Guidance of Antenatal and Postnatal Mental Health (NICE, 2007)**

treatment of mental illness in the antenatal and postnatal period; healthcare professionals involved should have appropriate supervision and training covering mental health assessments of women and subsequent referrals; and records of any mental illness or risk factors should be entered in women's medical notes (NICE, 2007).

SCPHNs in the United Kingdom are equipped with the skills to assess maternal mental health as it is an integral part of their training curriculum (Nursery and Midwifery Council, 2004). Assessment tools are often used and have been found to be useful when used in conjunction with SCPHNs' professional assessments of a mother's mood, appearance and interaction with their baby (Adams, 2002; Cowley & Billings, 1999; Gerrard, Holden, Elliot, McKensie, & Cox, 1993). While there is evidence of SCPHNs' general effectiveness in detecting and managing mental illness (Bull, McCormick, Swann, & Mulvill, 2004; Cowley & Billings, 1999), little is known about assessments particular to South Asian mothers, and whether they reflect an awareness of the specific risk factors affecting this group.

Literature in the area of postnatal mental health suggests a number of factors that increase levels of mental distress in women in general, and South Asian women in particular. In India, Adityanjee (1986) found rates of attempted suicide to be higher in married women. This was related to problems surrounding dowries and consequent maltreatment of brides in

extended families. In Pakistan, Khan and Reza (1998) reported that more young women attempted suicide following conflict with their spouse or family, other cultural factors such as arranged marriage and religion; psychological factors, principally self-esteem; and social factors, like changing gender roles. Issues specifically raised by UK Asian mothers following childbirth include: too much domestic work within a large extended family, infidelity on the husband's part, inability to engage in the "traditional" 40-day rest period following childbirth, and gossip and lack of confidentiality in close-knit, interrelated communities (Oates et al., 2004).

Other contributory factors to mental distress in South Asian women identified by a literature review undertaken were: restrictive customs and relationship difficulties—including being "controlled" by family members (Bhugra, 2004; Bhugra, Baldwin, Desai, & Jacob, 1999; Chew-Graham, Bashir, Chantler, Burman, & Batsleer, 2002; Cooper et al., 2006; Kingsbury, 1994; Newham Asian Women's Project [NAWP], 1998), forced marriages (Bhugra, 2004; Chantler, Burman, Batsleer, & Bashir, 2001; NAWP, 1998; Virdee, 2001), domestic violence (Belgrave Baheno, 1996; Chew-Graham et al., 2002; Hicks & Bhugra, 2003; Himelfarb Hurwitz, Gupta, Liu, Silverman, & Raj, 2006), isolation (Bhugra & Hicks, 2004, as cited in Bhugra, 2004; Chew-Graham et al., 2002; Fazil & Cochrane, 1998, as cited in Hussain & Cochrane, 2004), and living within extended families (Adityanjee, 1986; Chase-Lansdale, Brooks-Gunn, & Zamsky, 1994; Khokher & Khan, 2005; Oates et al., 2004; Shah & Sonuga-Barke, 1995; Sonuga-Barke & Mistry, 2000; Sonuga-Barke, Mistry, & Qureshi, 1998)—see Fig. 2, for a full list.

Although the presence of a single risk factor may increase mental distress, literature suggests that in most cases it is a combination of these factors that is linked to extreme manifestations of distress leading to suicide or self-harm, especially at a vulnerable time such as the postnatal period. SCPHNs' contact with, and assessment of mothers at this key point in time is crucial to detecting such risk, especially in light of evidence that suggests considerable barriers to this group of women accessing essential services (Bhardwaj, 2001; Cartwright & Anderson, 1981; Chantler et al., 2001; Chew-Graham et al., 2002; Curren, 1984; NAWP, 1998). Where services have attempted to understand and meet the needs of ethnic minority groups and pro-

