A critical review of listening visits in women with postnatal depression

› Abstract

This review explores national guidelines, and women's and health visitors' views on providing listening visits to women with mild-to-moderate postnatal depression. Antidepressants can provide quick relief for symptoms, but many women are reluctant to use medication due to potential side-effects and the impact on breastfeeding. Listening visits are often preferred by women, especially when delivered by an empathetic and intently listening health visitor. Listening visits also provide additional support for women who decline antidepressants, especially in areas with long mental health waiting lists. However, health visitors often feel ill equipped to provide listening visits in practice unless they have undertaken additional training. Guidelines and availability of providing listening visits also varies between clinical commissioning groups, which needs to be addressed.

Key words

› Listening visits › Postnatal depression › Mental health › Health visiting › Cognitive behavioural therapy

Postnatal depression affects 10–15% of women after birth and is triggered by a multitude of factors, including hormonal and biological changes (Royal College of Psychiatrists, 2015). Antenatal depression, combined with previous mental illness and low support, is the biggest risk factor for postnatal depression in women (Milgrom et al, 2008). Other risk factors include stillbirth, primiparity, stressful living conditions, such as poverty or insecure housing, major life events such as bereavements, past or present abuse, low self-esteem, past mental illness and family history of mental health problems (Mind, 2017).

Poor mental health accounts for 9% of maternal deaths in the UK, caused by suicide. Suicide in families leaves long-term implications for the child's wellbeing, attachment and future mental health (MBBRACE-UK, 2016). Untreated postnatal depression can cause long-term attachment difficulties, prevent a good transition to parenthood, cause developmental delays in the child and be a contributing factor in child protection cases (Milgrom et al, 2004; 2006; Hogg, 2013; Smith-Nielsen, 2016). Transition to parenthood and maternal mental health are two of the six high impact areas in health visiting (Public Health England (PHE), 2016).

In the author's locality, listening visits are offered to women who have mild-to-moderate depression or anxiety. This increases the level of service the family receives from Universal to Universal Plus. These listening visits can be used as an intervention on their own or alongside other interventions, such as infant massage from the nursery nurse, medications prescribed by the GP or other psychological treatments, such as Improving Access to Psychological Therapies (IAPT) group courses or individual counselling (NHS England, 2017). Often, these are delivered on a one-to-one basis at 2-weekly intervals until either the depressive symptoms have resolved or more acute mental health input and referral are required (Institute of Health Visiting (iHV), 2014).

Throughout my health visiting training I have observed many listening visits delivered by health visitors. I have witnessed a variety of approaches used during listening visits to give support to women with postpartum depression. These include health visitors who have no additional training, those who use the Solihull approach and those who have had additional training in; counselling, mindfulness, motivational interviewing or cognitive behavioural therapy approaches (iHV, 2014).

While individual practice varies in each area, it appears there is great disparity in the level of service offered to women, which could mean the difference between delivering an excellent service, improving postnatal depression in families or giving poor support to families that has no benefit and is financially inefficient in a struggling NHS.

Angela Willis
Registered midwife, SCPHN (Health Visiting), Great Western Hospital, Swindon
angela.willis5@nhs.net

The evidence base

The National Institute for Health and Care Excellence (NICE) guideline for antenatal and postnatal mental health (NICE, 2014: 31) states that 'all interventions for mental health problems in pregnancy and the postnatal period should be delivered by competent practitioners.' However, the guidelines do not state what makes the practitioner competent. It recommends cognitive behavioural therapy (CBT) and facilitated self-help for mild-to-moderate postnatal depression or anxiety. NICE also states that assessment of the mother–infant relationship is required during all visits and that health professionals should offer advice and support where required. Further interventions may be necessary if problems are observed with bonding and attachment due to poor maternal mental health.

The NICE guidelines should only be used as a tool, as many of the recommendations are open to interpretation. They do not specify what the interventions to improve the infant–maternal relationship may be, nor do they make recommendations for health visitors to undertake listening visits or obtain training in psychological therapies to support women with mild-to-moderate postnatal depression or anxiety.

