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Exploring the Role of Health Visitors in Supporting Mothers with Mental Health Problems.

Catherine Lowenhoff
Catherine.lowenhoff-2015@brookes.ac.uk
PhD student.
Oxford Brookes University
Oxford Institute of Nursing, Midwifery and Allied Health Research
European Academy of Nursing Science.

Thanks to:
Supervisory Board : Professor Jane Appleton,
Dr Nick Pike, Dr Jan Davison-Fischer
Institute of Health Visiting

CONTENT

- 7TH April World Health Day
- Depression is the leading cause of ill health and disability worldwide.
- More than 300 million people are now living with depression, an increase of more than 18% between 2005 and 2015.
- Goal of the campaign is that more people with depression, everywhere in the world, both seek and get help.

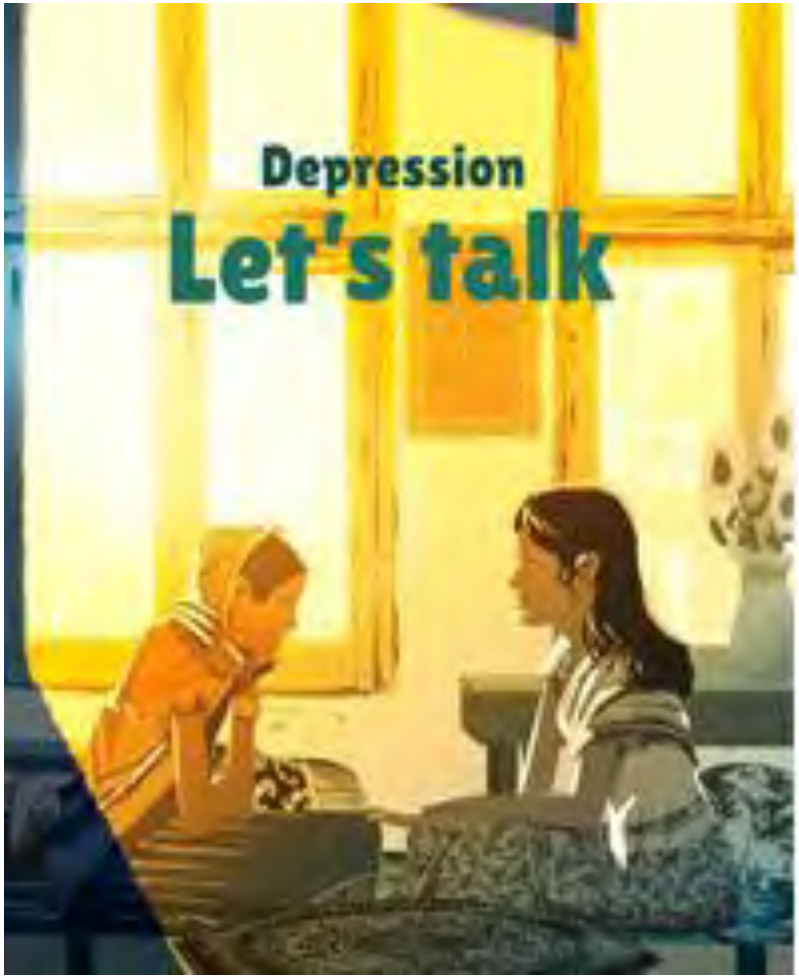
Focus on three groups that are disproportionally affected:

adolescents and young adults,

women of childbearing age (particularly following childbirth)

older adults (over 60s).

Talking with people you trust can be a first step towards recovery from depression.



BACKGROUND :
SIZE OF THE PROBLEM

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Perinatal mental ill-health is a major public health issue

- Affects up to 30% of woman during pregnancy or the year after birth (Gavin et al 2015)
- 50% of women with PMI's are not identified (Gavin et al 2015)
- Of the 50% who are identified, only 50% receive sufficient support to lead to recovery (Gavin et al 2015)
- Untreated PMI can result in adverse consequences for the mother, the partner, the child (Gavin et al 2015)
- The cost of not treating PMI far outweighs the cost of treating PMI (Bauer et al 2014)
- 72% of the additional cost is the cost of dealing with the adverse impact of PMI on the developing child - repercussions that can last a lifetime and may also impact on the next generation.(Bauer et al 2014)

