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Educating Health Visitors for their new role: psychological interventions

Abstract

This article describes a two day workshop designed around the needs of health visitors in respect of changes to their role. The focus of the training was on psychological interventions including solution focused approaches, the use of empathic relationship, and cognitive behavioural approaches in their widest sense and covered behavioural activation as well as working with negative thoughts. Evaluation both at the end of the workshop and after returning to practice was positive with some health visitors using the techniques taught.

Key words:

1 health visitors

2 psychological interventions

3 attachment

4 cognitive behavioural therapy

5 post natal depression

Box Summarising 5 key areas this Article covers

Key Areas

1 Health visitors require training in a range of psychological interventions

2 Empathic relationships can benefit both mothers and their babies and can be covered in a workshop

3 Health visitors should be introduced to practical techniques that help depressed mothers

4 Health visitors and their clients benefit from a knowledge of solution focused approaches and behavioural activation techniques

Educating Health Visitors for their new role: psychological interventions

Abstract

This article describes a two day workshop designed around the needs of health visitors in respect of changes to their role. The focus of the training was on psychological interventions including solution focused approaches, the use of empathic relationship, and cognitive behavioural approaches in their widest sense and covered behavioural activation as well as working with negative thoughts. Evaluation both at the end of the workshop and after returning to practice was positive with some health visitors using the techniques taught.

Introduction

In 2011 the Department of Health (DH) published the Health Visitor Implementation Plan (DH, 2011a). This document pledged to increase the Health Visiting workforce by 4200 by 2015 and deliver a new and enhanced model of support to families. Educating Health Visitors for a Transformed Service (DH, 2011b) endorsed this and set out a detailed plan to support the preparation of future practitioners, in order for them to fulfil the needs of this new service vision. These requirements are in addition to and do not affect regulatory body requirements (NMC 2004). Many of the content areas highlighted (DH, 2011b) are included in current health visiting programmes and will be familiar to practising health visitors, however the document included a number of new elements designed to enhance the model of support offered to families. All areas link health visiting practice to the goals and evidence of the Healthy Child Programme (DH, 2009).

In December 2011 a group of around 45 health visiting practice teachers from across West Yorkshire were asked to review the requirements as set out in DH (2011b). Their views were sought on what they considered to be the greatest gaps in knowledge and skills within the current health visiting workforce. Practice Teachers have a significant role in the preparation of health visiting students and are responsible for co-ordinating a complex programme of student experiences in clinical practice. They contribute greatly towards the summative assessment of student health visitors (NMC 2004). These expert practitioners are therefore well placed to review and assess current health visiting practice. Their needs are also a priority in terms of developing their own knowledge and skills to reflect the requirements of the new service vision (DH2011a) especially as they are required to role model best practice to student health visitors. Feedback consistently suggested gaps in knowledge and skills around psychological interventions (see Table 1).

Table 1: Health Visitor Skill and Knowledge Gap (Psychological Intervention)
<p>1 Motivating depressed mothers. Depressed mothers frequently lack the inclination to engage with their babies and activities that people normally find rewarding. Both solution focused and motivational interviewing were explored on the workshop.</p> <p>2 Person centred approaches. The need to work collaboratively with mothers according to their individual needs.</p> <p>3 Cognitive behavioural approaches including behavioural activation and working with negative thoughts</p>

This article discusses a training programme which was designed to introduce some basic psychological interventions to qualified health visitors within the Yorkshire and Humber region. It discusses the evidence base of the training programme, the interventions taught and the evaluation that took place following completion of the programme.

Past training initiatives

In recognising the potential of health visitors to support the perinatal mental health of Mums, there have been previous attempts to equip them with the skills to carry out psychological interventions (Holden et al. 1989; Appleby et al .2003; Turner et al. 2010; Morrell et al 2011). Morrell et al (2011) described a programme with the intention of developing person centred counselling and cognitive behavioural skills in health visitors. This programme lasted for five days and was evaluated very positively although the article did not describe whether such an investment resulted in benefits mothers and their families

Designing the current training programme (Yorkshire and Humber)