Cooper et al (2003) undertook one of the first controlled trials exploring psychological treatment for postpartum depression and found that it had short-term benefits for the infant–maternal relationship and attachment in comparison to standard primary care. The authors conclude that health visitors are best placed to deliver a one-to-one support service for women with postpartum depression, and provide cost-effectiveness in primary care treatment in comparison to other psychological treatments, with the same outcomes in short-term infant maternal attachment as specialist counselling services. These outcomes were improved for a period of up to 18 months following the cognitive behavioural interventions.

The PoNDER trial (Morrell et al, 2009) further supports the notion that trained health visitors are best placed to support women using listening visits with mild-to-moderate depression. A total of 4084 women took part in the study and were randomised between 'standard' and 'trained' health visiting care in a person-centred approach or cognitive behavioural approaches. Women received 8-weekly 1-hour visits from the trained health visitors. The results showed that women in the 'trained' health visiting pathway experienced significant improvement in their Edinburgh postnatal depression scores in comparison to the standard care pathway at 6-month follow-up and at 1 year postpartum. A National Institute for Health Research (NIHR) (2017) review both supports this study and recommends that training health visitors in either approach (CBT or person-centred care) is a cost-effective intervention for supporting women with postnatal depression in the community (Morrell et al, 2009).

» A recent study found conflicting evidence about the effectiveness of improving maternal postnatal depression in women using listening visits alone as an intervention «

A more recent study found conflicting evidence about the effectiveness of improving maternal postnatal depression in women using listening visits alone as an intervention. The RESPOND trial (Sharp et al, 2010) randomised 254 women who had major depression in the first 6 months post-birth into two categories: antidepressant prescription (usually SSRIs); or supportive listening visits from the health visitor for 4 weeks. Although initially randomised into either category, the women could change after the first 4 weeks of either intervention. As a result, many of the participants had received a combination of both interventions by the 18-week follow-up.

Sharp et al (2010) found that the use of antidepressant medication led to a significant improvement in maternal mental health in the first 4 weeks of diagnosis in comparison to listening visits. However, many women had worries about administering antidepressant medication, including possible addiction to the medication, side-effects and the stigma attached to using it. By 18 weeks, there was no difference between the two intervention groups, which could be attributed to the fact that many women had received both interventions by this point.

The authors concluded that GPs should offer more treatment options for women who do not want to take antidepressant medication. While the study did not evaluate the methods used during the health visiting listening visits and had no control group, it shows that listening visits can be used alongside antidepressant medication in primary care services.

Women's views of postnatal listening visits

Turner et al (2009) found that women reported listening visits provided by health visitors as

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beneficial to their wellbeing and a way to 'offload' or 'unlock' issues. They responded positively to home visits with a trusted health visitor who listened and provided the opportunity for them to talk, especially about relationships and expectations of themselves, in addition to their relationship with their children and any other concerns they had. This is supported by Seal (2013), who found that women had more positive views of listening visits when health visitors provided empathy and listened intently without problem focusing.

Women felt 'abandoned' once the listening visits were over and felt that eight visits were not sufficient to tackle postnatal depression, which led to starting antidepressant medication during the study period. However, this encouraged some to seek further support from counsellors or their GP after the visit had finished. Listening visits were most effective for women who experienced life events or life changes during the postnatal period. For those who had a history of previous mental health issues, or who had been previously medicated with antidepressants, eight listening visits provided the least benefit.

Shakespeare (2006) interviewed 39 participants and found women with chronic postnatal depression did not find listening visits worthwhile or therapeutic, and more intensive mental health support should be offered in these cases. Shakespeare also found that when women agreed with the diagnosis of having mild-to-moderate postnatal depression, listening visits provided by health visitors were beneficial, especially if the health visitor had a non-judgemental approach, gave time to listen, had a trusting relationship with the family and was approachable. Conversely, due to the stigma attached to postnatal depression, some women found listening visits intrusive, especially when they were unwilling to accept that they had postnatal depression.

Health visitors' views of listening visits

Brown et al (2014) undertook qualitative interviews with health visitors after CBT training for treatment for postnatal depression. Health visitors said they appreciated the training as it allowed them to consider changes in thought processes pivotal to postnatal mood and perception in women with mild-to-moderate postnatal depression. Health visitors also reported that, as CBT training was more cost-effective than prescriptions for antidepressants, a national UK training programme should be implemented to address the disparity between services when delivering listening visits (Brown et al, 2014). There is a growing body of evidence to support the cost-effectiveness of CBT for many disorders including postnatal depression (Wiles et al, 2016; Ammerman et al, 2017).

