The IHV welcomes the 2014 update of the original NICE guidance for managing antenatal and postnatal mental health and the contribution it will make to improved early recognition and management of perinatal mental illness.

We are issuing this guidance to help our perinatal mental health (PMH) champions and health visitors in general interpret the guidance in relation to health visiting (HV) practice as on first reading some aspects seem to suggest that the intervention services they have been trained to deliver are no-longer being supported by NICE whilst their method of case finding and holistic assessment is supported.

It is important primarily to remind health visitors that - in the words of NICE: “Guidelines are not a substitute for professional knowledge and clinical judgement. They can be limited in their usefulness and applicability by a number of different factors: the availability of high-quality research evidence, the quality of the methodology used in the development of the guideline, the generalisability of research findings and the uniqueness of individuals.”

Hence this new guidance, as with all NICE guidance should be considered in the context of its limitations as well as its very many benefits for improving care. In relation to health visiting practice this NICE guidance is inhibited by: –

- the availability of high-quality research evidence e.g. for the role of health visiting and specifically the use of listening visits which are not well defined or researched
- the generalisability of the available research findings
- the uniqueness of individuals (and uniqueness of each family and system)

The impact of Call to Action (DH, 2011) combined with the number of PMH Champions and HVs who have received perinatal mental health training using the iHV training is leading to HVs being more confident and effective in detecting perinatal mental illness, managing mild to moderate perinatal mental illness, assessing for risk and referring families appropriately for additional support in a timely manner. The content of the assessment and initial care for families with perinatal mental health is provided through the universal contacts that HVs have with every family. The mental health of the mother, her attachment to her baby and any risk factors to the emotional wellbeing of the family should be considered at every contact. Through skilled assessment and offering timely and quality interventions at the earliest possible moment, health visitors should be key to achieving good outcomes in perinatal mental health.

We are particularly pleased that NICE has now endorsed use of the EPDS as a tool to support care finding but would challenge their view that it does not require training for successful delivery. The iHV would not recommend that health visitors use it, unless for research purposes, without training in how to use it most effectively, as there is a literature on its misuse.

We are also delighted that NICE has expressly focused on the need to support the mother – baby relationship, something that health visitors are best placed to do but they require more capacity to do this well. Currently the iHV is rolling out training for all health visitors to strengthen their contribution to this important area for future wellbeing.

Many health visitors have additional training in the interventions that are recommended by NICE in the guidance which have a good evidence base, for example Cognitive Behavioural Therapy (CBT) based approaches. These interventions are delivered under the umbrella term of “listening visits”

The PMH Champions training was cascaded during the development of this guidance and the early indications are that the content of the ’listening visit’ is consistent with the recommended evidence base and messages in the guidance. However it is disappointing that there is little made of the enormous role that health visitors specifically have in this respect, although the contribution of primary care to providing low intensity interventions is included. There is a specific evidence base demonstrating that health visitors can both prevent and successfully manage mild to moderate postnatal depression. It is essential that they continue to be commissioned to deliver this role to prevent any further deterioration in the mother’s mental wellbeing before any other treatment becomes available, often several weeks, indeed currently their interventions frequently prevent the need for further referral. The iHV will be undertaking research to clarify what most health visitors include in a listening visit in 2014, it may be the term ‘listening visit’ needs to be reviewed in light of the Guidance to encompass facilitated self help in its widest sense.

In using guidelines, it is important to remember that the absence of empirical evidence for the effectiveness of a particular intervention is not the same as evidence for ineffectiveness (i.e. listening visits and the role of health visiting as opposed to facilitated self-help - a validated methodology for depression in general). Indeed how would mothers know about the range of options for self-help available to them if not guided by the health visitor who is normally the first professional to identify postnatal depression? Health visiting and non-directive counselling (listening visits) provides the mother with the opportunity to explore possible reasons for her illness, the current pressures on her and the support systems available to her and, for the health visitor to either intervene herself or to direct the mother towards local opportunities for
self help which will vary up and down the country, or to the GP for specific treatment or referral on. It is important to also remember that the universal services delivered by health visitors do not exclude any sections of society in offering their assessments and interventions.