Yorkshire and Humber commissioned a two day training programme based on the curriculum topics identified in *Educating health visitors for a transformed service* (DH, 2011a). Previous research on post natal depression suggested that psychological interventions may be of use to mothers with depression (see Sockol; et al. 2011 for a review). Previous training has focused on various psychological interventions, ranging from training in how to conduct listening visits with an emphasis on non directive counselling (Turner et al 2008) through to brief cognitive behavioural counselling (Appleby et al 2003;

Morrell et al, 2011). Other psychological interventions recommended in the Nice Guidelines (National Collaborating Centre for Mental Health, 2007) are quite complex or lengthy (ie interpersonal therapy) and not considered as an intervention that can be taught on a two day programme for health visitors. Senior health visitors were interviewed as to what they considered were the greatest gaps in knowledge and skills within the current health visitor workforce. Feedback consistently suggested the areas in Table 1.

A pilot two day programme was run with a group of experienced health visitors who had the role of practice facilitators and confirmed the appropriateness of the content and method. This workshop was well received and helped identify the constraints on health visitors in performing the more complex behavioural interventions. These constraints are discussed later in this article. Following this and with minor adjustments, additional workshops were facilitated and over 300 health visitors have attended with these being positively evaluated. A follow up by one of the authors (Ellis) suggested some application of learning to client work with some benefits experienced.

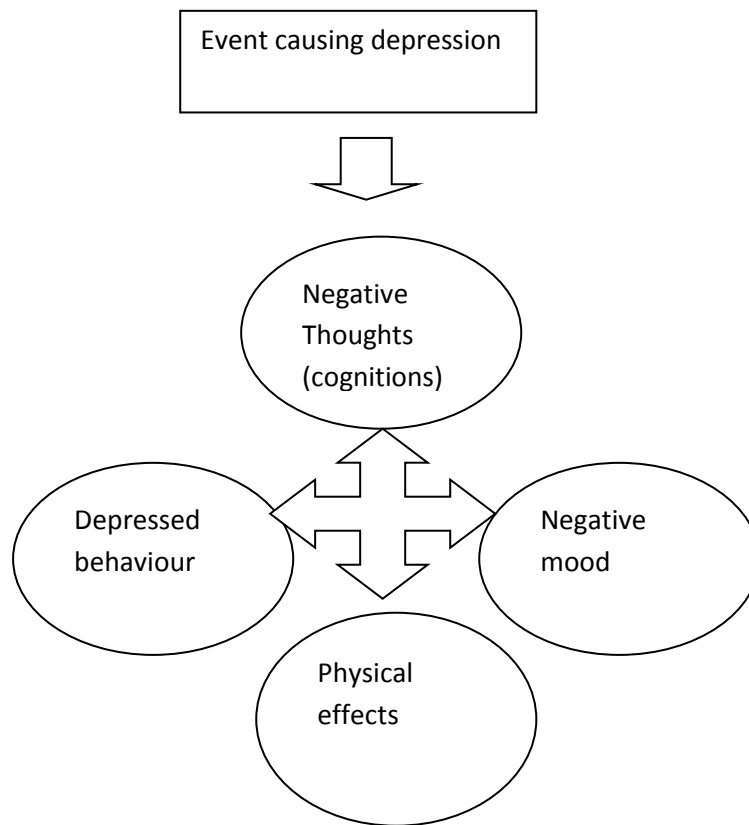
Workshop Content

This consisted of a balance between theory and practice, both of which had a firm rooting in empirical research. Given the lack of research involving health visitors and psychological work, the content was informed by considering research on therapeutic alliance and what works with people who are depressed. Content was designed by considering what works with people who are mildly or moderately depressed and especially what may be considered as appropriate strategies for health visitors to use especially given their time constraints and limited contact with mothers. O'Mahen et al's recent qualitative study (O'Mahen, 2012) suggests the areas that many depressed mothers found of help.