BACKGROUND : IDENTIFICATION AND TREATMENT

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Women have increased contact with a range of health professionals during pregnancy and the year after delivery

- GP's, Midwives, Obstetricians, Health Visitors
- There are increased opportunities for assessment of mental health status, vulnerability and risk (NICE 2014)
- Most commonly occurring perinatal mental health problems are depression and anxiety (Gavin et al 2015)
- 90% of depression and anxiety can be treated in primary care (NICE 2014)

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BACKGROUND :
ROLE OF THE HEALTH VISITOR

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Health visitors are all qualified nurses or midwives

- promote the health and well-being of mothers and their families during pregnancy and the first five years of the child's life.
- 4,5,6 model of health visiting
  - 4 Levels : universal, universal plus, universal partnership plus, community
  - 5 Mandated contacts (National Healthy Child Programme – antenatal, new birth, **6 weeks**, 1yr, 2yrs)
  - 6 High impact areas – acknowledged as areas where health visitors can make a significant difference to families
  - transition to parenthood, maternal mental health, breastfeeding, healthy weight/healthy nutrition, managing minor illnesses and reducing hospital admissions, health, well-being and development of the child aged 2.

(DoH et al 2014)

BACKGROUND :
UPDATED NICE GUIDELINE (1)

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Updated NICE guideline for antenatal and postnatal mental health (December 2014)

- 'Listening Visits' (intervention delivered by health visitors) no longer recommended as an evidence-based intervention for mothers with mild to moderate depression (was recommended in NICE 2007 version of the guideline)

- No longer specification to assess maternal mental health at 3-4 months (change from NICE guideline 2007, HCP 2009, national HV core service specification 2015/16)

BACKGROUND :
UPDATED NICE GUIDELINE (2)

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- Additional recommendations relevant to the role of the health visitor.
  - All healthcare professionals providing assessment and interventions for mental health problems in pregnancy and the postnatal period should
    - understand the variations in their presentation and course at these times, how these variations affect treatment, and the context in which they are assessed and treated (for example, maternity services, health visiting and mental health services). **[new 2014]**
    - Recognise that some women with a mental health problem may experience difficulties with the mother–baby relationship.
    - Assess the nature of this relationship, including verbal interaction, emotional sensitivity and physical care, at all postnatal contacts.
    - Discuss any concerns that the woman has about her relationship with her baby and provide information and treatment for the mental health problem. [new 2014]
    - Consider further interventions to improve the mother–baby relationship if any problems in the relationship have not resolved. [new 2014]

MIXED MESSAGES :
MANAGING UNCERTAINTY, COPING WITH COMPLEXITY

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Promoting role of health visitors in supporting mothers with PMI

- HV Implementation Plan 2011 - No. of HV's ↑by 50% between 2011-2015 in order to take on more extended roles
- Maternal mental health - one of the 6 high impact areas in which HV's acknowledged as having a key role
- HV's recognised expertise in supporting mother-infant relationships
- Policy focus on prevention, early intervention and mental health
- National campaign – maternal mental health – everyone's business
- DoH funding IHV to establish nationwide perinatal and infant mental health champions network and train HV's in perinatal mental health

Undermining role of health visitors in supporting mothers with PMI

- Exclusion of Listening Visits from NICE guideline 2014 (although they are still recommended in NICE guideline for Common Mental Health Problems 2011 and CKS for antenatal and postnatal mental health 2014)
- Transfer of commissioning of health visiting from the NHS to Public Health Departments of Local Authorities (Oct 2015)
- Radical cuts in public health budgets
- Focus on mandated contacts
- Decrease in number of health visitors / cuts in training budgets
- 25% of HV workforce qualified in the last 5 years – need for additional training, support and supervision

THIS PART OF MY RESEARCH (PHASE 1)

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AIMS

A. To explore the current attitudes, beliefs and practice of health visitors with regard to how they understand, organise and deliver the support they provide to mothers with mental health problems.