In addition, and of particular relevance in mental health and health visiting, any health visiting interventions should be delivered within the context of the whole family. One of the great strengths of health visiting is it looks beyond the individual. Indeed, the importance of also organising care in order to support and encourage a good therapeutic relationship with the family is at times as important as the specific treatments offered, as health visitors know. Furthermore their unique relationships with the family over a number of years allows them to enhance the potential quality of outcomes for the woman, her partner, her infant and any other children by working with the whole family. A individual health visitor’s relationship with any family with more than one child may be 8-10 years in length.

When it has been possible to develop this unique therapeutic relationship from pregnancy mothers feel more able to approach their health visitor to access appropriate support and guidance in times of need.

Non-directive counselling (or listening visits) – a definition

The fact that ‘listening visits’ have not been included in this guidance may in part be due to a lack of clear definition of what they should contain, although they were developed based on the work of Carl Rogers. The iHV today sees the ‘listening visit’ as an opportunity which encompasses a number of elements of support for the mother which may be delivered through a therapeutic relationship between the mother and the health visitor using a suite of low intensity interventions including, not only listening or non-directive counselling but also solution focused, CBT, sleep hygiene, one to one relationship work, mindfulness, promotional & motivational interviewing, strengths based approach, and supporting attachment and through directing the mother to other services or self-help. The strength of the added value of the ‘listening visit’/contact is that it is used as an opportunity to explore the wider aspects of the mother’s illness so that a more holistic, rather than purely individual approach, can be taken to her recovery which embraces the health status/needs of the whole family and helps to manage pressure points unhelpful to their health and her illness. We are delighted that NICE endorses the value of this fuller assessment.

This guideline does not, override the individual responsibility of healthcare professionals to make appropriate decisions, in consultation with the women and, if she agrees, her partner, family or carer. It just states what available robust evidence is saying. We are disappointed that the trials which have always supported health visiting interventions with non-directive counselling or listening visits were not considered large or robust enough for inclusion, but would like to warn strongly against this being interpreted by commissioners and health visitors that the range of interventions in the health visitors ‘tool kit’ are not effective, when we know they are. Indeed if NICE had specifically looked at the research base for health visitor intervention they would have found research endorsement for this. The case for investment in research for the most effective health visiting interventions is urgent as this guidance has once again proved.

The optimisation of psychological wellbeing, as promoted by the health visiting service as opposed to the management of mental health problems, is not covered in this guideline, however, the importance of this is implicit. It is regrettable that it is not more explicit as it is out of step with the policy environment in this respect.

The mental health needs of fathers, partners, other carers and children, whose health and functioning will inevitably be affected by mental health problems in women, are important and must not be neglected. Their needs have been considered in developing the recommendations in this guideline. In relevant places, the phrase ‘partner, family or carer’ has been used to remind readers of the continued importance of thinking about mental health problems and their impact on the family and any possible safeguarding issues.

Recommendations

1. Health visitors take careful note of the recommendations in the guidance and use them to enhance their services where relevant, but do not read them as a reason for discontinuing those parts of the services they deliver which have not had specific endorsement such as listening visits as these are reflected in the range of possible facilitated self help.

2. Health visitors use this guidance to articulate to commissioners the importance of the highly developed case finding and intervention processes they use to support the mental health of the mother and her family.

3. Health visitors are commissioned in sufficient numbers not only to support the mental health of the mother but that of her developing infant and the whole family.

4. Commissioners should note that the health visiting service has been using low intensity interventions and facilitated self-help as an integral part of the ‘listening visit’ for many years. The Guidance supports this aspect of the service whilst not specifically focusing on the HV role.

5. Health visiting service providers may wish/want to rename listening visit contacts to reflect the full content of the therapeutic relationship between the mother and the health visitor at this key time including facilitated self-help.

6. Health visitors build more audit and evaluation into their work, especially in relation to case finding and listening visits, this will be essential to make the case for future commissioning for this critical area of their public health practice.