It made sense to start the workshop by re-examining what helps with relationship building especially with mothers who may have their own attachment difficulties ie insecure, ambivalent or disorganised (Ainsworth et al. 1978). Bordin's work on establishing a focus through agreeing a purpose is still relevant today and especially helpful for health visitors who have a desire for structure in their work (Bordin, 1979). A recent review by Smith and Horne (2012) emphasised the benefits of focus through collaborative work. This part of the workshop validates what many health visitors already do and provides a good base to extend the health visitor's knowledge and skill. The oft mentioned skill of empathy, which many health visitors demonstrate, is receiving increased interest due to research revealing that neurological changes are facilitated through the provision of empathy. Switched off parts of the brain associated with attachment are triggered within a context of an empathic relationship (Schoore, 2011).

In addition, focus and purpose are facilitated through the application of the 'Five Systems Approach' to working with mothers who are depressed and anxious. The 'Five Systems Approach' was elaborated by Greenberger and Padesky (1995) and applied to post natal depression by Williams et al (2009); see diagram 1. If nothing else, health visitors have found this model especially useful for their work with depressed mothers. The use of simple models increase the likelihood of engagement because it allows both health visitors and mothers to share and understand their experience of post natal depression and anxiety.

Diagram 1: The Five Systems Model



Sharing, and understanding the '5 Systems Model' is often enough to generate a "sudden gain" where there is a sudden improvement in mood in mothers who are depressed and often predicts future improvement (Hunnicut-Ferguson et.al, 2012; Tang and DeRubeis et.al, 2007). Research points towards early work as the facilitator of this sudden shift, and has appeal to the 'time-poor' health visitor. The message being that work can be undertaken by a health visitor very early in the relationship that potentially steers the client to self maintain improvement.

The workshop covers both cognitive and behavioural parts of the cognitive behavioural approach. Behavioural activation as an intervention has a strong evidence base (Cuijpers, et.al, 2007; Martell et al. 2010) and one that has much to offer health visitors in their work with mothers (O'Mahen et al, 2012). Behavioural activation is recognised as a particularly important strategy in helping post natal depression, as it is associated with reduced activity. When depressed mothers stop doing things they get even more depressed. Health visitors easily see the link between reduced activity and depression and can share this with their mothers. Encouraging mothers to “pick up activities where they left off” can result in a positive shift in mood. It is a relatively safe and effective intervention, which although simple to understand requires a certain amount of health visitor effort in motivating mothers to get active. Thus, the workshop also covers methods of motivating people including a consideration of the thoughts that block behaviour or task completion (Beck, 1979).

Health visitors and their clients are quick to grasp the various types of thoughts that demotivate their clients and these have a long history of being described in depression (Beck, 1979; Beck, 2011; Burns, 1998). These thoughts lead to avoidance because they usually involve predicting something awful is to happen or will make them feel worse. O'Mahen (2012) articulates well the circumstances around birth which generate particular negative thoughts such as “I expected to immediately fall in love with baby and this didn't happen”, “Other Mums cope much better than I do”.

At this point, the health visitor enters the most complex part of the workshop, where they are taught to facilitate a counter-arguments to the negative thoughts that ‘swamp’ a mother's mind and which, if left alone, result in depression and anxiety. The interventions

taught are cognitive approaches. At the simplest level, health visitors can use their questioning skills to invite scepticism, and if undertaken diplomatically can help Mums question their own beliefs. Table 2 provide examples of useful questions.

Table 2: Examples of Guided Questions
“How do you know that if you took baby out in a pram you would feel worse?”
“What makes you think you are a lousy Mum?”
“What has led you to know that no other Mum feels the way you do?”
“What facts support your thought that baby would be better off with another family?”

Another useful intervention is to write down a clients thoughts - this operationalises the 'Five Systems Model'. When writing down clients responses the health visitor can note unrealistic thoughts under a thoughts column. Seeing these written in black and white can help a mother distance herself from her thoughts and this also invites scepticism or 'mindfulness': “Is this thought about being a poor Mum, really true?” Such distancing or decentring is an intervention that is found to be very helpful in both depression and severe anxiety (Butler et.al,2008).

A more advanced process for working with cognitions is the use of thought records. There are various models for recording and challenging thoughts, some are quite complicated and some are easy to follow. Used correctly they can greatly improve a person’s mood

(Greenberger and Padesky, 1995; Beck 2011) and once learned mothers can use thought records to improve their mood in the absence of the health visitor. Health visitors sometimes question whether they have the level of training to use these and they have a point here. The argument for supporting their use lies in the knowledge that many respected self help books contain chapters on these (Burns, 1998; Greenberger and Padesky, 1995,; Williams et. al, 2009) but with the input of a professional this must be more beneficial. Some health visitors are already making use of self help books and self help websites that facilitate this. This said, the implication is that health visitors should be accessing advanced skills training in order to use thought records effectively with the minimum of risk to mothers.