RISK FACTORS IDENTIFIED FROM LITERATURE	CITATIONS
<u>Generic</u>	
Mental History <i>Any previous depression or psychotic episodes.</i>	• SIGN, 2002; Dennis, 2005.
History of Suicide/ Self-harm <i>Any previous self-harm or suicide attempts</i>	• Merrill and Owens, 1986; Bhugra et al., 1999a.
Negative Birth Experience <i>Any obstetric complications during birth or the birth experience not being as positive as expected.</i>	• Cogill et al., 1986; Seeley et al., 1996; SIGN, 2002; Dennis, 2005.
Lack of support <i>Poor support networks, lack of family/friends, lack of close confiding relationships.</i>	• SIGN, 2002; Dennis, 2005.
<u>Culture Specific</u>	
Isolation <i>Lack of close confiding relationships/ friends. May be caused by being new to the country or not being able to speak English.</i>	• Fazil and Cochrane, 1998; Thompson and Bhugra, 2000; Chew Graham et al., 2002; Bhugra and Hicks, 2004; Bhugra, 2004.
Living within an Extended Family <i>Living with parents/ siblings, living with parents-in-law, living with other extended family members.</i>	• Unger and Cooley, 1992; Chase-Lansdale et al., 1994; Shah and Sonuga-Barke, 1995; Sonuga-Barke et al., 1998; Sonuga-Barke and Mistry, 2000; Oates et al., 2004; Khokher and Khan, 2005.
Relationship difficulties/ Conflict with the Mother-in-law <i>Negative relationships or any conflict between the mother-in-law and the daughter-in-law.</i>	• Unger and Cooley, 1992; Chase-Lansdale et al., 1994; Sonuga-Barke et al., 1998; Sonuga-Barke and Mistry, 2000; Oates et al., 2004.
Being 'Controlled' by Family Members <i>Being forced or to feel obligated to behave/act in a certain manner by another family member, such as partner, parents, parents-in-law etc.</i>	• Merrill and Owens, 1986; Kingsbury, 1994; NAWP, 1998; Cooper et al., 2006.
Domestic Violence <i>Violence within a relationship, where the perpetrator may be male or female. In this context mainly referring to violence to women from their partners.</i>	• Belgrave Baheno, 1996; George and Rahangdale, 1999; Chew-Graham et al., 2002; Hicks and Bhugra, 2003; Gill, 2004; Himelfarb Hurwitz et al., 2006.
Culture Conflict <i>Conflict caused by customs, practices and expectation of different cultures. Here referring to the conflict Asian women may face with the clash of Eastern &amp; Western cultural values.</i>	• Merrill and Owens, 1986; Handy et al., 1991; NAWP, 1998; Thompson and Bhugra, 2000; Bhardwaj, 2001.
Inter-racial Relationships <i>Being in a relationship with someone from a different ethnic/ racial background.</i>	• Mahy, 1993; Bhugra et al., 1999b.
Forced Marriages <i>Marriages that are forced, against the person's will. These are different to arranged marriages. Here mainly referring to women who have been forced to marry.</i>	• NAWP, 1998; Firkee and Bhatti, 1999; Chantler et al., 2001; Virdee, 2001; Bhugra, 2004.
Racism <i>Experience of antagonism from people of different racial backgrounds. Here referring to Asian women's experiences in the UK.</i>	• Curren, 1984; Fenton and Sadiq, 1990; Chew-Graham et al., 2002; Hussain and Cochrane, 2004.

**Figure 2. Risk Factors for Depression, Suicide and Self-Harm in South Asian Mothers, Identified by Previous Studies**

vided culturally sensitive care, there have been noticeable improvements in service uptake and compliance with treatment (Hussain & Cochrane, 2004; Rack, 1982; Webb-Johnson & Nadirshaw, 1993).

This study explores how SCPHNs assess and record the mental well-being of mothers from South Asian communities during the “new birth visit” in London, the capital city of the United Kingdom, and aims to answer the following three questions:

- (1) Do SCPHNs assess known risk factors for depression, self-harm and suicide when undertaking initial assessments of new mothers from South Asian communities?
- (2) Do SCPHNs document these risk factors in their records following initial assessments of new mothers from South Asian communities?
- (3) Do SCPHNs assess mothers from South Asian communities differently to mothers from other ethnic backgrounds? If this is the case, why?