B. To identify the contextual factors that influence their practice.

C. To list the core components that health visitors think should form the basis of a health visitor-led intervention.

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METHOD

- Sought permission from Institute of Health Visiting to distribute survey to members
- Granted ethics committee approval (Oxford Brookes University)
- Electronic survey (QUALTRICS) offered to all members of the Institute of Health Visiting (n=9474) (No. of FTE HV's in England in March 2016 approx 11,095)
- Survey available for completion March – May 2016.
- 41 questions
  - Influenced by the 12 domains of version 1 of The Theoretical Domains Framework (Mosavianpour et al 2016, Michie et al 2005)
  - 6 covering demographic details
  - 9 open-ended questions
- Analysed using NVIVO 11 software (inductive and deductive thematic analysis)

THEORETICAL DOMAINS FRAMEWORK

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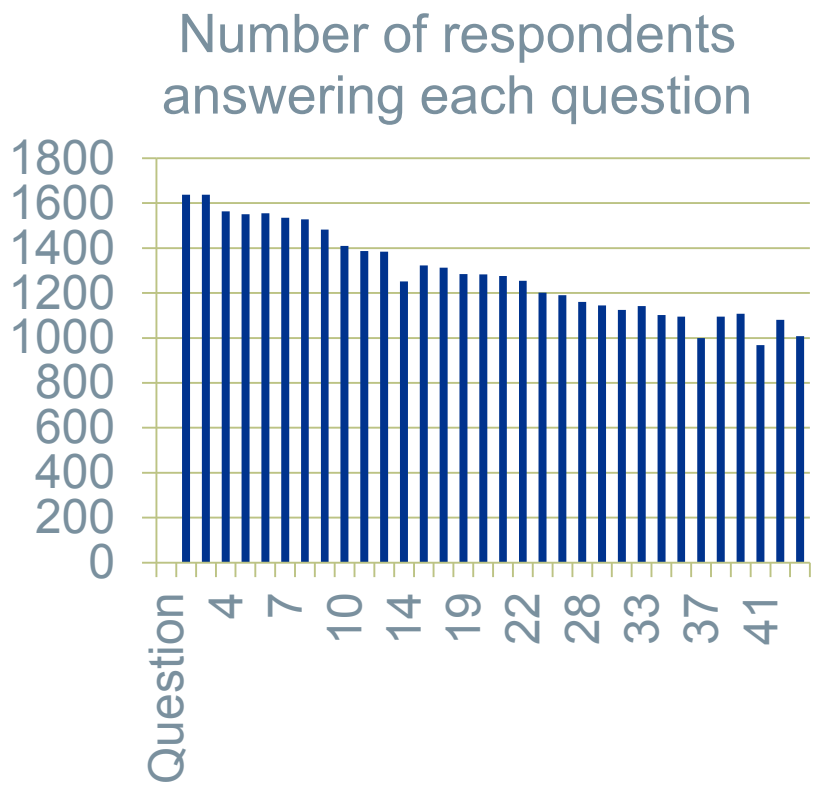
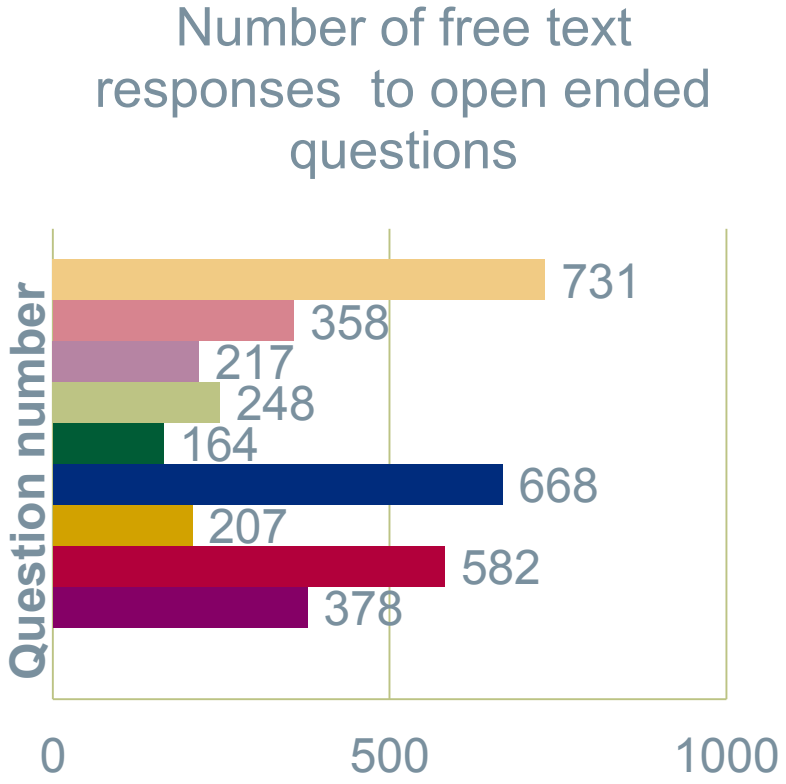
- Developed by Michie et al (2005) to provide a theoretical framework for understanding the determinants of practice particularly in relation to the implementation of evidence-based guidelines
- **Subsequently it has been used in a number of ways to explore and explain health care practice with a view to identifying the barriers and enablers to effective practice and to make recommendations regarding what needs to happen to improve practice and outcomes in the future.**
- A revised version with 14 domains instead of 12 was developed in 2012 (Cane, O'Connor, Michie)
- A recent systematic literature review concluded that the original TDF was a more comprehensive tool for assessing barriers to practice (Mosavianpour et al 2016)
- The original TDF represents a synthesis of 128 explanatory constructs from 33 theories of behaviour
- 12 domains: knowledge; skills; social /professional role and identity; beliefs about capabilities; beliefs about consequence;, motivation and goals; memory, attention and decision processes; environmental context and resources; social influences; emotion; behavioural regulation; nature of the behaviours.