There is also a neuroscience behind encouraging health visitors to engage in cognitive work. Parts of the brain associated with stress (the limbic system) are overactive at the expense of those parts of the brain (the cortex) that give mothers a sense of control resulting in a depressed and anxious mother whose attachment hormones (oxytocin) are displaced by stress hormones (Kumsta and Heinrichs, 2013; Pierrehumbert et.al, 2012). The aim is to eliminate or at least reduce negative thoughts and in so doing improve mood and reduce stress putting a mother in a better position to attune and attach to their infants. This shift between the different parts of the brain (Mind over Mood) is made possible through cognitive interventions (Bannick, 2012).

The neuroscience aspects of the workshop are well received. Some of the reasons for this is that there is emerging research that considers the impact of low oxytocin and dopamine on the mother's attachment behaviour and the corresponding impact on the child. Hughes and Baylis (2012) offer fascinating insights into brain changes following childbirth and how

various psychological interventions can stimulate parts of the mother's brain associated with empathy, attunement, and an empathic and caring capacity. These aspects are covered, albeit briefly, on the workshop.

The practical approach in the workshop is, not surprisingly, popular with health visitors. Problem solving therapy (Nezu et. al, 2013) offers health visitors insights into the benefits of working productively with mothers whose minds are crammed with countless and often poorly articulated problems. The liberating process of clearly defining and prioritising the problems in itself can improve a person's mood and reduce anxiety. Problem solving therapy has a good evidence base (Nezu et.al, 2013) although not as yet considered specifically with post natal depression.

Problem solving and solution focused work sit well with each other. Solution focused work offers a hopeful and empowering approach and has been employed within a community setting (Simm et. al, 2011). Goal setting in itself is motivational (Reeve, 2009) and the set of techniques described under the banner of motivational interviewing are often embraced by health visitors. Health visitors are often practical in approach and undertake complex challenges that transpire from working with poorly motivated mothers.

Problem solving strategies employed with mothers can also offer opportunities for decentring from painful thoughts. Health visitors helping mothers to externalise what is going 'round and round' in their heads are helping them de-clutter their client's minds are freeing up energy to be invested in parenting (Nezu et.al, 2013). Simply working with a mother to prioritise their problems and to brain storm solutions can lead to a sudden improvement in mood and a reduction in anxiety.

Methods of training

A variety of teaching methods are employed over the two days. The start of the training models a collaborative approach where health visitors' expectations are brought into the open. PowerPoint presentations offer the evidence base for many of the interventions described. The most engaging part of the workshop is the employment of service users in both role play and presentation. Service users help demonstrate the 'Five Systems Model' and offer insights into what mothers with post natal depression find useful. The personal journey from depression through to recovery is quite an emotional one and health visitors evaluate this section as being very helpful. Service user input requires sensitive and ethical management, but is more than worth the effort, participants are afforded a powerful insight and service users gain from knowing that their painful experience has been listened to and made a difference.

Evaluation

As this article is written, one of our colleagues (Ellis) is progressing a robust evaluation of the impact of this training. This will further consider what practical benefits such training has had on the work of the health visitor.

Conclusion

Despite its positive evaluation there are flaws in the training. Two days is far too short to deliver the competencies required to deliver in depth psychological interventions for helping depressed or anxious mothers. Cognitive behavioural approaches alone consist of a wide variety of techniques and it is still not known which particular ones have the greatest effect. Health visitors in their feedback find all the techniques of use but it is noticeable that their level of interest is at its highest when problem solving and solution focused techniques are covered. Sockol et. al (2010) in their meta analysis of treatments for perinatal depression are unable to conclude whether CBT is any better than any other psychological approaches with mothers. All this said, it is difficult not to conclude that the workshops are a very useful introduction to the potential benefits of training in psychological interventions.

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