## Methods

### *Design and sample*

The research design is a cross-sectional prevalence study and was carried out within a diverse and multi-cultural inner London district covered by a single NHS PCT which commissions and delivers services to 210,000 people—the third highest population density in the United Kingdom (ONS, 2002). Of this, South Asians make up 9% of the population, the largest subgroup being Bangladeshi, followed by Indians and Pakistanis.

The selection criteria were decided at the outset of the study. Participants included were qualified SCPHNs (health visitors) working within the PCT. SCPHNs working through agencies on an ad hoc basis and those not carrying out routine postnatal assessments were excluded. All 27 SCPHNs working within this PCT were informed of the study verbally in staff meetings and those fitting the inclusion criteria were then invited by letter to participate individually in a “one-off” tape recorded interview, lasting no longer than 30 min. Ten initially volunteered (37%) but subsequently 2 withdrew citing lack of time, leaving a final sample of 8 (30%). Of the 8, 4 described their ethnic background as White British, 3 as Black African, and 1 as Black British. Their health visiting experience varied, ranging between 2 and 25 years. More than half (5/8) had over 20 years of work experience.

Interviews were conducted in a number of different health centres, community centres, and GP’s surgeries. The choice was dependant upon convenience for

participants, and availability of resources. In all cases private rooms were used for interviews ensuring minimal distraction and confidentiality. All interviews were carried out by the same researcher using the interview guide.

For the second part, 60 records of South Asian mothers and 60 records of non-South Asian mothers were selected as follows:

- (1) From each of the six SCPHN teams, records of the 10 most recent babies born to South Asian families were chosen.
- (2) Each of those records was paired with another set of records for a non-South Asian family, based on location of residence (residing on the same street).

Of the South Asian sample, 48% of the records belonged to Bangladeshi, followed by 35% to Indians, 15% to Pakistanis, and 2% to Bhutanese mothers. In the control sample, White women made up 37%, followed by 17% Black Africans, 13% Turkish, 11% Black British, 8% Black Caribbean, 7% Eastern European, and 7% Mixed race women. The categories for ethnicity were those documented in records in accordance with PCT guidelines. Ethical approval was sought and granted from the NHS Research Ethics Committee, and trust management approval was granted by the local Research and Development manager.

### *Measures*

The study incorporates both qualitative and quantitative data collection from two different sources: (1) mixed method interviews with SCPHNs and (2) audits of SCPHN records.

A mixed method approach was considered the most appropriate for this study in order to enhance reliability and validity.

A semistructured interview guide was devised for the first part of data collection to obtain detailed information about the content of SCPHNs’ assessments. The interview guide was divided into two sections: (1) assessment of mothers’ mental wellbeing in general and (2) assessment of South Asian mothers’ mental wellbeing. Open-ended questions were used and topics included—how mental health assessments were conducted, whether any risk factors were identified and what information was provided during “new birth” visits. The variables measured in the interviews were

the factors identified in Table 1 based on information from the literature highlighted earlier in Fig. 2.

For the second part, a “tick box” style audit checklist was devised containing the risk factors presented in Table 2. This was again based on the information identified from the literature in Fig. 2. In addition to the main risk factors, information was also collected on a number of subfactors in order to gain a better understanding of the assessments carried out. For example, in addition to collecting information on “lack of support,” information was also collected on sources of support—“support from partner,” “support from extended family,” and “social support/friends/community” (see Table 2). Each set of records was audited using this check-list. The information collected from the records did not necessarily have the same wording as the items in Fig. 2, but was included in the results as long as it was considered to have the same meaning (e.g., Psychological history and Mental history). The audit was performed by the same researcher, thus minimizing risk of instrument-related error, where different results are collected due to differing interpretations of the questions asked

TABLE 1. *Interview Reports of Risk Factors Assessed by 8 SCPHNs During Initial Assessments of South Asian Mothers*

Factors assessed	Number of participants/ SCPHNs (total = 8)
Assessment recommendations by NICE (2007)	
Mother's mood/feelings	8
Mother's appearance	7
Interaction with baby	7
Mental history	6
Generic risk factors	
History of self-harm/suicide	0
Negative birth experience	4
Lack of support	8
Culture specific risk factors	
Isolation	3
Living within an extended family	7
Relationship difficulties/conflict with mother-in-law	5
Being “controlled” by family members	4
Domestic violence	3
Culture conflict	1
Interracial relationships	1
Forced marriages	0
Racism	0

Note. NICE = National Institute of Clinical Excellence; SCPHN = Specialist Community Public Health Nurses.