RESULTS :
RESPONSE RATE

No. of HV's who started the survey = 2026
Maximum no. of respondents per question = 1637
Minimum no. of respondents per question = 968
Mean = 1283
(13% of IHV members; 11%FTE HV workforce)



9 open-ended questions: total number of free text responses = 3,563 (170 pages A4)
Issues around training = 582
Perceptions about what other HV's think = 668
What needs to happen next =731



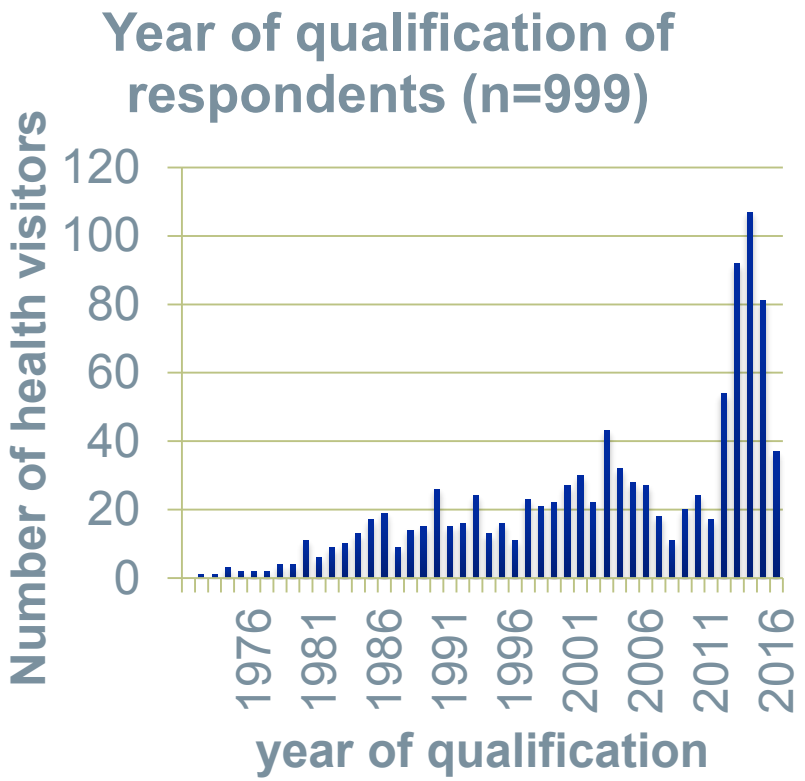
RESULTS :

REPRESENTATIVENESS OF SAMPLE

29% respondents qualified between 2010 and 2015 (compared with 25% of HV workforce)