Health visitors felt that CBT was more complex to learn than person-centred therapy, but that this could be overcome by undertaking the training over a number of days or a week. They also reported that delivering CBT listening visits to women helped to bridge gaps between waiting lists for mental health services and improved relationships with families.

Barriers to providing listening visits

A qualitative study of 13 health visitors explored their views on postpartum anxiety (Ashford, 2017). The participants found there was a lack of specialised mental health service provision in the UK for postnatal anxiety and that it was challenging to differentiate between 'normal' postnatal anxiety in a mother and symptoms that required more specialised interventions.

Health visitors also reported that the disparity in training provided during and after qualification as public health nurses, specifically for the detection and treatment of postnatal depression and anxiety, was inequitable and further increases inequalities between individual health visiting services in the UK. This has an impact on service provision to women with postnatal depression and anxiety between clinical commissioning group (CCG) boundaries and further increases the 'postcode lottery' gap (Brown et al, 2014; Ashford, 2017).

Another barrier reported by health visitors is a lack of time and shortage of health visitors in the UK (Department of Health and Social Care (DHSC), 2011; Brown et al, 2014; Ashford, 2017). In addition, some participants said they did not want to be perceived as a 'counsellor' after completing the CBT training as they felt that this was outside the remit of the health visitor.

Recommendations for practice

- The studies in this critical review have used different protocols to deliver listening visits,

which makes it challenging to standardise care, guide policy making and evaluate primary care services. Some studies used interventions on a monthly basis, while others used weekly listening visits to evaluate the effectiveness of delivering listening visits by health visitors, allowing them to tailor care to the individual family's needs after postnatal depression assessment. Some families benefit from a more intensive service and need weekly listening visits, while others may only require a monthly visit to help reduce their anxieties and stress levels, and provide the opportunity to confide in a trusted professional.

- The differences between NICE guidelines (2014) and the NIHR (2017) report need to be addressed. If listening visits are not commissioned by local authorities, this will create challenges for the health visiting service in providing listening visits to women. Early intervention is paramount to nurturing the mother–infant relationship and attachment; for some mothers who screen positive for mild-to-moderate depression, listening visits provide alternative support and treatment in comparison to antidepressant therapy or group therapies (Turner et al, 2009).
- Health visitors who have additional training in CBT or person-centred approaches ensure the best outcomes for improving mild-to-moderate postnatal depression and anxiety (Shakespeare, 2006; Turner, 2009). As registered health visitors are required to undertake 35 hours of continual professional development (CPD) every 3 years (NMC, 2015), by enrolling on a CBT course we could enhance our skills as to provide the best services to women and families and improve maternal infant relationships. There is a CPD budget in most commissioned healthcare services for health visitors to use, which can fund further relevant studies (Health Education England, 2017).

Conclusion

For women who require antidepressant medication, have a previous history of mental health conditions, or who develop moderate-to-severe postnatal depression or anxiety, collaborative working is key to improving outcomes for both mother and baby from health and safeguarding perspectives (Hogg, 2013; NMC, 2015; MBBRACE-UK, 2016; PHE, 2016; MIND, 2017; NIHR, 2017). In these cases, further interventions and multidisciplinary working may be required and consent from the woman should be sought to make the referral to other agencies.

Key points

- Listening visits provide a choice of treatment and support to women who have mild-to-moderate depression, especially those who decline medications
- Women report that listening visits are beneficial when delivered by empathetic trusting health visitors who listen to them
- Cognitive behavioural therapy (CBT) is a recognised psychotherapy for postnatal depression and health visitors are well placed to provide these interventions
- While health visitors appreciate CBT training and providing listening visits to women; the lack of time and staffing can affect service provision and availability

Communication with other agencies and mental health teams ensures the best treatment for women with mental health conditions to prevent maternal mortalities and improve outcomes for families. If women report mild-to-moderate concerns about their mental health during routine screening, offering listening visits at home provides further support to women and also monitors and reviews mental health and wellbeing; providing early intervention and multidisciplinary support where required (iHV, 2014). JHV

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