(Cormack, 2000). Anonymity was maintained for all data collected throughout the study.

A pilot study (two interviews and an audit of four records) was performed to determine the suitability of the questions asked, that is, that they could deliver appropriate information for the purpose of this study. This also enhanced the researcher's skills in interviewing, tape recording, transcribing, and collecting data using the designed checklist. The information yielded from this study was considered appropriate and therefore no modification was necessary to the research tools. Data gathered from the pilot were incorporated in the main results.

### **Analytic strategy**

Data obtained from the interviews were analyzed using quantitative content analysis, which is a process used to scrutinize large amounts of textual information and identify its properties. Firstly, the tape-recorded interviews were transcribed verbatim. Each transcript was then manually searched for predetermined themes, identified from the literature review. Finally each theme was coded, extracted from the transcript, and placed under the relevant topic headings.

Descriptive statistics were used to describe and summarize data from the records audit. The difference in documentation between matched pairs of records (for South Asian and non-South Asian mothers) were analyzed using McNemar Test for differences in proportions using Stats Direct Statistical Software (V2).

## **Results**

### ***Self-reported assessment practices***

All SCPHNs interviewed were unaware of any policy or guidelines for the assessment of postnatal depression within the PCT, and did not use any assessment tool when assessing the risk of depression in new mothers. Instead they reported that they assessed psychological well-being by asking mothers questions about their mood/feelings. Seven of the 8 SCPHNs used observation of the mothers' appearance and the mothers' interaction with their babies, in addition, to form their assessments (Table 1). Topics of questions asked by the SCPHNs during their assessment of new mothers included mental history (6/8); negative birth experience (4/8); support network (8/8); and isolation (3/8).

For South Asian mothers, additional topics considered were “living within an extended family” (7/8), “conflict with the mother-in-law” (5/8), “being controlled by family members” (4/8), and “domestic violence” (3/8). “Culture conflict” and “interracial relationships” were viewed by one participant as a risk factor. Factors such as “history of self-harm/suicide,” “forced marriages,” and “racism” were not highlighted by any of the participants.

While 3 SCPHNs viewed the extended family as a source of additional support for the mother, four identified potential negative aspects:

I'd look at whether or not there is any extended family or if she's here probably isolated on her own. . . . So I always look at extended family, has she got extended family around her, has she got friends

around her, has she been working, so I look at her social status or social background, her friends, relatives (Participant-4).

[I consider] . . . their living situation, are they living with an extended family . . . , I mean not that that's going to say that she is going to be postnatally depressed but it can sometimes have a bearing on the situation (Participant-2).

. . . most of these families [South Asian] live with the in-laws so there isn't time for mum to actually to have on her own. You know to have that quiet five minutes, so those are the kind of questions that I will be asking. Is she able to make decisions for herself? (Participant-5).

The mother-in-law is the head of the family, so she more or less would tell the daughter what to do, how to behave and what to answer (Participant-5).

TABLE 2. Factors Documented in SCPHNs' Records Following Initial Assessments of South Asian Mothers and Non-South Asian Mothers