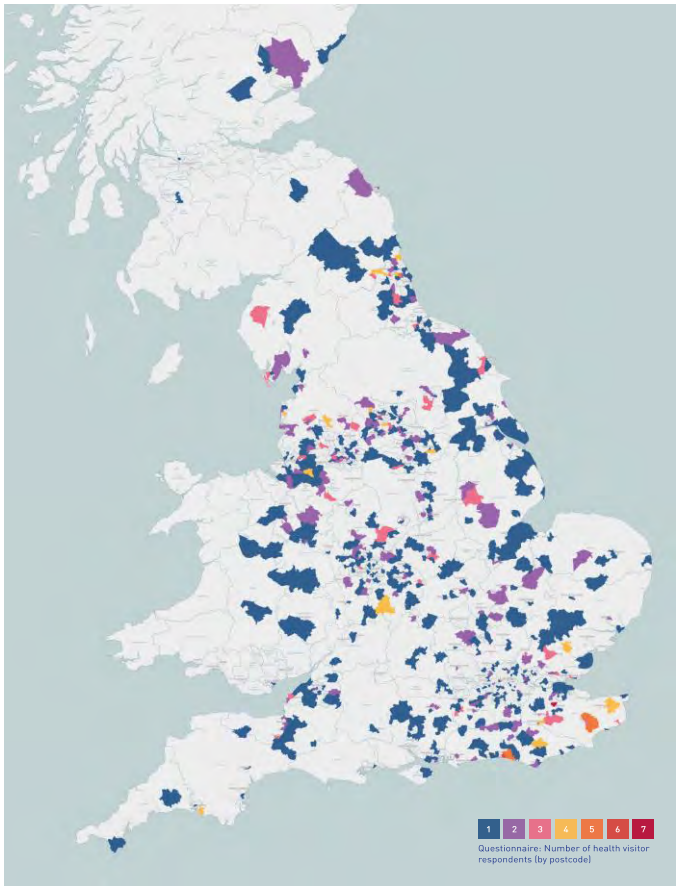
No of years working as a health visitor (n=1108)

Range=0-45, mean=11.48, SD=10.48



Distribution of respondents who entered work postcode (n=968)

Map created with Tableaux software



%	**AIM A : Attitudes, beliefs and practice – understand, organise and deliver Support to mothers with PMHP's** **General perceptions of health visiting practice**
96%	agreed that supporting mothers with mental health problems should be a core component of the work that health visitors do.
89%	thought it was feasible to expect HV's to be able to identify and support mothers with mental health problems
76%	Felt confident that their managers thought that supporting mothers with MHP's should be a core component of HV practice
27%	**Felt confident that their commissioners thought that supporting mothers with MHP's should be a core component of HV practice**
90%	were confident that the majority of the HV's in their organisation were assessing maternal mental health at 6-8/52
30%	**were confident that the majority of the HV's in their organisation were assessing maternal mental health at 3-4/12**
56%	**thought that most of the HV's in their organisation offered LV's as a therapeutic intervention to mothers identified with mild to moderate depression**
79%	Reported that their organisation had a protocol, policy or pathway that specified what actions health visitors should take, and the sort of support that health visitors should provide, to mothers with mental health problems
55%	**Felt that there was agreement within their organisation regarding the structure and duration of the intervention that health visitors offer to women with mental health problems**

AIM A : Attitudes, beliefs and practice – how HV's understand, organise and deliver Support to mothers with PMHP's

Health Visitors' views on Listening Visits

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%	
56%	Received training in LV's
47%	Feel that they have NOT received sufficient training in how to deliver LV's
85%	Currently offer LV's to mothers with MHP's
88%	Believe they have a clear understanding of what is meant by LV's
75%	Believe they have the necessary knowledge and skills to deliver LV's safely and effectively
77%	Feel confident in their ability to deliver LV's
80%	Always offer LV's as an option of support to mothers identified with additional mental health needs
71%	Feel confident that LV's will lead to improved outcomes for the mother
30%	Have enough time to deliver the number of visits they think are necessary
48%	Are able to offer LV's to every woman who the HV thinks needs them
43%	Agree that HV's have had a little bit of training in a lot of different techniques. This makes it difficult to decide which ones to use when supporting mothers with MHP's
68%	Do not think that the term LV's adequately describes the support that they provide to mothers with MHP's
45%	Agree that LV's are a bit of a mystery. There doesn't seem to be any agreement on what they are and how to do them

%	**AIM A : Attitudes, beliefs and practice – how HV's understand, organise and deliversupport to mothers with PMHP's** **Governance**
19%	Felt confident or very confident that all HV's receive regular high quality supervision relating to the support that they offer to mothers with mental health problems
34%	Felt confident or very confident that all HV's use routine outcome measures to assess the impact of any intervention they deliver to address maternal mental health outcomes
76% 52% 22%	System in place for recording the number of women who have MH assessed by HV System in place for recording number of women offered MMH intervention by HV System in place for recording outcome of HV MMH intervention
45%	Felt confident or very confident that HV's involve women in reviewing the efficacy of any intervention they have delivered to address maternal mental health issues
17%	Felt confident or very confident that there were systems in place to monitor and evaluate treatment adherence with regard to HV management of perinatal mental health problems
11%	Felt confident or very confident that systems were in place to monitor health visitor competence with regard to their management of perinatal mental health problems.

