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Mental health context for minoritised ethnic individuals

Summary

Perinatal birthing minoritised ethnic women and people are known to suffer from poorer outcomes and are particularly disadvantaged when it comes to mental health (MH) care in the United Kingdom. This brings about the question of identifying contextual factors that contribute towards this and how they play an important role when delivering interventions. Context not only reveals the reasons behind the health inequalities that birthing minoritised ethnic women and people face directly, but also plays an essential role in shaping the experiences and needs of birthing women and people to achieve positive MH outcomes.

Why minoritised ethnic birthing people in particular?

One of the leading causes of maternal death antenatally and in the first year postpartum is mental ill health; between 10-20% of birthing women and people suffer from perinatal MH problems.[1] Research has highlighted that antenatal depression is recognised as a risk factor for Asian and African ethnicities; birthing women and people of Black and minoritised ethnic background scored highly on the Edinburgh Postnatal Depression Scale (>13) and are less likely to be asked about their MH.[2,3] With the MBRRACE-UK report finding that the risk of maternal mortality in 2018-2020 was over three and a half times higher among Black and minoritised ethnic birthing women and people as compared to White birthing women and people, bringing attention to MH is critical to decrease this statistic.[1]

Social & Cultural Context

The UK has a long history of colonialism which has shaped its social and cultural norms. As a result, minoritised ethnic birthing women and people experience barriers to healthcare and are more likely to face racial and gender-based discrimination. Minoritised ethnic communities receive inadequate MH provision as services fail to engage with communities, potentially due to prejudice amongst professionals from their preconceived notions about those experiencing poorer social determinants of health.[4] Alongside this, cultural factors also play a role in the way minoritised ethnic birthing women and people present to professionals. Black Caribbean birthing

women and people were identified as finding disclosing MH to HCPs 'culturally taboo' and believed emotional problems should not be discussed outside of the family.[5]

Birthing women and people from different cultures may describe somatic rather than psychological symptoms- Bangladeshi women described 'aching and trembling in their hearts' which could indicate depressive symptoms.[6] Additionally, it is identified that whilst Americans experienced feelings of depressed mood first and feelings of guilt and restlessness once depression worsens, Koreans experienced the opposite.[7] This suggests that birthing women and people from different cultures exhibit varying depressive symptoms, thus we need to move away from a Eurocentric mindset to identify and treat birthing women and people who may present 'differently'.

The lower socioeconomic status (SES) among ethnic minorities presents obstacles to accessing MH services, with birthing women and people facing financial hardship finding it difficult to access alternative forms of treatment such as social media, yoga/meditation classes and private mother and baby groups.[8] The Office of National Statistics found that children in Pakistani and Bangladeshi households were 2.8 and 2.4 times as likely respectively to live in a low-income household compared with children of White British background; Pakistan and Bangladesh are both in the top 5 most common country of birth to non-UK born birthing women and people.[9,10] Therefore, professionals should consider the link between ethnicity and lower SES; accessibility of the proposed intervention should always be taken into consideration.

Economic & Structural Context

In 2018, NHS England received £23 million in funding for 30,000 additional birthing women and people to receive specialist MH care in early pregnancy to ensure MH is integrated at the earliest possible stage.[11] Despite the additional £4.2 million towards MH charities to continue support of MH services throughout the COVID-19 pandemic, withdrawal of face-to-face services and deployment of HCPs to other areas resulted in concerns that needs of many mothers and children may be missed.[12] Cost pressures require innovative measures; the promotion of digital health such as video-based consultations are encouraged to replace unnecessary face-to-face appointments.[13] Since the COVID-19 has greatly accelerated digital health, support strategies need to be in place to support people to gain access to digital health services and provide alternatives that are just as effective.[14]

The UK workforce has a chronic shortage of midwives, with ongoing concerns regarding staff retention- service capacity issues were identified as a reason connected to over a fifth of perinatal deaths.[15] Additionally, midwife burnout is increasingly prevalent, 67% of midwives reported moderate to high levels of work-

related burnout.[15] Staff shortages make continuity of care difficult, making it harder for birthing women and people to build up rapport with their midwife and discuss their MH.[16] This further makes the NHS Long Term Plan aim for 75% of birthing women and people from Black and minoritised ethnic backgrounds to receive Continuity of Care more unachievable. [17] A resource gap is also present, with the NHS not delivering on its mandate to reduce perinatal mental illness, with 23% of maternity professionals receiving no education on maternal MH.[16] Therefore, a suggestion is further work on career development to enhance both education levels and job satisfaction.

What interventions can be provided?

A meta-analysis found that primary care interventions such as Cognitive Behavioural Therapy were found to be effective for reducing symptoms of postnatal depression and shown to be equally effective as antidepressant medication.[18] Interpersonal Psychotherapy (IPT) was also found to be effective; IPT during pregnancy and in the postpartum period was found to lead to overall clinical improvement.[18] Minoritised ethnic groups have a low level of antidepressant use; this may indicate their inclination towards non-pharmacological treatments.[19] In future research, investigating the reasons for low rates of antidepressant use among minoritised ethnic groups can help identify their specific needs.

Development of specialist perinatal MH midwives have shown to be vital in providing more individualised care.[17] They also support maternity colleagues by promoting education and training, quality improvement and providing advice to ensure optimal personalised care to birthing women and people and their families.[16] In a study, less than half of midwives screened were aware of the MH services provided by psychiatric nurses and psychologists; this impeded referral pathways due to poor awareness of other professionals' roles and the insufficient time for appointments.[20] A suggestion is multidisciplinary training between maternity and psychological services; a counselling training programme significantly improved midwives' knowledge and confidence to counsel birthing women and people on MH. [21]

Conclusion

As highlighted by the MBRRACE-UK report, minoritised ethnic birthing women and people are at a disadvantage when it comes to MH outcomes in the UK.[1] Minoritised ethnic birthing women and people are found to experience poorer outcomes due to factors such as lower SES and lack of cultural competency in healthcare. This is further exacerbated by structural inequalities in the economic and healthcare system. A comprehensive approach that addresses contextual factors is vital to ensure that minoritised ethnic birthing women and people receive the appropriate quality of care they deserve under a healthcare system that is committed to promote equity.

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