	South Asian (N = 60)		Comparison group (N = 60)		Difference (%)	Two-sided p value
	n	%	n	%		
Assessment recommendations by NICE (2007)						
Mother's mood/feelings	15	25	18	30	5	.6776
Mother's appearance	15	25	18	30	5	.6776
Interaction with baby	12	20	10	17	-3	.7905
Mental history	12	20	14	23	3	.8036
Generic risk factors						
History of self-harm/suicide	2	3.3	4	6.7	3.4	.6875
Negative birth experience	0	0	0	0	0	n/a
Lack of support	27	45	18	30	-15	.049*
Support from partner	33	55	21	35	-20	.0428*
Support from extended family	28	47	18	30	-17	.0414*
Social support/friends/community	3	5	5	8.3	3.3	.7266
Culture specific risk factors						
Isolation	2	3.3	4	6.7	3.4	.6875
Living within an extended family	26	43	9	15	-28	.0015**
Family composition	40	67	45	75	8	.3593
Type of family: nuclear/extended	27	45	14	23	-22	.0241*
Relationship difficulties/conflict with mother-in-law	8	13	1	1.7	-11.3	.0391*
Relationship with husband/partner	6	10	5	8.3	-1.7	> .9999
Being “controlled” by family members	0	0	0	0	0	n/a
Domestic violence	3	5	1	1.7	-3.3	.625
Culture conflict	0	0	0	0	0	n/a
Interracial relationships	0	0	0	0	0	n/a
“Type of marriage” (arranged/forced)	0	0	0	0	0	n/a
Marital status	17	28	3	5	-23	.0013**
Racism	2	3.3	4	6.7	3.4	.6875

Note. NICE = National Institute of Clinical Excellence; SCPHN = Specialist Community Public Health Nurses.

\*p = < 0.05. \*\*p = < 0.01.

So it was there that she actually revealed that she couldn't do this and that because of her mother-in-law and father-in-law actually controlling her, actually her husband supporting that as well (Participant-3).

But I have come up against the problem that often they are not allowed, they seem to be quite housebound or they are too busy to do anything (Participant-8).

Three SCPHNs reported domestic violence as a risk factor and suggested that the perpetrator may not be just the husband, but also other family members:

You can have other issues which are contributing to the depression, that can be domestic violence and that can come from men or from women and what I have found some of these young mothers have been brought over here and they have no family of network for themselves so I do keep a very close eye on those mothers (Participant-8).

Three SCPHNs discussed the difficulties surrounding arranged marriages, especially if one partner originated from a different country. The main issues pertained to isolation, pressures put upon them, and health implications of marrying a close relative. None mentioned forced marriages.

All SCPHNs (8/8) claimed to assess South Asian mothers in exactly the same manner as mothers from other ethnic backgrounds, and 7 said that they would provide mothers with the same information about support services. One SCPHN provided additional information to South Asian mothers about support groups and counselling services that were specific to Asian women.

Some obstacles were identified by the SCPHNs in their assessment of South Asian women. They were language barrier (6/8), lack of privacy/access during assessments (4/8), lack of time for relationship building (3/8), and professionals' lack of knowledge about the South Asian culture (2/8).

### ***Documentation of risk factors***

The most commonly documented features for South Asian mothers were records of "family composition" (67%), "support from partners" (55%), "support from extended family" (47%), "type of family—extended/nuclear" (45%), and whether they were "living within an extended family" (43%).

The least common aspects documented were "history of self-harm/suicide" (3.3%), "isolation" (3.3%), "domestic violence" (5%), "social support/

friends/community" (5%), and "racism" (3.3%). There was no documentation about any mothers' negative birth experience, "being controlled by family members," culture conflict, interracial relationships, or "type of marriage" (arranged/forced) (Table 2).

Variation in documentation between South Asian mothers and the control group was seen for several factors (Table 2). There were statistically significant differences in documentation of "marital status" (−23%,  $p = .0013$ ), "type of family" (−22%,  $p = .0241$ ), "living within an extended family" (−28%,  $p = .0015$ ), "support from partner" (−20%,  $p = .0428$ ), "support from extended family" (−17%,  $p = .0414$ ), "lack of support" (−15%,  $p = .049$ ), and "relationship difficulties/conflict with mother-in-law" (−11.3%,  $p = .0391$ ). All these factors were more frequently documented in records of South Asian mothers when compared with the control group.

There was no significant difference (−6%,  $p = .5034$ ) between the two groups of women in the documentation of information provided by SCPHNs on support services, during the "new birth" visit. The records for 73% of the South Asian group and 67% of the comparison group suggested that women were informed about the SCPHN (health visiting) service and child health clinics. No documentation was found on any culture-specific information given to mothers in the records audited.

## **Discussion**

This study found that SCPHNs assessed general risk factors for postnatal depression and some culture-specific factors when assessing South Asian mothers; however, the documentation of risk factors did not fully reflect the self-reported practices. There was also a difference in the risk factors documented for South Asian women and those from other ethnic backgrounds.