%	**AIM A : Attitudes, beliefs and practice – how HV's understand, organise and deliver support to mothers with PMHP's** **Skills and techniques used in the work that health visitors do with mothers with mental health problems.**
95%	Techniques to promote positive mother-infant interactions
85%	Non-directive counseling techniques / person-centred approach
82%	Motivational interviewing
70%	The Solihull Approach
68%	Facilitated / guided self-help
63%	Promotional interviewing
59%	Relaxation techniques
56%	Solution-focused therapies
54%	Mindfulness techniques
48%	Cognitive Behavioural techniques
36%	Family Partnership model

AIM B : TO IDENTIFY THE CONTEXTUAL FACTORS THAT INFLUENCE THEIR PRACTICE.

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Aim C. To list the core components that health visitors think should form the basis of a health visitor-led intervention.

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Potential elements of HV intervention framework agreed by respondents

Developing a supportive, collaborative, therapeutic alliance to facilitate expression and sharing of maternal narrative, thoughts and feelings. Be clear about HV remit. Provide anticipatory info

Providing info about common physiological and psychological changes associated with childbirth as well as info about mental health problems and ways to overcome them

Emphasising the uniqueness of individuals, experiences and relationships, and importance of finding interventions that take into account individual and family needs, values and circumstances

Exploring perceptions of stress, coping and availability of social and emotional support

Discussing the importance of sleep, rest and relaxation and other elements of self-care (NEST-S)

Providing opportunities to talk about relationships including domestic abuse

Observing and supporting mother-infant relationships

Providing an opportunity to discuss thoughts and feelings about infant management and the transition to parenthood

Exploring mothers own experience of being parented

Thinking about the impact of life events on mental health

Considering the possible relationship between alcohol, substance misuse and mental health

Considering the interplay between physical health issues and symptoms of mental illness

Facilitating collaborative problem solving, behavioural activation and cognitive restructuring

Communicating a normalising, recovery-focused message

SURVEY FINDINGS: FREE TEXT RESPONSES FROM HV'S A – Z OF CORE COMPONENTS AND KEY CLINICAL ACTIVITIES (1)

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Component	Tools/Models/techniques	Clinical activities
Assessment	Whooley, GAD2, PHQ9, GAD7, EPDS, HADS, PIOS Psychosocial assessment Family Health Needs Assessment Genograms Promotional Interviewing / Guides Construction of personal narrative	Assessing family relationships and support networks Assessing risk / vulnerability/ current mental state Assessing the mother, the baby and the mother- baby interaction (and for fathers) Identifying preferred futures Monitoring mother and baby's well-being Talking about childhood experience and impact of this on MMH / Identifying root causes in the woman's past in order to suggest individualised care
Advice and support		Providing anticipatory guidance Providing advice and support with regard to parenting, relationships, coping and attachment
Building therapeutic relationship	Family Partnership Model	Adapting style and model used according to the individual client and the difficulties they present with Building trust / confidence Demonstrating empathy / Instilling hope Explaining HV role, knowledge and skills Negotiating amount and frequency of contacts Recognising strengths / assets
Group based approach	Baby massage PND groups / postnatal groups Pram walking groups Postnatal yoga	

SURVEY FINDINGS- FREE TEXT RESPONSES FROM HV'S
A – Z OF CORE COMPONENTS AND KEY CLINICAL ACTIVITIES (2)

