Letter to the Editor

RESPONSE TO "FLYING UNDER THE RADAR: ENGAGEMENT AND RETENTION OF DEPRESSED LOW-INCOME MOTHERS IN A MENTAL HEALTH INTERVENTION"

I read with interest the article by Beeber et al[1] about identifying the barriers and strategies that are used to engage and retain mothers in mental health interventions. As a pediatric emergency nurse, I am obligated to recognize parental issues that may affect a child's well-being. Unfortunately, the in-home intervention used in this study proved to be an ineffective therapy method. The authors identified the most difficult barrier as "the crushing lack of resources that placed the mother's mental healthcare behind more pressing essential family needs." "We could not get the mother to see the work as essential to her health and well-being." The women receiving the in-home intervention experienced numerous distractions and anxiety-enhancing situations and encounters.

Depression is the primary mental illness diagnosed in America, with an estimated 25% of all women experiencing at least 1 event. Even though research supports a biological basis for mental illness, including depression, there is still a significant public stigma.[2] I agree with McCrae[3] in that "Individuals diagnosed with mental illnesses are shunned, less likely to be hired, and less likely to be accepted as neighbors." Home visits may allow the nurse to observe firsthand the "contextual factors" that enrich our understanding of patients' situations. Yet Beeber et al[1] concluded that the lack of privacy and the constant presence of children, significant others, relatives, and neighbors cause interruptions in the nurse-client therapy, thus making it difficult to establish a working relationship. Furthermore, the exposed client may no longer escape the "radars" of her family and neighbors.

The Office of Disease Prevention and Health Promotion[4] identifies 10 risk factors for depression, 1 of which is sexual/physical abuse. The presence of the abuser in the home prevents the client from freely discussing her concerns due to fear of physical or emotional retaliation by the source. Also, from experience, a threatening environment can prove anxiety provoking to the nurse, causing a reduction in therapeutic interventions.

For depression to become less stigmatized in society, changes in the perceptions of the general public must occur. Raingruber[5] states an excellent point: "To help reduce stigma, widespread use of public service/education ads" should be "designed to emphasize the treatable nature of depression and normalize it." I agree that it is necessary to modify the healthcare providers' attitudes toward depression. The *Program of Assertive Community Treatment* (*PACT*), in existence since the late 1960s, seems to be a very successful program.

PACT is a service-delivery model that provides comprehensive, locally based treatment to people with serious and persistent mental illnesses. Unlike other community-based programs, PACT is not a linkage or brokerage case-management program that connects individuals to mental health, housing, or rehabilitation agencies or services. PACT recipients receive the multidisciplinary, round-the-clock staffing of a psychiatric unit—within the comfort of their own home and community. To have the competencies and skills to meet a client's multiple treatment, rehabilitation, and support needs, PACT team members are trained in the areas of psychiatry, social work, nursing, substance abuse, and vocational rehabilitation. The PACT team provides these necessary services 24 hours a day, 7 days a week, 365 days a year.[6]

Despite the documented success of PACT, sadly it is only available statewide in 7 states, the District of Columbia, and a few other individual areas.

I believe the results of this study will be valuable in discovering new ways to help determine the optimal mental health program modalities to engage and retain low-income mothers with depression in treatment programs.

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