While a number of risk factors were reported to be assessed by the SCPHNs and located in the documentation, "extended family" was often referred to as a source of additional support for the mother rather than a risk factor. This view of health professionals is also reflected in the literature (Jones & Dougherty, 1982; Oates et al., 2004; Stern & Kruckman, 1983; Thompson, 1997). Living within extended families may appear supportive, but can also create a number of difficulties, such as increased levels of conflict with family members, and high demands placed on women

to fulfill a “tripartite role” of mother, wife, and daughter-in-law (Oates et al., 2004; Sonuga-Barke & Mistry, 2000). Research exploring relationships between family structure and mental health of South Asians in the United Kingdom highlight the increased levels of anxiety and depression felt by mothers living within extended families, compared with mothers living within nuclear families (Cooper et al., 2006; Oates et al., 2004; Shah & Sonuga-Barke, 1995; Sonuga-Barke & Mistry, 2000). Some SCPHNs showed an awareness of the difficulties South Asian mothers may experience within extended families and discussed relationship difficulties between South Asian women and their mother-in-laws, which often plays a major part in the mother’s mental well-being. The mother-in-law being over-intrusive, controlling and overbearing has been strongly related to maternal depression and anxiety (Chase-Lansdale et al., 1994; Oates et al., 2004; Sonuga-Barke et al., 1998; Unger & Cooley, 1992).

Less than half the participants commented on “extended families” and “relationship difficulties with mother-in-laws” as factors for consideration during their assessments; this was also reflected in the records audit, where less than 50% of the records for South Asian women highlighted those factors. Two possible explanations may account for this. First, not all SCPHNs were assessing those risk factors, hence the low rate of documentation in the records for South Asian mothers. Secondly, SCPHNs were considering the risk factors in all their assessments but only documenting them when there was risk present. Either way, in the absence of any documented risk factors, it is difficult to ascertain whether they were actually ever assessed.

When comparing the documentation around “support from partner” between the two groups of records (South Asian and non-South Asian mothers), this was significantly higher in the South Asian group. This may simply be a result of more South Asian mothers being married and therefore more likely to be with a partner. During the interviews SCPHNs identified “lack of support” for the mother to be one of the main risk factors for psychological morbidity. Documentation around “lack of support” was also higher for South Asian women compared with the non-South Asian group. This is an interesting finding as this group was also documented as having more support from their partners and the extended families. This contradictory finding may suggest that

although South Asian women have support from their partners and family, they still feel isolated. An explanation for this finding could centre around maintaining “family honor” and a fear of being stigmatized by the Asian community, well documented factors to be associated with mental stress and depression, which often result in self-harm in Asian women (Bhardwaj, 2001; Bhugra, 2004; Chew-Graham et al., 2002; Hicks & Bhugra, 2003; NAWP, 1998; Virdee, 2001).

It has been suggested that through the close-knit, interrelated nature of their communities, South Asian women often “suffer in silence” due to lacking confiding relationships, fear of gossip and lack of confidentiality (Chew-Graham et al., 2002; NAWP 1998; Oates et al., 2004). This could explain the higher levels of stress experienced by South Asian mothers. The increased rate of “lack of support” found in this group may also be that the SCPHNs were specifically looking for this factor in South Asian mothers through their own awareness of the difficulties associated with extended families.

The controlling nature of the family towards their daughter or daughter-in-law was perceived by some SCPHNs to have a negative impact on the woman’s mental health. Restrictive customs and over-controlling parents have been documented as common features affecting South Asian women who have attempted suicide and self-harm (Bhardwaj, 2001; Bhugra, Baldwin, Desai, & Jacob, 1999; Kingsbury, 1994; Merrill & Owens, 1986; NAWP, 1998). Interestingly, this factor was not documented in any of the records audited for both groups of women (South Asian and non-South Asian). Apart from this factor simply not being considered by SCPHNs, another reason for the absence of any documentation could be due to the difficulty associated with the assessment of this particular risk. Lack of privacy from family members was emphasized by the health visitors to be obstructive to the assessment of South Asian mothers. This was also highlighted in the study by Thompson (1997). Lack of privacy can prevent SCPHNs from asking questions about the mother’s relationship with other members of the family. Another explanation could be the SCPHNs’ inability to build effective relationships with mothers, owing to the shortage of staff, which can prevent mothers from disclosing such information to the health professionals (Peckover, 2003).