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Component	Tools/models/techniques	Clinical activities
Offering Therapeutic intervention	CBT, CBC (CREST), CBA, CFT, MBT 5 Areas Approach / Living Life to the Full Coaching / emotional coaching Counselling / NDC / PCA Family Systems therapy Psychodynamic/ Psychoanalytic/ TA Visualisation techniques MI, Solihull Approach, SFT /SOP guide	Active listening. Listening and acknowledging how a person is feeling. Allowing them to express their feelings in a safe and accepting environment Helping mothers to recognise and balance extreme / negative thoughts Structured problem solving / behavioural activation/ activity scheduling Child Care, reassurance, enjoyable activities, targeted support, behavioural targets
Psycho-education	Boots Well-being plan Postnatal Depression Development Wheel Maternal mood booklets	Raising awareness of emotional challenges new mothers face Providing information about common mental health problems and what to do about them DiscussIng physical and emotional changes related to childbirth to combat against unrealistic expectations and over-ambitious goals 'Normalising' thoughts and feelings Helping to increase parental understanding regarding the developing parent-infant relationship and helping them to understand the impact of their own MH, stress etc. on the child.
Self-Care	Diet Enjoyable activities Exercise Promoting self-efficacy/ self-esteem/ self worth Relaxation techniques Time for self Stress management techniques Support (social ,emotional, practical)	Providing information about diet and Vitamin D Focusing on things mother can influence and increasing circle of control Helping mother to get own needs met Teaching and mentoring in promoting self-esteem (specific tools from moretolife.uk) Nurturing and developing self-supporting opportunities

SURVEY FINDINGS: FREE TEXT RESPONSES FROM HV'S A – Z OF CORE COMPONENTS AND KEY CLINICAL ACTIVITIES (3)

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Component		Clinical activities
Self-Help	Northumberland Self-help booklets	
Supporting transition to parenthood	Family Links Positive Parenting model Parenting programmes / Early parenting groups PEEP	
Supporting and nurturing parent infant relationship	Building a Happy Baby (UNICEF) Circle of Security Dynamic Maturational model Five to Thrive Gro Brain HUGS NBAS / NBO Parent-Child game The Social Baby Video Interaction Guidance / WWW What every parent needs to know	Thinking about infant mental health, bonding and attachment Using reassurance and knowledge about the developing brain to support interactions and reciprocity Strengths-based approach to mother-infant, father-infant intervention Improving maternal reflective function and mentalising ability Use NBO to highlight to mothers (particularly those with mental heath problems) what their babies are capable of and how they respond, and give anticipatory guidance on how to interact with their infants and the importance of doing so in order to build better relationships and to help mothers to feel better about these aspects of their care.
Supporting partners and relationships	Healthy Relationships Tool	Advocating to 'plan a date' with partner
Signposting and Referrals		

CONCLUSIONS

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- Confusion about
  - **Definition of maternal mental health problems** (MHP). Are we all talking about the same thing - anxiety, depression, stress / psychological distress / adjustment difficulties. What about promotion of emotional well-being and prevention of mental ill-health?
  - **Roles and responsibilities of different professionals** and how they do or should work together
  - **When, how often and how the assessment should be done.**.Difference between assessing to identify need, vulnerability and risk,, using identification questions and looking for specific symptoms.
  - **Who should be assessing and managing maternal mental health problems** - presumption that if it is only a matter of asking a few simple questions about assessment or 'listening' then anybody can do it. Has been suggested that this can be delegated to staff nurses, nursery nurses, CC workers. Concerns that without appropriate training 'listening' can do more harm than good. On the other hand suggestion that only HV's with additional mental health qualifications have the necessary knowledge and skills to support mothers with MHP's.
  - **Who the intervention is for.** The mother, the baby, the partner
  - **What the intervention is and what the essential / active ingredients are**. (flexible adaptation or the 'zone of drastic mutation!')
  - **How to evaluate competence and efficacy**
  - **What training, supervision and support is needed**
  - **Outcomes** – what should we be measuring and how should we be measuring it?

NEXT STEPS

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- Engage with expert group of health visitors in a consensus building exercise (2 round real-time technological Delphi study)
- Clarify the core components and key clinical activities of a health visitor intervention for mothers with mental health problems that will include consideration of the influence of, and impact on, partners and babies.
- Core components will include essential prerequisites and consideration of context
- Produce a draft intervention framework that is based on evidence from research and evidence from practice and is feasible and acceptable to health visitors.
- Test it out in feasibility / pilot study

THANK YOU

- ANY QUESTIONS?

- Catherine.lowenhoff-2015@brookes.ac.uk

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