The topic of arranged marriages in South Asian women was mentioned in the interviews. Although

arranged marriages are reported to increase stress (Hicks & Bhugra, 2003; Khan & Reza, 1998), and forced marriages documented to increase risk of self-harm and suicide in South Asian women, the SCPHNs did not discuss forced marriages, possibly due to health professionals' lack of awareness, or their fear of causing offence by making generalizations about the South Asian community. Previous research suggests this "fear" can often result in incomplete and inaccurate assessments being made (Hussain & Cochrane, 2004). Questions normally put to Caucasian clients as a matter of routine may be avoided for fear of stereotyping mothers from a particular culture which the SCPHNs may know very little about. However, the records audit revealed that "type of marriage" (arranged/forced) was not documented in any of the records for both groups of women, suggesting that this factor was not considered by SCPHNs when assessing mothers' psychological well-being.

The significant difference noted in the documentation surrounding "marital status" for South Asian women (more of whom were recorded as "Married") and non-South Asian women, could reflect that, traditionally, Asian women are more likely to be married before having children (NAWP, 1998), and therefore married at the point of contact with the SCPHN. It is difficult to be precise about the marital status of the remaining mothers, as entries were only made for married women. Married South Asian women are reported to have higher rates of depression, suicide and self-harm compared with unmarried South Asian women (Adityanjee, 1986; Bhugra & Hicks, 2004, as cited in Bhugra, 2004; Fazil & Cochrane, 1998, as cited in Hussain & Cochrane, 2004; Khan & Reza, 1998). Although this information may not be collected knowingly by SCPHNs, consideration of marital status during assessments could lead to a better understanding of the client's situation, enabling practitioners to provide more effective care. The higher rate of documentation addressing "support from partner" in the South Asian group (compared with the control group) could again be a result of more South Asian mothers being married and therefore more likely to be with a partner.

In the literature, interracial relationships have been reported to increase stress and play an important role in precipitating suicide attempts (Bhugra, Baldwin, Desai, & Jacob, 1999; Mahy, 1993). Although one SCPHN mentioned this as a factor they consider during their assessments of new mothers, the audit

tool failed to collect information on this factor due to it not being included in the checklist. Domestic violence however was raised by some SCPHNs as a risk factor for depression, self-harm and suicide in South Asian mothers but documentation on this factor was very low for both groups (South Asian and non-South Asians). It is well documented that domestic violence is under-reported by women, and it may be particularly significant in the Asian community due to societal pressures and the inferior status traditionally given to women in South Asian communities (Gill, 2004; Heise, 1994; NAWP, 1998). The low rates documented in both groups reflect the complex nature of assessing this factor, again highlighting the importance of having adequate time for client/professional relationship-building, where women are more likely to disclose such information to health visitors (Peckover, 2003).

A small number of records audited contained documentation on "history of self-harm or suicide" for both the South Asian and non-South Asian group, suggesting that although SCPHNs did not mention this in the interview, they still considered this factor and sometimes documented it. Similarly, racism was found to be documented in some records, suggesting either a low incidence of racism (which is possible in light of the multicultural nature of the area), or simply that this factor was not being considered by SCPHNs during the "new birth visit." The presence of some documentation of this factor suggests that it is likely that racism is not raised as an important issue during postnatal assessment of mothers.

Obstacles identified by SCPHNs in assessing South Asian mothers were emerging themes that resonate with the findings of other studies; in particular, lack of knowledge by frontline professionals, and language barriers, are regularly highlighted in studies of health professionals' dealings with South Asian communities (Bhardwaj, 2001; Chantler et al., 2001; Hawthorne, Rahman, & Pill, 2003; Rack, 1982; Thompson, 1997). Participants in this study felt unable to undertake effective assessments of South Asian mothers due to lack of understanding of South Asian culture, affecting the care provided. Lack of privacy from family members has been highlighted in previous studies (Thompson, 1997), preventing health professionals from asking questions about the mother's relationship with other family members. This, along with lack of time can also act as a barrier to SCPHNs building effective relationships with mothers.

There is some conflicting evidence as to whether Asian women are more likely to seek help from professionals from the same ethnic background or from their own communities (Chantler et al., 2001; Chew-Graham et al., 2002; Hussain & Cochrane, 2002, 2003; NAWP, 1998; Thompson, 1997). However, where services are more ethnically sensitive and tailored to meet the needs of particular ethnic groups, there are higher rates of service uptake and compliance (Hussain & Cochrane, 2004; Rack, 1982; Webb-Johnson & Nadirshaw, 1993). In this study only one SCPHN claimed to provide South Asian mothers with culture specific information about services. This suggests a need for improvement in the type of information given to women during "new birth" visits.

### **Limitations**

The 30% response rate may have been a result of the increased staff shortage within the trust during sample recruitment (the SCPHN service being depleted by a third of its workforce). Although the sample size may appear relatively small, the data obtained from the eight interviews are in-depth and rich in nature, with several reoccurring themes, which are likely to hold a broad relevance for all SCPHNs.

Using a two-method approach aimed to increase the validity of this study, but it is acknowledged that both methods have some limitations. Both involved collecting data from self-reported sources (interviews and SCPHNs' records), and the information gathered does not necessarily reflect the exact assessment made by SCPHNs. The use of an observational method may have complemented the existing findings, but it was not feasible for this study due to the time and resource limitations. The audited records did not necessarily belong to the sample of SCPHNs interviewed; and so restricted direct comparison of data from the two sources to some extent.

While having one researcher collecting data adds reliability to the information obtained, it is acknowledged that it may also limit the validity of the data. The audit tool used failed to collect any information on "interracial relationships," a factor which has frequently been cited to increase the risk of mental distress in South Asian women (Bhugra, Baldwin, Desai, & Jacob, 1999; Mahy, 1993). This factor was overlooked in the checklist during the development process, and this omission was not detected during the pilot stages due to it not being mentioned in any of the records. However, if there had been any documenta-

tion of this factor in the SCPHNs' records, the audit checklist would have been revised to include it. The lack of documentation of this factor suggests that its omission from the audit tool would not have had any impact on the results, other than to imply that SCPHNs do not document this risk factor.

### **Conclusions**

Although the SCPHNs were aware of some culture specific issues, a recommendation would be for SCPHNs to have a better understanding of the culture specific needs and risk factors of the South Asian population that they work with, in order to carry out more effective assessments. This could be done by setting up special interest groups within the PCT that explore ways of increasing staff awareness of specific cultural issues and needs.

To provide effective client centred care it is also essential to raise awareness of the increased risk of depression, self-harm and suicide in South Asian communities for all professionals working with them. One neighbouring PCT offers staff training specifically for depression, suicide and self-harm in South Asian women, which has proven to be very successful (NAWP, 2004). Such initiatives within this PCT might be extremely beneficial.

As literature suggests South Asian women are more likely to access culture specific services, another recommendation would be for this PCT to develop local resource packs for each base containing information for culture-specific services. This could ensure consistency in the information provided to mothers by SCPHNs.

The findings around documentation of risk factors highlight the importance of fully documenting all factors considered and assessed during any assessment. There is also a clear need for this PCT to have clinical guidelines and care pathways for the assessment and management of mental wellbeing in postnatal mothers, in order to provide consistent standards of care.

Additional findings from this study suggest that the use of advocates/interpreters and adequate time allocation for postnatal contacts might enable SCPHNs to carry out more effective assessments and subsequently provide more effective care to South Asian women in the postnatal period.

Replication of this study in other settings would provide a better understanding of assessments carried out by SCPHNs. A study that incorporates interviews

with SCHPNs about their assessments and an audit of their records would also be useful in making direct comparisons between “what SCHPNs say they do” and “what they actually document.” In addition to this, an observational study would provide further insight into the assessment process of SCPHNs.

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